# APPENDIX

## Public Board Meeting

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
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<tr>
<td>Appendix 1</td>
<td>Trust Balanced Scorecard for December 2019 (Agenda Item 6a)</td>
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</table>
RNOH TRUST BALANCED SCORECARD

FY: 2019 - 20

Indicators are measured against Target e.g. Hand Hygiene = 100%
Some indicators have an Amber Threshold value e.g. Hand Hygiene target = 100%, Threshold = 90%; Performance between the two will result in an Amber Status
(Targets may be internal or external, this is indicated on the chart for each indicator)

Indicators' Statuses are calculated as follows:

<table>
<thead>
<tr>
<th>Indicator on:</th>
<th>Month and Overall Status calculation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Month: Actual vs Month Target/Month Amber Threshold; Overall: YTD Actual vs YTD Target/YTD Amber Threshold</td>
</tr>
<tr>
<td>Annual Target</td>
<td>Month: YTD Actual vs Month Target/Month Amber Threshold; Overall: YTD Actual vs Month Target/Month Amber Threshold</td>
</tr>
</tbody>
</table>

Variance is measured like Month Status above against Target
Following month Forecast is measured against Target when the number is provided, otherwise it is a qualitative assessment provided by indicator lead.

DQA (Data Quality Assurance) RAG Rating

- Assurance in data quality and completeness
- Gaps identified in data quality and completeness
- Significant gaps identified in data quality and completeness

YTD (Year To Date) Chart Legend: Target Actual SPC Average (24 mth)

Indicators marked with an * provide figures for previous month(s)
Indicators marked with an ** are on the Annual Target; all the rest are on the Monthly Target
Indicator definitions and the list of abbreviations can be found at the end of the report
UCL and LCL are based on 3 standard deviations; 1st-2nd-3rd standard deviation is marked as coloured area;
SPC CHARTS

Statistical process control - A method to support the robust statistical interpretation of measures presented over time and to understand if your process has special cause and/or common cause variation.

XmR chart - The XmR chart has two parts. The X-chart displays the data points over time together with a calculated average. The calculated average is then used to calculate the upper and lower process limits. The moving range (mr) chart shows the difference between consecutive observations and is recorded as a positive number. The average is displayed and then used to calculate the upper/lower process limits.

Time series - Values of a quantity obtained at successive times, often with equal intervals between them.

Mean line - Represents the arithmetic average data plotted on the chart.

Control limits - Two lines, one above and one below the average line, which define the variation of the dataset. Also known as process limits. 99% of data should fall within the process limits.

Upper/Lower Control limit the lines above/below the average line (mean), define the upper/lower boundary of expected variation.

Rebasings - Redrawing the reference lines on the chart to reflect a change in the system.

Variation:

- Common cause variation - Also known as Random variation, periodic changes in the data that are predictable and expected.
- Special cause variation - Changes in the data that are unpredictable and unexpected.
- Shift - A special cause variation defined by a run of seven or more consecutive points above or below the mean.
- Trend - A special cause variation defined by a run of six or more consecutive points increasing or decreasing. It does not matter where the run starts or finishes in relation to the mean line.

Outlier - A single point above or below the control limits.
**OVERALL COMMENTARY - ACCESS TO SERVICE**

All cancer access standards except the 62 day referral to treatment standard were achieved in November. The 31 day first treatment and 31 day subsequent treatment was 100%. Performance against the two week wait target was above trajectory with a performance of 97.7%. The 62 day referral to treatment target was missed with a performance of 40% against the 85% target. The Trust had low treatment numbers in November (2.5 accountable treatments, of which 1.5 breached the 62 day target) which drives the low performance figure. The two patients that breached the standard were as a result of a capacity constraints in biopsy and an administrative error which meant that the Trust had not recorded the cancer pathway start date correctly for a patient that was transferred into RNOH. A further treatment was confirmed after the reporting window had closed which improved the Trust performance to 57.1%. This improvement will be reflected in the Trust performance at the end of the quarter when all cancer data is resubmitted.

The diagnostic wait standard returned to compliance in November, with a performance of 99.6%.

In November, the Trust achieved 86.45% against the Referral to Treatment standard. This was a deterioration in performance from October (87.67%). The total number of backlog pathways increased from 766 in October to 839 in November.

Performance against this standard has been an outlier for the last three months, primarily as a result of changes to staffing in the Pain Management team, leading to reduced outpatient capacity and increased waiting times for new appointments. The RIT backlog for this service increased from 153 in October to 177 in November.

It was set out in the 2018/19 Refreshing NHS Plans guidance that the size of the Trust RIT waiting list should be no higher at the end of the financial year than at the beginning of the financial year 2018/19, and where possible, it should be reduced. This expectation continues into 2019/20. The total waiting list size in March 2018 was 6044 and this continues to be the benchmark the Trust is measured against nationally for the 2019/20 year. There was a very small reduction in pathways in November; from 6214 in October to 6190.

Whilst below 92%, the Trust is performing similarly when compared with other standalone specialist orthopaedic trusts (RNOH 86.4%, ROH 84.0% and RIAH 88.1%). For T&O specifically, RNOH performs at 87.4%, materially better than mean 81.7% (England) and 80.5% (London). (November comparison data).
OVERALL COMMENTARY - WORKFORCE

Current Performance: - This month has seen a favourable increase of 1.52% in the appraisal compliance rate. This takes the appraisal rate back into the threshold of the Trust following a decline last month.
- Core Skills Training Compliance is on a steady figure of 86.71%. The Learning and Development Service continues to ensure the correct staff are attached to the appropriate learning competency on ESR with the support of the subject of the SMEs and Professional Leads.
- The temporary staffing % of total workforce has marginally increased this month by 0.09% and remains within the Trust threshold. In addition agency usage for December has decreased month on month. This is the seventh drop in a row and a 10% decrease since the start of the financial year. This is possibly due to the new rules from NHSI on booking admin staff and the Xmas break in December.
- The rate for sickness absence has marginally increased this month by 0.09% and remains within the Trust threshold.
- The vacancy rate has continued its downward trend and has fallen to below 10% for the first time since June 2018.

Risks and Issues: - Despite the increase in the appraisal rate it is important for managers to continue to work with staff to complete appraisals in a timely way.
Appraisal meetings are essential interactions between managers and their staff.
- Quality Assurance Process has been set up with regular meetings with SMEs and Professional Leads for the subject areas looking at the monthly compliance data, delivery plan over the next financial year and well as any additional support that maybe required for the following quarter.
- We are continuing to work with our most accessed Agencies and challenge them to assist with filling day shifts for Nursing in particular.
- Trust continues to implement an efficiency programme increasing completions via e-learning, and encouraging staff to complete training, where possible, before joining the Trust.
- An increase in the sickness absence rate for the winter months is expected due to health problems being triggered or worsened by cold weather and the outbreak of influenza.

Actions this month: - To continue highlighting hotspots to the Divisional Leadership Teams to assist with increasing the appraisal compliance figure. Appraisal training to help support managers in the Trust’s process and increase the quality of the discussion and output.
- Further development has taken place to accept Inter Authority Transfer (IAT), these transfer’s will allow mandatory competencies to be transferred and will help to remove duplicate training.
- We are assessing all the framework agencies with a view to reducing the volume of those being used to increase new lines of work and to encourage added consistency with those staff being used.
- To assist with Retention a career clinic is taking place with staff offering professional career advice to help retain staff, also a review of the exit interview form and
OVERALL COMMENTARY - DIGITAL SERVICES

The KPI performance for December overall showed a continuing trend of targets being maintained. The only issue was that the target for SLA performance was not achieved. Unfortunately it was also below the tolerance level.

Coding performance has been maintained with the major performance target for the Freeze date being at 100%. There are now 2 vacancies within the department but processes have been put in place to ensure that the risk to any financial loss is mitigated. Recruitment is underway and until the recruitment is completed these mitigating actions will be maintained.

Targets for Appraisals and Mandatory Training have been met with Appraisals achieving 100% and Mandatory Training at 99%.

Other than an outage to N3 services which was outside of our control the Clinical and Non-Clinical applications plus the Digital Infrastructure maintain vary high levels of performance. Over the Christmas period the usual change freeze was imposed to ensure that there were no interruptions to services during a period when supplier and internal resource availability is limited.

It is also pleasing the report that the number of outstanding tickets have been reduced this month. This had been outside of target for the previous month. The stability of the systems and infrastructure during the month allowed more calls to be cleared and closed. Our customer satisfaction rating was at 100% for the second month running. It is pleasing that the service is well received by Trust staff.

The roll out of Windows 10 has commenced. The expectation is that this will be completed by 31st March 2020. This will provide staff with a modern look and feel and improved performance. This means also that Office 2010 will be replaced with Office 2016 with eLearning materials available to help staff familiarise themselves with the changes.

A pilot of the replacement for Emergency Bleeps using Vocera commenced. This is being run in parallel with the existing bleep system with the intention of ensuring a smooth transition to Vocera once the pilot has been completed.
OVERALL COMMENTARY - ESTATES, FINANCE REPORTS

Estates:

No buildings were lost due to infrastructure failure in this quarter. 

The capital allocation for backlog maintenance works was increased therefore the % committed for this quarter cumulative from April to December 2019 was 97.72% of the allocated budget.

Finance Reports:

Please see Finance Director’s report for further information.
<table>
<thead>
<tr>
<th>Clinical Quality</th>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. F&amp;F – Patients who would recommend the Hospital - Effective</td>
<td>96.1%</td>
<td>96.7%</td>
<td>&gt;= 97.0%</td>
<td>&gt;= 95.0%</td>
<td>2 h Caring</td>
<td>within Threshold within Threshold</td>
<td>17</td>
<td>PF</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>2. Paed F&amp;F – Patients who would recommend the Hospital</td>
<td>93.7%</td>
<td>94.4%</td>
<td>&gt;= 97.0%</td>
<td>&gt;= 95.0%</td>
<td>2 h Caring</td>
<td>Target not met Target not met</td>
<td>17</td>
<td>PF</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>3. Complaints - Rate per 1000 bed days - Effective</td>
<td>2.5</td>
<td>1.7</td>
<td>&lt;= 1.5</td>
<td>&lt;= 1.7</td>
<td>2 h Caring</td>
<td>Target not met Target not met</td>
<td>18</td>
<td>PF</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>4. Mixed Sex Accommodation Breaches - Effective</td>
<td>118</td>
<td>18</td>
<td>0</td>
<td>&lt;= 2</td>
<td>2 h Caring</td>
<td>Target not met Target not met</td>
<td>18</td>
<td>PF</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>5. Length of Stay - Effective</td>
<td>83.5%</td>
<td>80.2%</td>
<td>&gt;= 88.0%</td>
<td>&gt;= 86.0%</td>
<td>2 h Effective</td>
<td>Target not met Target not met</td>
<td>19</td>
<td>PF</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>6. Discharges in Time for Lunch - Effective</td>
<td>9.8%</td>
<td>10.9%</td>
<td>&gt;= 13.6%</td>
<td>&gt;= 11.6%</td>
<td>1a Effective</td>
<td>Target not met within Threshold</td>
<td>19</td>
<td>PF</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>7. Discharge Experience - Effective</td>
<td>91.7%</td>
<td>94.9%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 90.0%</td>
<td>2 h Caring</td>
<td>within Threshold within Threshold</td>
<td>20</td>
<td>PF</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>8. Patient Perception of Nurse Staffing Levels - Effective</td>
<td>91.4%</td>
<td>88.1%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 85.0%</td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>20</td>
<td>PF</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>9. Never Events - Safe</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>21</td>
<td>PF</td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>10. Clinical Incidents - Rate per 1000 bed days - Safe</td>
<td>55.0</td>
<td>58.3</td>
<td>&gt;= 40.0</td>
<td>&gt;= 30.0</td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>21</td>
<td>PF</td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>11. Paediatric Clinical Incidents - Rate per 1000 bed days</td>
<td>24</td>
<td>27</td>
<td>&gt;= 40</td>
<td>&gt;= 30</td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>22</td>
<td>PF</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>12. % of Clinical Incidents with Significant Harm (all patients) - Safe</td>
<td>1.9%</td>
<td>1.7%</td>
<td>&lt;= 1.5%</td>
<td>&lt;= 3.0%</td>
<td>2 h Safe</td>
<td>within Threshold within Threshold</td>
<td>22</td>
<td>PF</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>13. Rate of Incidents with Feedback to Reporter - Safe</td>
<td>82.7%</td>
<td>92.3%</td>
<td>&gt;= 75.0%</td>
<td>&gt;= 60.0%</td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>23</td>
<td>PF</td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>14. Safety Thermometer - RNOH Acquired Harms - Safe</td>
<td>2.2%</td>
<td>0.8%</td>
<td>&lt;= 5.0%</td>
<td>&lt;= 5.60</td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>23</td>
<td>PF</td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>15. Trips and Falls - Rate per 1000 Bed Days</td>
<td>3.61</td>
<td>4.45</td>
<td>&lt;= 5.04</td>
<td>&lt;= 5.60</td>
<td>2 h Safe</td>
<td>Target not met Target met</td>
<td>24</td>
<td>PF</td>
<td></td>
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<td>24</td>
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### BALANCED SCORECARD

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<tr>
<th>Clinical Quality</th>
<th>Status YTD</th>
<th>Status Month</th>
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<th>Lead</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Pressure Ulcers (Grade 1 &amp; 2) - Safe</td>
<td>3</td>
<td>0</td>
<td>&lt;= 3</td>
<td>&lt;= 5</td>
<td></td>
<td>2h Safe</td>
<td>Target met</td>
<td></td>
<td></td>
<td>PF</td>
<td>24</td>
</tr>
<tr>
<td>17. Pressure Ulcers (Grade 3 &amp; 4) - Safe</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>&lt;= 1</td>
<td></td>
<td>2h Safe</td>
<td>Target met</td>
<td></td>
<td></td>
<td>PF</td>
<td>24</td>
</tr>
<tr>
<td>18. Pressure Ulcers (Device Related) - Safe</td>
<td>4</td>
<td>6</td>
<td>&lt;= 4</td>
<td>&lt;= 6</td>
<td></td>
<td>2h Safe</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>PF</td>
<td>25</td>
</tr>
<tr>
<td>19. Planned vs Actual Staffing - Nursing</td>
<td>95.3%</td>
<td>94.0%</td>
<td>100.0%</td>
<td>&gt;= 95.0%</td>
<td></td>
<td>2h Safe</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>PF</td>
<td>25</td>
</tr>
<tr>
<td>20. Mortality Rate - Safe *</td>
<td>0.2%</td>
<td>0.0%</td>
<td>&lt;= 1.0%</td>
<td></td>
<td></td>
<td>2h Effective</td>
<td>Target met</td>
<td></td>
<td></td>
<td>PF</td>
<td>26</td>
</tr>
<tr>
<td>21. Clostridoides Difficile - Infection</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&lt;= 1</td>
<td></td>
<td>2h Effective</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>PF</td>
<td>26</td>
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<tr>
<td>22. Gram Negative Blood Stream Infection</td>
<td>4</td>
<td>1</td>
<td>&lt;= 4</td>
<td>&lt;= 5</td>
<td></td>
<td>2h Effective</td>
<td>Target met</td>
<td></td>
<td></td>
<td>PF</td>
<td>27</td>
</tr>
<tr>
<td>23. Hand Hygiene</td>
<td>94.8%</td>
<td>90.4%</td>
<td>&gt;= 98.0%</td>
<td>&gt;= 95.0%</td>
<td></td>
<td>2h Safe</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>PF</td>
<td>27</td>
</tr>
<tr>
<td>24. Paediatric Hand Hygiene</td>
<td>90.7%</td>
<td>79.0%</td>
<td>&gt;= 98.0%</td>
<td>&gt;= 95.0%</td>
<td></td>
<td>2h Safe</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>PF</td>
<td>28</td>
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## BALANCED SCORECARD

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<tr>
<th>Access to Services</th>
<th>Status YTD</th>
<th>Status Month</th>
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<th>Amber Threshold</th>
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</tr>
</thead>
<tbody>
<tr>
<td>25. Referral to Treatment Open Pathways *</td>
<td>88.2%</td>
<td>86.4%</td>
<td>&gt;= 92.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target not met Target not met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>26. Paediatric Referral to Treatment Open Pathways *</td>
<td>95.2%</td>
<td>94.2%</td>
<td>&gt;= 92.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>27. Diagnostic Waits *</td>
<td>99.3%</td>
<td>99.6%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>28. Cancer 2 Week Wait Standard *</td>
<td>96.1%</td>
<td>97.7%</td>
<td>&gt;= 93.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>29. Paediatric Cancer 2 Week Wait Standard *</td>
<td>&gt;= 93.0%</td>
<td></td>
<td></td>
<td></td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>30. Cancer 31 day diagnosis to first treatment standard *</td>
<td>97.2%</td>
<td>100.0%</td>
<td>&gt;= 96.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>31. Cancer 31 day wait for subsequent treatment standard *</td>
<td>96.7%</td>
<td>100.0%</td>
<td>&gt;= 94.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>32. Cancer 62 day standard referral to treatment standard *</td>
<td>80.5%</td>
<td>40.0%</td>
<td>&gt;= 85.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target not met Target not met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>33. Clinical Letters Completed on Target</td>
<td>&gt;= 80.0%</td>
<td></td>
<td>&gt;= 75.0%</td>
<td></td>
<td>2h Responsive</td>
<td>Target not met Target not met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>34. Clinic Percentage On Time Starts</td>
<td>91.4%</td>
<td>92.4%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 88.0%</td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>35. Theatre Capacity/ Session Uptake</td>
<td>89.2%</td>
<td>83.9%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 84.0%</td>
<td>Responsive</td>
<td>Target not met within Threshold</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>36. Intra-session Theatre Utilisation</td>
<td>85.6%</td>
<td>83.5%</td>
<td>&gt;= 85.0%</td>
<td>&gt;= 80.0%</td>
<td>Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>37. Children's HDU Utilisation</td>
<td>59.5%</td>
<td>46.8%</td>
<td>&gt;= 50.0%</td>
<td>&gt;= 40.0%</td>
<td>Effective</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>36</td>
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</tr>
<tr>
<td>38. Contact Centre Incoming Telephone Call Responsiveness</td>
<td>85.4%</td>
<td>85.0%</td>
<td>&gt;= 80.0%</td>
<td>&gt;= 75.0%</td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>36</td>
<td></td>
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<tr>
<td>39. Non-Contact Centre Incoming Telephone Call Responsiveness</td>
<td>71.7%</td>
<td>63.7%</td>
<td>&gt;= 70.0%</td>
<td>&gt;= 60.0%</td>
<td>2h Responsive</td>
<td>Target met Target met</td>
<td>● ●</td>
<td>● ●</td>
<td>LD</td>
<td>37</td>
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</table>
## BALANCED SCORECARD

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>40. Established Posts (Wte)</td>
<td>1595</td>
<td>1592</td>
<td>&lt;= 1617</td>
<td>&lt;= 1642</td>
<td></td>
<td>Well-led</td>
<td>Target met</td>
<td></td>
<td></td>
<td></td>
<td>TN 39</td>
</tr>
<tr>
<td>41. No of Staff WTE (excl. bank and agency)</td>
<td>1418.4</td>
<td>1432.7</td>
<td>&lt;= 1365.0</td>
<td>&lt;= 1390.0</td>
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<td>Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
<td></td>
<td>TN 39</td>
</tr>
<tr>
<td>42. Vacancy Rate (%)</td>
<td>11.1%</td>
<td>10.0%</td>
<td>&lt;= 9.5%</td>
<td>&lt;= 11.5%</td>
<td></td>
<td>Well-led</td>
<td>within Threshold</td>
<td></td>
<td></td>
<td></td>
<td>TN 40</td>
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<tr>
<td>43. Retention Rate</td>
<td>87.8%</td>
<td>87.9%</td>
<td>&gt;= 88.5%</td>
<td>&gt;= 87.5%</td>
<td></td>
<td>Well-led</td>
<td>within Threshold</td>
<td></td>
<td></td>
<td></td>
<td>TN 40</td>
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<tr>
<td>44. Temporary Staffing as a % of Total Workforce</td>
<td>7.6%</td>
<td>6.0%</td>
<td>&lt;= 10.0%</td>
<td>&lt;= 11.0%</td>
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<td>Well-led</td>
<td>Target met</td>
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<tr>
<td>45. Agency as a % of Temporary Staffing Usage</td>
<td>17.9%</td>
<td>9.0%</td>
<td>&lt;= 30.0%</td>
<td>&lt;= 33.0%</td>
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<td>Target met</td>
<td></td>
<td></td>
<td></td>
<td>TN 41</td>
</tr>
<tr>
<td>46. Appraisal rates</td>
<td>78.2%</td>
<td>82.4%</td>
<td>&gt;= 92.0%</td>
<td>&gt;= 82.0%</td>
<td></td>
<td>Well-led</td>
<td>within Threshold</td>
<td></td>
<td></td>
<td></td>
<td>TN 42</td>
</tr>
<tr>
<td>47. Medical Staff Appraisal (%)</td>
<td>95.7%</td>
<td>93.1%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 92.0%</td>
<td></td>
<td>Well-led</td>
<td>within Threshold</td>
<td></td>
<td></td>
<td></td>
<td>TN 42</td>
</tr>
<tr>
<td>48. Core skills training compliance (%)</td>
<td>86.4%</td>
<td>86.7%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 85.0%</td>
<td></td>
<td>Well-led</td>
<td>within Threshold</td>
<td></td>
<td></td>
<td></td>
<td>TN 43</td>
</tr>
<tr>
<td>49. Sickness Absence (%) *</td>
<td>3.4%</td>
<td>3.4%</td>
<td>&lt;= 3.0%</td>
<td>&lt;= 4.0%</td>
<td></td>
<td>Well-led</td>
<td>within Threshold</td>
<td></td>
<td></td>
<td></td>
<td>TN 43</td>
</tr>
<tr>
<td>Research &amp; Innovation</td>
<td>Status YTD</td>
<td>Status Month</td>
<td>Month Target</td>
<td>Amber Threshold</td>
<td>12 Month Rolling</td>
<td>Trust Objective &amp; CQC Domain</td>
<td>Summary YTD/Month</td>
<td>Forecast</td>
<td>DQA</td>
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<td>-----------------------------------------------------------</td>
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</tr>
<tr>
<td>50. Research - Protocol violations and deviations</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>&lt;= 2</td>
<td></td>
<td>4l Well-led</td>
<td>Target met within Threshold</td>
<td>IH</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. Research - Recordable adverse events</td>
<td>15</td>
<td>3</td>
<td>0</td>
<td>&lt;= 3</td>
<td></td>
<td>4l Well-led</td>
<td>Target met within Threshold</td>
<td>IH</td>
<td>45</td>
<td></td>
<td></td>
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<tr>
<td>52. Patient Follow Up Visits</td>
<td>1184</td>
<td>107</td>
<td>&gt;= 40</td>
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<td></td>
<td>4l Well-led</td>
<td>Target met Target met</td>
<td>IH</td>
<td>46</td>
<td></td>
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</tr>
<tr>
<td>53. Research - Projects Submitted per Month</td>
<td>3</td>
<td>5</td>
<td>&gt;= 3</td>
<td></td>
<td></td>
<td>4l Well-led</td>
<td>Target met Target met</td>
<td>IH</td>
<td>46</td>
<td></td>
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<tr>
<td>54. Research - New patients recruited</td>
<td>343</td>
<td>51</td>
<td>&gt;= 25</td>
<td>&gt;= 20</td>
<td></td>
<td>4l Effective</td>
<td>Target met Target met</td>
<td>IH</td>
<td>47</td>
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<tr>
<td>IM&amp;T</td>
<td>Status YTD</td>
<td>Status Month</td>
<td>Month Target</td>
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<td>Trust Objective &amp; CQC Domain</td>
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<td>------</td>
</tr>
<tr>
<td>55. Coding Completeness (end of 3rd working day)</td>
<td>89.1%</td>
<td>87.9%</td>
<td>&gt;= 85.0%</td>
<td>&gt;= 80.0%</td>
<td>1g Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
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<tr>
<td>56. Coding Completeness (mid-month flex) *</td>
<td>100.0%</td>
<td>100.0%</td>
<td>&gt;= 98.0%</td>
<td>&gt;= 95.0%</td>
<td>1g Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>49</td>
</tr>
<tr>
<td>57. Coding Completeness at freeze date *</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>&gt;= 99.0%</td>
<td>1g Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
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<tr>
<td>58. Mandatory Submissions Compliance</td>
<td>99.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>&gt;= 95.0%</td>
<td>2j Effective</td>
<td>Target met within Threshold</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>50</td>
</tr>
<tr>
<td>59. Clinical Systems Availability</td>
<td>99.9%</td>
<td>99.9%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>51</td>
</tr>
<tr>
<td>60. Non-Clinical System Availability</td>
<td>100.0%</td>
<td>100.0%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>51</td>
</tr>
<tr>
<td>61. Infrastructure Availability</td>
<td>99.9%</td>
<td>100.0%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>52</td>
</tr>
<tr>
<td>62. Number outstanding IT Service Desk Calls at month end</td>
<td>198</td>
<td>163</td>
<td>&lt;= 200</td>
<td>&lt;= 220</td>
<td>2j Effective</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>52</td>
</tr>
<tr>
<td>63. Service Level Agreement Achieved</td>
<td>95.9%</td>
<td>89.0%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 90.0%</td>
<td>2j Effective</td>
<td>Target not met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>53</td>
</tr>
<tr>
<td>64. Customer Satisfaction</td>
<td>97.2%</td>
<td>100.0%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 85.0%</td>
<td>Responsive</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>53</td>
</tr>
<tr>
<td>65. Digital Services Appraisal Rate</td>
<td>95.2%</td>
<td>100.0%</td>
<td>&gt;= 92.0%</td>
<td>&gt;= 82.0%</td>
<td>1d Well-led</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
<td>54</td>
</tr>
<tr>
<td>66. Digital Services Mandatory Training compliance</td>
<td>98.5%</td>
<td>99.1%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 85.0%</td>
<td>1d Well-led</td>
<td>Target met</td>
<td>Target met</td>
<td>•</td>
<td>•</td>
<td>SP</td>
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<td>Estates</td>
<td>Status YTD</td>
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<td>Trust Objective &amp; CQC Domain</td>
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<td>-----</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>72. Infrastructure and Building Availability (Quarterly)</td>
<td>100.0%</td>
<td>100.0%</td>
<td>&gt;= 99.0%</td>
<td>&gt;= 98.0%</td>
<td>1c</td>
<td>Safe</td>
<td>Target met Target met</td>
<td>•</td>
<td>•</td>
<td>MAM</td>
<td>56</td>
</tr>
<tr>
<td>73. Six Facet Property Appraisal (Quarterly)</td>
<td>213.37</td>
<td>97.72</td>
<td>&lt;= 534.00</td>
<td></td>
<td>1c</td>
<td>Safe</td>
<td>Target met Target met</td>
<td>•</td>
<td>•</td>
<td>MAM</td>
<td>56</td>
</tr>
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</table>
## Appendix 1 - Balanced Scorecard

### 67. Finance and Use of Resources Risk Rating

<table>
<thead>
<tr>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
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</thead>
<tbody>
<tr>
<td>&gt;= 3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1g</td>
<td>Well-led</td>
<td></td>
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<td>HW 58</td>
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</table>

### 68. Liquidity Metric

<table>
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<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
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</tr>
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<tbody>
<tr>
<td>&gt;= -63.0</td>
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<td>Well-led</td>
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<td></td>
<td>HW 58</td>
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</table>

### 69. Normalised I&E Margin

<table>
<thead>
<tr>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;= -1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Well-led</td>
<td></td>
<td></td>
<td></td>
<td>HW 59</td>
</tr>
</tbody>
</table>

### 70. Performance against I&E Control Total

<table>
<thead>
<tr>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
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<tbody>
<tr>
<td>0.00%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Well-led</td>
<td></td>
<td></td>
<td></td>
<td>HW 59</td>
</tr>
</tbody>
</table>

### 71. Agency Metric - performance against NHSI Ceiling

<table>
<thead>
<tr>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>12 Month Rolling</th>
<th>Trust Objective &amp; CQC Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
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<tbody>
<tr>
<td>&lt;= -11%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Well-led</td>
<td></td>
<td></td>
<td></td>
<td>HW 60</td>
</tr>
</tbody>
</table>
Clinical Quality overall commentary:
Strategic Objective: Deliver targeted improvements in clinical excellence

Actions:
- a) Developing clinical leadership and management systems and processes for the management of clinical excellence.
- b) Monitoring and evaluating the impact of changes in clinical excellence.
- c) Ensuring compliance with national clinical excellence standards.
- d) Engaging with local stakeholders to promote clinical excellence.

Strategic Risk Description:
The Trust faces increasing challenges recruiting and retaining medical staff. The Royal National Orthopaedic Hospital (RNOH) has experienced difficulty recruiting to non-consultant posts in orthopaedics, anaesthetics, paediatrics and urology. National trainee numbers have declined. Individual PAs have struggled to recruit to posts which have negatively impacted on night time cover and out of hours care. Current arrangements to manage this do not deliver robust operational control of the Trust. Budgetary pressures have increased as a result of agency and locum staff utilisation. Historical contractual arrangements require updating. These circumstances combine to make it challenging to effectively deliver a safe clinical workforce.

The Royal National Orthopaedic Hospital NHS Trust Board Assurance Framework 2019-20

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Action Plan to Address Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver targeted improvements in clinical excellence</td>
<td>Effective controls are in place and Board satisfied that appropriate assurances are available.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due date</th>
<th>Progress Update</th>
<th>Status: Not Yet Started/In progress</th>
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</thead>
<tbody>
<tr>
<td>a) Creating a foundational platform to enable further staffing role changes in the future by providing core services centrally</td>
<td>Lila Dinner</td>
<td>01-Oct-19</td>
<td>NE 1 - complete</td>
<td>Complete</td>
</tr>
<tr>
<td>b) Picture Managed Resident Medical Officer (RMO) Service</td>
<td>Lila Dinner</td>
<td>01-Oct-19</td>
<td>DMS-VAT - complete</td>
<td>Complete</td>
</tr>
<tr>
<td>c) Streamlining BiAs with other Trusts to ensure RNOH can access the full range of required supplementary clinical services</td>
<td>Lila Dinner</td>
<td>01-Apr-20</td>
<td>Reference directory now published on Grapevine to improve access to existing services. Clinical Advisory Group is in the process of setting up the first meeting has taken place. Refresh of policy on honorary contracts and on designated body connection for doctors on SLA</td>
<td>In progress</td>
</tr>
<tr>
<td>d) Engage with Gateway Programme - GALS and NHS Professionals to support introduction to practice of UK medical students from EU medical schools</td>
<td>Lila Dinner</td>
<td>01-Apr-20</td>
<td></td>
<td>In progress</td>
</tr>
<tr>
<td>e) CCCD movement in procurement of novel technologies for clinical staffing issues</td>
<td>Lila Dinner</td>
<td>Apr-20</td>
<td>New CSMC issue is to be prioritised and appointed to.</td>
<td>In progress</td>
</tr>
</tbody>
</table>
### Strategic Objective: Deliver targeted improvements in High Quality Care

**Annual Objectives:**
- A) Improve shared learning from incidents through the introduction of safety huddles into all clinical departments by January 2020.
- B) Improve consistency in ward outcomes through the introduction of ward accreditation in all in-patient areas by March 2020.
- C) Improve retention and career progression for Healthcare Assistants via the introduction of a Registered Nurse Apprentice route into the Trust by March 2020.
- D) Improve staff to patient communication via the introduction of a communication tool by October 2019.

#### Risk Key

<table>
<thead>
<tr>
<th>Extreme Risk</th>
<th>High Risk</th>
<th>Medium</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-25</td>
<td>8-12</td>
<td>4-6</td>
<td>1-3</td>
</tr>
</tbody>
</table>

**Source of Risk:** (External Environment, Risk Register, Strategic Objective, Board or Committee, etc.)

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>BAF REF No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver targeted improvements in High Quality Care</td>
<td>SR2a</td>
</tr>
</tbody>
</table>

**Risk Open Date:** Oct-18

**Risk Review Date:** Oct-19

**Lead Committee:** Clinical Standards & Innovation Committee

### Strategic: Risk Description:

**Capacity and capability of clinical and non-clinical staff to undertake improvement in the quality of care.**

#### Assurances on Control

- **Positive Assurance** (1st, 2nd or 3rd line):
  - Controls: (Preventative, Corrective, Directive or Detective)
  - Assurances on Control: (Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.)
  - Negative Assurance: (Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory intervention, Legal challenges, etc.)

#### Gaps in Control:

- **Green**: Effective control is in place and Board satisfied that appropriate assurances are available.
- **Amber**: Effective control is in place but assurances are uncertain and/or insufficient.
- **Red**: Effective controls may not be in place and assurances are not available to the Board.

#### Assurances on Control

- **Positive Assurance Review Date**

#### Action Plan to Address Gaps

- **Action Plan to Address Gaps**

---

**External provider to be commissioned to provide introduction to QI training programme on the RNOH site**

John Bateson

**Funding agreed for programme at improvement programme board in September 2019**

**a) Access to training based on external capacity to provide**

- **b) Limited finance available to support rapid roll out of QI training**

**c) Recognition and reward system for QI to be developed**

**a) Increasing numbers of staff trained in QI methodology**

**b) Improvement KPI’s as measured and reported via the Improvement programme board**

- **Monthly**

---

**Appendix 2 - SR2a_ BAF_ 2019-20**

Page 20 of 98
The Royal National Orthopaedic Hospital NHS Trust Assurance Framework 2019-20

Strategic Objective: Deliver targeted improvements in High Quality Care

Annual Objectives:
- a) Improve shared learning from incidents through the introduction of safety huddles into all clinical departments by January 2020.
- b) Improve consistency in ward outcomes through the introduction of ward accreditation in all in-patient areas by March 2020.
- c) Improve retention and career progression for healthcare assistants via the introduction of a Registered Nurse apprenticeship route into the trust by March 2020.
- d) Improve staff to patient communication via the introduction of a communication tool by October 2019.

Risk Open Date: Oct-18
Risk Review Date: Jan-20
Lead Committee: Clinical Standards & Innovation Committee

Effects:
- Risk Rating
- Consequence
- Likelihood
- Total Score
- Risk Movement

Inherent Risk:
- 5
- 4
- 20
- 3
- 10
- 2
- 15

Residual/Current Risk:
- 5
- 3
- 10

Target Risk:
- 5
- 2
- 10

Assurances on Control
- Positive Assurance Review Data

Controls: (Preventative, Corrective, Directive or Detective)
- Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory intervention, Legal challenges, etc.

Gaps in Assurance:
Where effectiveness of control is yet to be ascertained or negative assurance on control received.

Action Plan to Address Gaps

Progress Update

Effective control is in place and Board satisfied that appropriate assurances are available.

Action Plan by Address Gaps

Effective control is thought to be in place but assurances are uncertain and not available.

Effective controls may not be in place and assurances are not available to the Board.

Strategic Risk Descriptions:
- a) Nursing vacancy rate of circa 18%
- b) Particular pressure in relation to band 5 nursing posts
- c) Increased agency costs to maintain safe staffing levels
- d) Focus on delivery of clinical services resulting in less focus on quality improvement

Assurance on Control:
- CQC inspection improvement from requires improvement to good
- National in-patient survey improvement - 3rd best in London
- CHPPD and planned vs actual staffing levels
- Other outcomes data - HAPU, falls, infection rates, FFT
- e-rostering compliance monitored weekly via bank and agency meeting and monthly via divisional performance reviews

Evaluation:
- Extreme Risk 15-25
- High Risk 8-12
- Medium 4-6
- Low Risk 1-3

Source of Risk: (External Environment, Risk Register, Strategic Objective, Board or Committee, etc.)

Risk Key

Positive Assurance: (Preventative, Corrective, Directive or Detective)
<table>
<thead>
<tr>
<th>Strategic Risk Description</th>
<th>Inherent Risk</th>
<th>Control</th>
<th>Current Risk</th>
<th>Reasonable Assurance Rating</th>
<th>Consequence</th>
<th>Risk Open Date</th>
<th>Source of Risk</th>
<th>Risk Rating</th>
<th>Risk Reviews</th>
<th>Risk Key</th>
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<tbody>
<tr>
<td>Gaps in control: Where are we failing to put controls in place? Where are we failing in making them effective</td>
<td>15-25</td>
<td>Extreme</td>
<td>4</td>
<td>G</td>
<td></td>
<td>Apr-19</td>
<td>External Environment, Risk Register, Strategic Objective, Board or Committee, etc.</td>
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<td></td>
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</table>

### Action
- **Lead:**执行主任/风险所有者
- **Risk Open Date:** Apr-19
- **Status:**在进度中

#### Action Plan
- Develop programme to review and address FU:New OP ratios
- POA case for investment to address backlog and provide sufficient capacity going forward

#### Risk Management
- **Lead Committee:** Corporate Executive Committee
- **Executive Lead/Risk Owner:** Lucy Davies
- **Gaps:**
  - Patient care in the NHS
  - POA for identified demand, taking into account recommendations from April 2019 NHSI Theatre Review, signed off by Executive Committee by December 2019.

#### Controls:
- Assurances on Control
- Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory action, Legal challenges, etc.

#### Strategic Risk Description
- **Inherent Risk:** Insufficient theatre, bed or clinic capacity to achieve planned activity levels.
- **Control:** Assurances on Control
- **Current Risk:** Insufficient theatre, bed or clinic capacity to achieve planned activity levels.

#### Risk Open Date
- **Due Date:** Oct-19
- **Lead Committee:** Executive Lead Risk Owner
- **Executive Lead/Risk Owner:** Lucy Davies

#### Risk Reviews
- **Due Date:** Jan-20
- **Lead Committee:** Executive Committee

#### Risk Movement
- **Reasonable Assurance Rating:** G, A, R
- **Risk Review Date:** Jan-20

### Appendix
- **BAF REF No:** SR3
- **BAF 150-7:** POA for identified demand, taking into account recommendations from April 2019 NHSI Theatre Review, signed off by Executive Committee by December 2019.
- **BAF 2019-20:** Nov-19

### Source of Risk
- **External Environment, Risk Register, Strategic Objective, Board or Committee, etc.**
## Strategic Objective: Develop a culture of Improvement

**Gaps in control:**
- Lack of recognition of improvement activity
- Perception that staff ‘need permission’ to undertake improvement activity
- Lack of motivation to undertake improvement activity
- Lack of confidence to undertake improvement activity
- Lack of knowledge and skills in improvement methodology
- Inadequate improvement activity to improve quality of care, quality of staff experience, financial savings and infrastructure improvements

**Cause:** Staff lack confidence, motivation, resource and capacity to embrace opportunities for improvement.

### Action Plan to Address Gaps
1. **Access to training based on internal and external capacity to provide**
   - Access to improvement training for staff (internal and external training offered)
   - Improvement training included in staff induction
   - Improvement training has been integrated into the induction for all new staff for 5 months. With planned sessions, we are increasing our training capacity and creating the centralized support resource for all staff.
   - Improvement training included number of improvement projects including assessment of quality, design and execution of improvement activity
   - Staff Survey results re improvement

2. **Resources to support staff undertaking improvement (Life QI etc)**
   - Improvement Strategy KPIs including number of improvement projects including assessment of quality, design and execution of improvement activity
   - Staff Survey results re improvement

3. **Central improvement resource to support staff**
   - Improvement Strategy KPIs including number of improvement projects including assessment of quality, design and execution of improvement activity
   - Staff Survey results re improvement

4. **Organizational conversations led by improvement with support from Valyou/Staff Experience**
   - Improvement Strategy KPIs including number of improvement projects including assessment of quality, design and execution of improvement activity
   - Staff Survey results re improvement

5. **Access to training based on funding**
   - Access to training based on internal and external capacity to provide
   - Access to training based on funding

6. **Recognition and reward system for QI to be developed**
   - Action Plan to Address Gaps

7. **Improvement Strategy Sub Committee**
   - Action Plan to Address Gaps

8. **Development of Improvement Champions**
   - Action Plan to Address Gaps

9. **Development and Establishment of RNOH Improvement Tools**
   - Action Plan to Address Gaps

10. **Development and Establishment of Improvement Champions**
    - Action Plan to Address Gaps
### Strategic Objective
Deliver the VAL-YOU (organisational development) programme to improve retention and staff experience

#### Annual Objectives:
- Deliver Phase 2 of the Conflict Resolution project by 31 March 2020.
- Deliver the agreed Equality Achievement projects by 31 March 2020.
- Delivery of Management Skills Programme for all first line managers by 31 March 2020.

### Risk Open Date:
Oct-18

### Risk Review Date:
Jan-20

### Risk Key
- Extreme Risk 15-25
- High Risk 8-12
- Medium 4-6
- Low Risk 1-3

### Causes:
- Lack of resources - funding or staff within WOD function to deliver annual objectives.
- Lack of commitment, knowledge and skills from staff including Trust Board, senior leadership team and amongst staff to improve staff experience
- Lack of time within work schedule to undertake staff experience improvement

### Inherent Risk
- Likelihood: 5
- Consequence: 4
- Total Score: 20

### Residual/ Current Risk
- Likelihood: 4
- Consequence: 3
- Total Score: 12

### Target Risk
- Likelihood: 2
- Consequence: 2
- Total Score: 4

### Assurances on Control
- Positive Assurance (1st, 2nd or 3rd line)
  - Improving Staff Survey results (3rd in London and UK)
  - Improving vacancy and turnover rates
  - Staff Experience Strategy KPIs
  - Staff Survey results
  - WOD Committee oversight
- Positive Assurance Review Date
  - Next month

### Action Plan to Address Gaps
- Review of planned activities and prioritisation dependent on available resource
- Deliver Phase 2 of the Conflict Resolution project by 31 March 2020
- Deliver the agreed Equality Achievement projects by 31 March 2020
- Delivery of the Leadership Development Programme Phase 3 – including OLT and use of Apprenticeship Levy – by 31 March 2020
- Delivery of Management Skills Programme for all first line managers by 31 March 2020

### Gaps in control:
- Where effectiveness of control is yet to be ascertained or negative assurance on control received.

### Gaps in Assurance:
- Where are we failing to put controls in place. Where are we failing in making them effective

### Action:
- Effective control thought to be in place but assurances are uncertain and/or insufficient
- Effective control may not be in place and assurances are not available to the Board

### Performance Metrics
- Best staff experience in the NHS

### Annual Objectives:
- Deliver Phase 2 of the Conflict Resolution project by 31 March 2020.
- Deliver the agreed Equality Achievement projects by 31 March 2020.
- Delivery of Management Skills Programme for all first line managers by 31 March 2020.
### Risk Key

<table>
<thead>
<tr>
<th>Risk Key</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Extreme Risk</td>
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</tr>
<tr>
<td>Low Risk</td>
<td>1-3</td>
</tr>
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</table>

### Purpose

The Royal National Orthopaedic Hospital NHS Trust Board Assurance Framework 2019-20

### Strategic Objectives

Deliver the Recruitment and Retention programmes to recruit and develop a workforce of appropriately skilled and engaged staff.

### Annual Objectives

- Deliver Phase 2 of the Safer Staffing Programme by 31 March 2020.
- Deliver Nursing Recruitment and Retention Project Phase 2 by 31 March 2020.
- Deliver Agency Reduction Project by 31 March 2020.

### Strategic Aim

Deliver the Recruitment and Retention programme to recruit and develop a workforce of appropriately skilled and engaged staff.

### Strategic Risk Description

Failure to recruit and retain the workforce, as a result of capacity and resource and available workforce, will result in increased staff turnover, challenges recruiting staff, failure to raise concerns and reduce ability of staff to perform thus impacting on quality of care.

### Consequence

- Inherent Risk:
  - Likelihood: 5
  - Effect: 4
  - Total Score: 20

- Residual/Current Risk:
  - Likelihood: 4
  - Effect: 3
  - Total Score: 12

### Target Risk

- Target Risk:
  - Likelihood: 4
  - Effect: 2
  - Total Score: 8

### Assurances on Control

- Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory intervention, Legal challenges, etc.

### Gaps in Assurance

- Where effectiveness of control is yet to be ascertained or negative assurance on control received.

### Controls: (Preventative, Corrective, Directive or Detective)

- Staff Experience Strategy KPIs
- Balanced Scorecard KPIs
- WOD Committee and Executive Committee oversight

### Action Plan to Address Gaps

- Draft and submit business case for investment in medical resourcing, resourcing function, e-rotostering for medical staff and AHP's investment in commercial partner for provision of bank staff and direct engagement models.
- Deliver Phase 2 of the Safer Staffing Programme by 31 March 2020.
- Deliver Nursing Recruitment and Retention Project Phase 2 by 31 March 2020.
- Deliver Agency Reduction Project by 31 March 2020.
### Risk Key

<table>
<thead>
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</tr>
</tbody>
</table>

### Strategic Objective

*Annual Objectives:* Disposal of western development zone by March 2020

### Source of Risk:

- External Environment
- Risk Register
- Strategic Objective
- Board or Committee, etc.

### Risk Open Date:

Oct-19

### Executive Lead / Risk Owner:

Mark Masters

### Lead Committee:

Executive Committee

### Risk Review Date:

Dec-19

### Risk Rating

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
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<tbody>
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<td>16</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

### Controls: (Preventative, Corrective, Directive or Detective)

- Positive Assurance
- Precautionary (1st, 2nd or 3rd line)

### Action Plan to Address Gaps

- Effective control thought to be in place but assurances are uncertain and/or insufficient.

#### Gaps in Control

- Failure or delay in completing WDZ land sale by August 2021.
- Failure or delay in completing WDZ land sale by August 2021.

#### Action:

- Value provided by Deloitte Sale being monitored by land Sale short-life working Group and Redevelopment Programme Board
- Effective control thought to be in place but assurances are uncertain and/or insufficient.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control may not be in place and assurances are not available to the Board.

### Effective control

- Board satisfied that appropriate assurances are available.
- Effective control thought to be in place but assurances are uncertain and/or insufficient.
- Effective control is in place and Board satisfied that appropriate assurances are available.

### Risk Open Date:

Oct-19

### Executive Lead / Risk Owner:

Mark Masters

### Lead Committee:

Executive Committee

### Effective control

- Board satisfied that appropriate assurances are available.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control may not be in place and assurances are not available to the Board.

### Risk Review Date:

Dec-19

### Risk Rating

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- Positive Assurance
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### Effective control

- Board satisfied that appropriate assurances are available.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control may not be in place and assurances are not available to the Board.

### Risk Open Date:

Oct-19

### Executive Lead / Risk Owner:

Mark Masters

### Lead Committee:

Executive Committee

### Effective control

- Board satisfied that appropriate assurances are available.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control may not be in place and assurances are not available to the Board.

### Risk Review Date:

Dec-19

### Risk Rating

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<tr>
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### Controls: (Preventative, Corrective, Directive or Detective)

- Positive Assurance
- Precautionary (1st, 2nd or 3rd line)

### Action Plan to Address Gaps

- Effective control thought to be in place but assurances are uncertain and/or insufficient.

#### Gaps in Control

- Failure or delay in completing WDZ land sale by August 2021.
- Failure or delay in completing WDZ land sale by August 2021.

#### Action:

- Value provided by Deloitte Sale being monitored by land Sale short-life working Group and Redevelopment Programme Board
- Effective control thought to be in place but assurances are uncertain and/or insufficient.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control may not be in place and assurances are not available to the Board.

### Effective control

- Board satisfied that appropriate assurances are available.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control may not be in place and assurances are not available to the Board.
<table>
<thead>
<tr>
<th>Risk Key</th>
<th>Extreme Risk</th>
<th>High Risk</th>
<th>Medium</th>
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<td>15-25</td>
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<td>4-6</td>
<td>1-3</td>
</tr>
</tbody>
</table>

**Strategic Objective:**

- Define the site redevelopment projects
- Annual Objective:
  - b) Delivery of the Multi-storey Car Park by March 2021.
  - c) Delivery of the residential accommodation by August 2021.
  - f) Delivery of Theatre Day Case and Admissions Unit by March 2021.

**Source of Risk:** (External Environment, Risk Register, Strategic Objective, Board or Committee, etc.)

**BAF REF No:** SR8

**Risk Open Date:** Oct 18

**Lead/ Risk Lead:** Mark Masters

**Risk Review Date:** Jan 20

**Lead Committee:** Executive Committee

<table>
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<tr>
<th>Effects</th>
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</table>

**Controls:** (Preventive, Corrective, Directive or Detective)

- Assurances on Control
  - Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
  - Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory intervention, Legal challenges, etc.

**Review Date:**

- Proceed plan for the provision of a new P&O building in the Central Development Zone (CDZ), are being progressed.
- 04-Sep-19

**Action:**

- Redevelopment Team pursuing alternative funding solutions

**Lead:** Mark Masters

**Due date:**

- Progress Update

**Status:** Not yet Started/In Progress/Complete
Executive Lead / Risk Owner

### Lead Committee:
- Total Score: 16

### Action Plan to Address Gaps

**Gaps in control:**
1. CareCERT monitoring alerts
2. Independent Cyber security assessments
3. Cyber security action plan

(c) Deliver Responsive, Secure & Resilient Digital Services

### Plans created to deliver capability improvements

1. Programme plan for the Digital Programme of Work
2. Digital Strategy Delivery Board
3. Digital Committee
4. Executive Committee

### Constraints:
- Preventative
- Corrective
- Directive
- Detective

#### iii) Continuously changing nature of the attacks
#### iii) Staff inadvertently responding to any cyber attack and infecting the Trust
#### iv) Continuously changing nature of the attacks

(c) Deliver Responsive, Secure & Resilient Digital Services

### ii) Resources do not adapt to the training provided

### i) Materials to improve the adoption of any digital capability are not developed to meet the demands of the Trust

### (b) Develop Digital capability

### (c) Deliver Responsive, Secure & Resilient Digital Services

### b) Develop Digital capability

### i) Progress against the action plan and report from the external assurance on control received.

### ii) Intended efficiencies to be gained within the provision of patient care will not be realised

### (c) Deliver Responsive, Secure & Resilient Digital Services

### a) Deliver Year 1 Programme of Work (within the resource constraints already highlighted) – March 2020.

### Risk Review Date:
- Sep-19

### Effectiveness of controls is yet to be ascertained or negative assurance on control received.

### History of Score:
- Extreme Risk: 15-25
- High Risk: 8-12
- Medium: 4-6
- Low Risk: 1-3

### Risk Movement:
- Extreme Risk
- High Risk
- Medium
- Low Risk

### Risk Control:
- Positive Assurance: Reports, Audits, Dashboards, Minutes, Incident Reports, External evidence, Regulatory, Legal challenges, etc.
- Negative Assurance: Incidence Reports & Investigations, Negative Surveys, External Borrowing, Regulatory decisions, Legal challenges, etc.

### Risk Open Date:
- Sep-20

### Risk Board:
- Executive Lead / Risk Owner
- Lead Committee:
  - Executive Committees

### Controls:
- (Preventive, Corrective, Directive or Detective)

### Assurance on Control:
- Positive Assurance
- Negative Assurance

### (4th line) Positive Assurance Review Date

### Risk Open Date:
- Sep-20

### Risk Source:
- (External Environment, Risk Register, Strategic Objective, Board or Committee, etc.)

### Risk Key:
- Red
- Amber
- Green

### Strategic Risk Description:
- Responsibility to implement the objectives set out in the Trust’s digital strategy.

### Strategic Objective:
- Strategic Aim:
  - Annual Objectives:
  - Resilient Infrastructure
  - Improved infrastructure
  - Improved infrastructure
  - Effective control thought to be in place but assurances are uncertain and/or insufficient.

### Risk Rating:
- Inherent Risk: 4
- Likelihood: 5
- Target Risk: 20

### Summary:
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Archive
- Effective control thought to be in place but assurances are uncertain and/or insufficient.
- In progress

### Action Plan to Address Gaps

### Status:
- Not Yet Started / In Progress
- Complete

### Effectiveness of controls may not be in place and assurances are not available to the Board.

### Exception:
- Exceptional or unanticipated but essential work has been received which have delayed the Year 1 Programme of Work. Similarly delays in funding preparations have particularly delayed the RPVA project. Recruitment had been undertaken at risk but funding has now been sanctioned.
- The action has yet been taken towards the provision of materials and training to deliver appropriate safeguarding capability.
- The Cyber Security Action Plan is being progressed to ensure that we meet the plan to Cyber Essential Accreditation by Q4 2019/20. The roll out of Windows 10 has commenced which is another key element in meeting the Cyber Essential Accreditation.
### Strategic Objective:

**Objective:**
Capital equipment provision to enhance care and Trust operations

**Annual Objectives:**
1. Deliver annual Diagnostic Imaging replacement programme (DIRP) to ensure existing services are maintained and upgraded with current technology in line with Imaging Strategy.
2. Deliver and finalise additional opportunities for developing imaging capacity and capability to meet current demand, reduce outsourcing and support NLP Diagnostic Imaging provision.

**Source of Risk:**
[External Environment, Risk Register, Strategic Objective, Board or Committee, etc.]

**BAF REF No:**
SR10

### Principal Risk Description:

**Lack of sufficient funding for the ongoing delivery of the annual Diagnostic Imaging Replacement Programme (DIRP) and the development of imaging capacity and capability, thereby creating the risk of a sub-standard service to our patients with potentially unreliable and technically inferior diagnostic imaging equipment.**

### Causes:

<table>
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<tr>
<th>Issue</th>
<th>Inherent Risk</th>
<th>Likelihood</th>
<th>Total Score</th>
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<tbody>
<tr>
<td>Inability to fund the DIRP and the development of imaging capacity and capability which will continue to increase the potential for equipment failure and possibility of sub-optimal patient diagnosis.</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

**Risk Rating: Extreme Risk**

### Controls:

**Preventative, Corrective, Directive or Detective**

**Assurance on Control**

- Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory Intervention, Legal challenges, etc.

**Positive Assurance Review: Sale**

**Risk Key**

<table>
<thead>
<tr>
<th>Risk Key</th>
<th>Red</th>
<th>Amber</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Risk</td>
<td>15-25</td>
<td>8-12</td>
<td>1-3</td>
</tr>
<tr>
<td>High Risk</td>
<td>15-25</td>
<td>8-12</td>
<td>1-3</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>4-6</td>
<td>4-6</td>
<td>4-6</td>
</tr>
<tr>
<td>Low Risk</td>
<td>1-3</td>
<td>1-3</td>
<td>1-3</td>
</tr>
</tbody>
</table>

### Risk Movement

<table>
<thead>
<tr>
<th></th>
<th>Risk Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Action Plan to Address Gaps

**Lead:**

- **Mike Giles & Luke Martin**: 27-Nov-19

**Status:**

- Not Started
- In Progress
- Complete
### Strategic Objective:
**Achieve financial stability**

#### Annual Objectives:
- (a) Development of a Board approved Medium Term Financial Plan including a financial strategy for sustainability by 30 September 2019.
- (b) Delivery of £7.8m Private Care income target within budgeted resource by 31 March 2020.
- (c) Facilitate identification and delivery of efficiency and productivity schemes to ensure RNOH meets its CIP target by 31 March 2020, and develop a medium term plan detailing priority areas for efficiencies over the next five years by 30 September 2019.
- (d) Influence national payment mechanisms in conjunction with the National Orthopaedic Alliance to ensure complexity is factored into agreed payment mechanisms by 31 March 2020.

#### Gaps in Control:
- Where are we failing to put controls/systems in place? Where are we falling in making them effective?

#### Gaps in Assurance:
- Where are we failing to put controls/systems in place? Where are we falling in making them effective?

#### Effective Control:
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective control thought to be in place but assurances are uncertain and/or insufficient.
- Effective controls may not be in place and assurances are not available to the Board.

### Action Plan to Address Gaps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due date</th>
<th>Progress Update</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support and drive NOA tariff engagement to ensure shared objectives with EWG to influence tariff change</td>
<td>Director of Finance</td>
<td>31-Dec-19</td>
<td>Update of top box making procedures underway to inform NOA-EWG discussions. CEO attendance at EWG NHSE&amp;I tariff meetings.</td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>Model Hospital training to SLT to aid identification of efficacy opportunities through benchmarking data</td>
<td>Director of Finance</td>
<td>31-Oct-19</td>
<td>Sessions booked with RJAH MH specialist to provide training and share learning</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>PCD refresh of growth strategy, including risks and opportunities</td>
<td>Director of Finance, PCD GM</td>
<td>31-Mar-20</td>
<td>Modelling underway, including case for additional theatre. Procurement of external support - preferred bidder selected and negotiations around work package in progress</td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>Medium Term plan for sustainability including support to/from the system and five year efficiency plan</td>
<td>Director of Finance</td>
<td>31-Jan-20</td>
<td>#TFTP Board review 18 Sept. Board agreed proposals for priorities for support to and from the system to aid sustainability agreed for discussion with NCL STP (date for discussion TBC).</td>
<td>In progress</td>
<td></td>
</tr>
</tbody>
</table>
Reward Key

- Extreme Risk: 15-25
- High Risk: 8-12
- Medium Risk: 4-6
- Low Risk: 1-3

Strategic Objective: To deliver world class neuro-musculoskeletal research and education

Annual Objectives: Delivery of the RNOH Research, Education and Innovation Strategic review.

Strategic Risk Description:
Failure to deliver a strategic review will prevent the RNOH delivering world class neuro-musculoskeletal research and education.

Risk Open Date: Oct-18
Executive Lead/ Risk Owner: Lucy Davies
Lead Committee: Clinical Standards & Innovation Committee
Risk Review Date: Jan-20

Assurance on Control
(Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.)
(Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory intervention, Legal challenges, etc.)

Gaps in Assurance:
Where effectiveness of control is yet to be ascertained or negative assurance on control received.

Green
Effective control is in place and Board satisfied that appropriate assurances are available.

 Amber
Effective control is in place but assurances are uncertain and/or insufficient.

Red
Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due Date</th>
<th>Progress Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exec Committee agreeing new approach to re-setting the academic strategy and review of leadership</td>
<td>Rob Hurd</td>
<td>Mar-20</td>
<td>In Progress</td>
<td></td>
</tr>
</tbody>
</table>
### Strategic Objective:
**Lead national programmes to improve NHS sustainability**

#### Annual Objectives:
- Agreement of strategy and financially sustainable long term plan and associated governance for Stanmore Health Consulting Directorate (incorporating all projects and programmes within this) by RNOH Trust Board by 31 March 2020.
- Agreement of funding and programme milestones and KPIs for translating GIRFT into new areas not currently in GIRFT England Programme by 30 September 2019.
- GIRFT funding and structures longer term (from April 2021) agreed as part of NHS I/E contract and NHS Long Term Plan implementation plan by 31 March 2020.

#### Gaps in Assurance:
- Many examples of Trust by Trust, Specialty by Specialty and in the public domain.
- Positive Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory Intervention, Legal challenges, etc.

#### Assurances on Control:
- Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory Intervention, Legal challenges, etc.

#### Strategies:
- Establishment of Stanmore Health Consulting Subcommittee of Strategy & Sustainability Committee to agree clear purpose, aims and delivery plans for SHC.
- NHS I / RNOH joint review and investigation of GIRFT Leadership, Governance & Culture - Reporting to September GIRFT Board and September RNOH Strategy & Sustainability Committee.
- Internal Audit of GIRFT recruitment processes and expenses.

#### Risk Description:
NHS Improvement, NHS England and other stakeholder funding bodies do not continue to support (through funding and contractual arrangements) the RNOH as a provider of clinical improvement programmes run through the Stanmore Health Consulting Directorate of RNOH - of particular note the main SHC programme/project (GIRFT England) is formally funded until March 2021 and so there is particular uncertainty beyond that point as to the scale of SHC activities.

#### Causes:
- External: As part of the "coming together" nationally of NHS Improvement and NHS England they have been reviewing their aims, objectives and operating models over the last 18 months and this is continuing over the months ahead (currently in "Phase 3" scheduled to complete later this calendar year) - NHS Improvement are now more clearly seeing their role as supporting Quality Improvement rather than regulation and, as such, have indicated the need to integrate GIRFT more closely with their regional structures - including the potential for the transfer of GIRFT resources and staff in the longer term into NHS I/E Regions, rather than utilising RNOH as a GIRFT partner.
- Internal: Combined with the uncertainties caused by environmental factors described above, the rapid expansion of the GIRFT England Programme over the last 2 years (staff to 200 staff from 2017 to 2019) and the focus on the operational delivery of the programme has meant that leadership development and organisational development has been less well developed than elsewhere in RNOH.

#### Controls:
(Preventative, Corrective, Directive or Detective)
- Assurances on Control (Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.)
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory Intervention, Legal challenges, etc.

#### Source of Risk:
- External Environment, Risk Register, Strategic Objective, Board or Committee, etc.

#### Risk Key:
- Green: Effective control is in place and Board satisfied that appropriate assurances are available.
- Amber: Effective control thought to be in place but assurances are uncertain and/or insufficient.
- Red: Effective controls may not be in place and assurances are not available to the Board.

#### Risk Rating:
- Inherent Risk:
- Residual/Current Risk:
- Target Risk:

#### Risk Movement:
- Risk Open Date: Apr-19
- Risk Review Date: Jan-20
- Executive Lead / Risk Owner: Rob Hurd
- Lead Committee: Trust Board
<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due date</th>
<th>Progress Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) A clear purpose/aim and underpinning objectives and plans need to be agreed for Stanmore Health Consulting to provide assurance that these are aligned to the Strategic Arms of the RNOH.</td>
<td>Rob Hurd and Rachel Yates</td>
<td>31st March 2020</td>
<td>Draft Business Plan proposed to Executive and SLT; SHC staffing structure engagement and consultation process underway - outcome to Trust Board in March</td>
<td>In progress</td>
</tr>
<tr>
<td>b) Agreement needs to be reached with NHS I on the proposed arrangements from the end of the current GIRFT England programme from April 2021.</td>
<td>Rob Hurd and Tim Briggs</td>
<td>31st March 2020</td>
<td>In dialogue with NHS I - agreement to agree by 31st March 2020.</td>
<td>In progress</td>
</tr>
</tbody>
</table>
## Strategic Objectives

- Undertake a leadership role where appropriate and relevant in regional setting of Sustainability and Transformation Programmes

### Annual Objectives:


b) Annual Report on lessons learned from NCL STP pilot of GIRFT enabling system change to GIRFT and RHCH Board by 31 March 2020.

c) Contribute to leading relevant elements of STP including workforce, nursing, finance, estates and digital by 31 March 2020.

### Strategic Risk Description:

STP unable to approve pre-consultation business case process.

### Causes:

- Lack of financial resources of the scale of support / implementation resources required to realise the patient care, staff experience, teaching, training and financial benefits of the NCL Adult Elective Orthopaedics review.

### Effects:

- Inability to progress with recommendations for the new clinical service model for orthopaedics in the NCL STP.

### Risk Open Date:

Apr-19

### Risk Review Date:

Jan-20

### Risk Owner:

Rob Hurd

### Executive Lead:

Trust Board

### Lead Committee:

Trust Board

### Source of Risk:

- External Environment
- Risk Register
- Strategic Objective
- Board or Committee

### BAF REF No:

SR14

### Inherent Risk:

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

### Residual/ Current Risk:

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

### Target Risk:

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

### Assurances on Control

- Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
- Negative Assurance: Incidence Reports & Investigations, Complaints, Negative Surveys, External Borrowing, Regulatory

### Gaps in Assurance

- Where effectiveness of control is yet to be ascertained or negative assurance on control received.

### Actions:

- Engagement events have been arranged targeting specific concerns raised around AHP involvement and transport issues raised.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due Date</th>
<th>Progress Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rob Hurd</td>
<td>01-Mar-20</td>
<td>Events scheduled as part of Autumn engagement and consultation events</td>
<td>In progress</td>
</tr>
</tbody>
</table>

### Risk Movement

- Green: Effective control is in place and Board satisfied that appropriate assurances are available.
- Amber: Effective control thought to be in place but assurances are uncertain and/or insufficient.
- Red: Effective controls may not be in place and assurances are not available to the Board.
## Risk Key

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Risk</td>
<td>15-25</td>
</tr>
<tr>
<td>High Risk</td>
<td>8-12</td>
</tr>
<tr>
<td>Medium</td>
<td>4-6</td>
</tr>
<tr>
<td>Low Risk</td>
<td>1-3</td>
</tr>
</tbody>
</table>

### Source of Risk:
- External Environment
- Risk Register
- Strategic Objective
- Board or Committee, etc.

### BAF REF No:
- SR15

### Strategic Risk Description:
Failure of sufficient executive leadership, integration and coordination with RNOH Charity CEO and Trustees will result in aims and objectives of Trust strategy.

### Causes:
- a) Lack of resources and time within executive team to deliver annual objectives
- b) Lack of commitment, knowledge and skills from staff including Trust Board, senior leadership team and amongst staff to work with Charity
- c) Lack of time, resources or commitment from Trust Charity leadership to support delivery of annual objectives

### Effects:
- a) Quality of care, quality of staff experience, financial savings and infrastructure improvements may not be delivered without charitable funding
- b) Increased incidents of perceived bullying, harassment and discrimination
- c) Increased vacancy, sickness and turnover rates
- d) Inability to achieve 'Outstanding' rating
- e) Loss of 'Good' rating

### Assurances on Control:
- Positive Assurance (1st, 2nd or 3rd line)

### Positive Assurance Review Date:
- Effective use of charitable funds to deliver key research, quality and staff experience projects
- Next month

### Gaps in Assurance:
Where effectiveness of control is yet to be ascertained or negative assurance on control received.

### Action Plan to Address Gaps

| Action | Lead | Due date | Progress Update | Status: Not Yet Started

See controls.
Key information and conclusions

This paper is presented to the Board following publication of *How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability* (Nursing Quality Board, 2013).

The paper presents the findings of the three previous Shelford group – Safe staffing acuity reviews and an update following the move to the New Stanmore building,

Ward managers / lead nurse’s act in a supervisory role following recommendations from Francis (2013) and the wards consistently achieve safe staff to patient ratios.

At this time the DHON for London Irish and Duke of Gloucester are currently monitoring the staffing numbers closely. Data for DoG wards suggest that a small uplift in staff might be required in the future, however only two SNCT data collections have been completed and therefore further assessment is required before this can be determined.

Due to the fluctuation in bed base and throughput (table 41) it has been a challenge to confidently predict a safe staffing requirements as the SNCT is based on lower bed capacity than the Professional judgment.

The impact of vacancies is impacting on the feel within the clinical areas. Work is currently underway to recruit into these post but this is a National / International Issue.

1.0 Introduction

1.1 Trusts Boards have a duty to ensure safe staffing levels are in place and patient the right to be cared for by appropriately qualified and experienced staff in a safe environment as set out in within the National Health Service (NHS) Constitution and the Health and Social Care act (2012). There has been significant focus on this issue since the publication of the Francis Report, with guidance being released from the National Quality Board, NHS England and NICE.

2.0 The Safer Nursing Care Tool

2.1 The Safer Nursing care tool (SNCT) is NICE approved and is based on the assessment of patient acuity and dependency, with patients being allocated to one of 5 cohorts. These are outlined in table 1 below.

<table>
<thead>
<tr>
<th>Acuity / Dependency Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient requires hospitalisation Needs met by provision of normal ward cares.</td>
</tr>
<tr>
<td>1a</td>
<td>Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.</td>
</tr>
</tbody>
</table>
1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.

2 May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / unit.

3 Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

2.2 This quantitative assessment is only one element of the tool. Once the above data is collected then a process of applying professional judgement is required to triangulate the views of senior professionals. The overall establishment setting process should take into account both parts of the process.

2.3 The Shelford group have recently released the paediatric tool, an implementation plan is currently under development.

2.3 This staffing review was performed during, November 2018, March 2019 and July 2019, for the wards moving to the new build the data collection was delayed to allow for a settling period due to the merger of three wards into two with an increase of 6 beds as part of the opening of the new build. The SNCT identifies that by taking an average of the three acuity scores this allows for season variation.

2.4 Each ward area had headroom of 23% applied as per the SNCT recommendation. 17% is allocated to the wards and 6% is held in a central pot, this is utilised for maternity leave and long term sickness.

2.5 All areas completed a ‘bottom up’ review completed by the ward managers using professional judgment to identify the required staffing levels required. The ‘Bottom up review’ is important to capture nursing demands that may not be captured using the SNCT alone. The results of the SNCT and the professional judgment are then triangulated.

3.0 Safecare

3.1 The Safe Care tool has been introduced within the Trust as part of the E-Rostering project. The Acuity / dependency is measured on all inpatient wards three times per day and recorded on Safecare. The tool links with the E-rostering system and utilises the SNCT multiplies to calculated required Care Hours Per Patient day (CHPPD). Safecare provides visibility across wards and areas transforming rostering into an acuity based tool.

CHPPD are calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight.

4.0 Data validation

4.1 To validate data collection for establishment review the following actions were taken:

- Inter-reliability exercise was undertaken with ward managers to ensure consistently with application of the acuity tool. A plan is in place to repeat this exercise with ward staff.

-
• Comparing recommended establishment for both CHPPD and SNCT.
• External benchmarking with other organisations using the NHS improvements (NHSI) Model Hospital Dashboard.

4.2 Data Alignment
There is an ongoing piece of work to ensure the E-roster template is in line with the agreed establishment requirements and the funded establishment. Processes have been identified and put in place that should prevent misalignment in future.

No changes to clinical staffing will be made without approval from the Director of Nursing. An auditable record of all changes is recorded on the E-roster system.

5.0 Joint Reconstruction & Cancer Division

5.1 Duke of Gloucester
The Royal National Orthopaedic Hospital (RNOH) and University College Hospitals Foundation Trust (UCLH) form the London Sarcoma Service (LSS). Both organisations provide specialist care for patients with all types of soft tissue and bone sarcoma. The London Sarcoma Service is dedicated to provide care of the highest quality for all patients with musculoskeletal malignancies and related diseases.

Duke of Gloucester is the Ward where these patients will have their inpatient stay. On the 8th December 2018 the ward relocated to the Stanmore Building and now incorporates Joint Reconstruction patients, who would have previously been nursed on Margaret Harte Ward (MHW). This unit performs large number revision procedures each year for patients from across the UK and is recognised for its specialist expertise in this area. A wide range of techniques are used including cemented and uncemented fixation as well as extensive experience in custom made prostheses using CAD CAM.

Duke of Gloucester when it opened on the 8th December 2018 opened to its 32 beds. However, since 28 February 2019 the ward has opened to 28 beds. This was a reflection of the RN vacancy levels which was compounded by sickness, maternity leave and Duke of Gloucester having loaned London Irish 2.63 WTE Registered Nurses. This enabled London Irish to open to 22 beds. A decision was made following consultation with the DON, DDON and the DHON for Specialist Surgery that London Irish would open up to 26 beds and Duke of Gloucester would remain at 28 beds open. This gave us the bed base that we had in the wards previously prior to the new build. It also allowed the team on Duke of Gloucester to feel valued as they saw that the patient to staff ratio was consistently lower on London Irish with a lower acuity of patient.

Patient acuity on Duke of Gloucester ward is predominantly at level 1b due to the large percentage of patients that need support with two transferring, complex wound management, patients and or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome and confused patients requiring 1 to 1 supervision.

In 2018-2019, 1 to 1 specials cost Duke of Gloucester £24,000 and Margaret Harte Ward £18,000 which in not factored into the budget.
### Table 2 Duke of Gloucester Budget / Vacancy

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budgeted FTE</th>
<th>Actual FTE</th>
<th>Vacant FTE</th>
<th>% Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Band 2</td>
<td>14.77</td>
<td>15.24</td>
<td>-0.47</td>
<td>-3.18%</td>
</tr>
<tr>
<td>Nurse Band 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Band 5</td>
<td>19.5</td>
<td>16.60</td>
<td>2.9</td>
<td>14.87%</td>
</tr>
<tr>
<td>Nurse Band 6</td>
<td>5.21</td>
<td>5.21</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nurse Band 7*</td>
<td>3.00</td>
<td>2.00</td>
<td>1</td>
<td>33.33%</td>
</tr>
</tbody>
</table>

Data Source: pulled from finance & ESR  *includes Practice Educator

### Table 3 Required V’s Actual CHPPD

Data source: E-roster / Safccare

Table three identifies the number of shifts that meet or fell below the required CHPPD from the 1st July – 31st July 2019.

### Table: 4 Temporary staffing

Data source: E-roster: 1/6/19-31/7/19
Data source: Safecare

Patient acuity on Duke of Gloucester ward is predominantly at level 1b due to the large percentage of patients that need support with two transferring, complex wound Management, patients and or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome and confused patients requiring 1 to 1 supervision.

Table 6 Duke of Gloucester Acuity Review Results

<table>
<thead>
<tr>
<th>DoG</th>
<th>RN WTE</th>
<th>HCA WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCT multipliers</td>
<td>26.2</td>
<td>11.2</td>
</tr>
<tr>
<td>Professional judgment*</td>
<td>33.60</td>
<td>21.35</td>
</tr>
<tr>
<td>Triangulation</td>
<td>29.9</td>
<td>16.28</td>
</tr>
</tbody>
</table>

Due to the change in ward only two SNCT data collection has been used to calculate the SNCT (Feb & July 2019), the Shelford group recommends a minimum of three before reducing staffing.

5.2 DHON Comments & Recommendations
- The SNCT has been calculated using bed data from the reduced bed base.
- We continue to work closely with the Nursing Recruitment and Retention Group to help address the vacancies within the ward.
- We are looking to appoint a pharmacy technician to support the ward.
- Spot checks on the acuity scoring have found some staff underscoring the patient Acuity. Training has been delivered and will be continued to monitor.
- The present review is indicating that the RN would need to be increased and the HCA presently is appropriate, however this is based on 2 data collections and a further assessment will be required.
### Table 7 Nursing KPI’s

<table>
<thead>
<tr>
<th>Nursing Indicators</th>
<th>Staffing Indicators</th>
<th>Patient Experience</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Document</strong></td>
<td><strong>Nutritional Assessment in 24 hours</strong></td>
<td><strong>Sepsis Rate</strong></td>
<td><strong>Hand Hygiene</strong></td>
</tr>
<tr>
<td>Prevention Urobact</td>
<td>96%</td>
<td>100%</td>
<td>67%</td>
</tr>
<tr>
<td>91%</td>
<td>91%</td>
<td>6%</td>
<td>100%</td>
</tr>
<tr>
<td>100%</td>
<td>77%</td>
<td>3%</td>
<td>100%</td>
</tr>
<tr>
<td>96%</td>
<td>96%</td>
<td>7%</td>
<td>100%</td>
</tr>
<tr>
<td>96%</td>
<td>96%</td>
<td>5%</td>
<td>100%</td>
</tr>
<tr>
<td>96%</td>
<td>96%</td>
<td>3%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Planned vs Actual</strong></td>
<td><strong>F&amp;P Response Rate</strong></td>
<td><strong>Ecoli</strong></td>
<td><strong>CRIF</strong></td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>99%</td>
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<td>98%</td>
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<td>95%</td>
</tr>
<tr>
<td><strong>Clinical Incidents</strong></td>
<td><strong>Red Occupancy</strong></td>
<td><strong>F&amp;P Recommendation (Average YTD)</strong></td>
<td><strong>MRSA</strong></td>
</tr>
<tr>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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<tr>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Safety Thermometer - Warms Free Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95%</td>
<td>95%</td>
<td></td>
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<td>94%</td>
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<tr>
<td>90%</td>
<td>90%</td>
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<td></td>
</tr>
</tbody>
</table>

Duke of Gloucester
6.0 Specialist Surgery Division

6.1 Short Stay Unit
The Short Stay Unit has a total of 37 beds spread over two wards, Jackson Burrows Ward (20 Male beds) and The Coleman Unit (17 Female beds). The Wards are single sex wards and look after patients who are in hospital for up to 5 days. The patients are undergoing a wide range of surgical and diagnostic procedures. The majority of these are Orthopaedic in nature and the Nursing Team get a wide range of experience, for example –shoulder, hip, knee and peripheral nerve surgery.

Table 8 Short Stay Unit Budget/ Vacancy

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budgeted FTE</th>
<th>Actual FTE</th>
<th>Vacant FTE</th>
<th>% Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Band 2</td>
<td>13.59</td>
<td>13.00</td>
<td>0.59</td>
<td>-7.51%</td>
</tr>
<tr>
<td>Nurse Band 3</td>
<td>3.00</td>
<td>2.80</td>
<td>0.20</td>
<td></td>
</tr>
<tr>
<td>Nurse Band 5</td>
<td>24.07</td>
<td>17.09</td>
<td>6.98</td>
<td>37.31%</td>
</tr>
<tr>
<td>Nurse Band 6</td>
<td>7</td>
<td>4.76</td>
<td>2.24</td>
<td>32.00%</td>
</tr>
<tr>
<td>Nurse Band 7</td>
<td>1.00</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Data source: E-roster (pulled from Finance & ESR)

Table 9 Required V’s Actual CHPPD

Table nine identifies the number of shifts that meet or fell below the required CHPPD for the month of July 2019.
Short Stay Unit has 37 beds of which 17 are allocated to females and 20 to males. Due to the high vacancy factor and short and long term sickness on the unit there has been a reliance on bank and agency. This has been further compounded by the fact that the Short Stay Unit from Dec 2018 to Sept 2019, Table 11b below identifies the wider use of short stay beds with long stay patient both JRU and Spinal. The unit especially JBW cannot invariably close at weekends due to no of long stay patients.

During the month of July 2019 we had an increase in agency spend, this was over the school holiday period where staff had to take last minute emergency leave, carer’s leave and sickness.

High activity—experience pressure due to unavailability of Beds in Stanmore Building (closed beds LIW & DoG) due to staffing issues, therefore the unit has to absorb Long Stay patients suitable for the named wards.

Unit had only two weekend partial closures as follows
- 20/07/2019- Saturday Evening-JBW only
- 21/07/2019-All day-JBW only
- 27/07/2019 (BH weekend)-Evening JBW only
- 28/07/2019-(BH weekend)-All day –JBW only

- Week Day-23/07/2019- Evening –JBW only
- Week Day-30/07/2019- Evening –JBW only

Table 11 Patient Acuity (July 2019)
Highest percentages of patients are level 0 using the SNCT multipliers. Although this does not reflect the thought put of the unit and the number of patients requiring transfer to theatres on one shift during November the ward reported 23 patients needing escorts to theatre.

**Table 11b: Short Stay Unit patients discharged Dec 2018 – Sept 2019**

For more information on throughput see Section 10.0

SNCT multipliers incorporate three data sets to allow for sessional variation. The average bed usage during the November collection was lower than the following data sets.

### Table 12 Short Stay Unit Review Results

<table>
<thead>
<tr>
<th>SSU</th>
<th>RN WTE</th>
<th>HCA WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCT multipliers</td>
<td>20.76</td>
<td>13.4</td>
</tr>
<tr>
<td>Professional judgment</td>
<td>31.06</td>
<td>15.24</td>
</tr>
<tr>
<td>Triangulation</td>
<td>25.91</td>
<td>14.32</td>
</tr>
</tbody>
</table>

*Not including band 7

6.2 DHON Comments & Recommendations

- The short stay review results reflect the staffing required at present.
- Need to review the elective admissions as there is a higher demand Monday to Friday, and reduced demand at weekends. Will look at possibility of a 6 day unit.
- SSU should specialise in short stay day cases, however we have seen an increase in the beds being used for 1B longer stay patients, (Table 11b, shows over a 10 month period short stay having 48% of patient outside of day case / short stay which impacts on the ability to turn around short stay beds. Focus need to be realigning outliers to the right areas and speciality, in the best interest of patient care / experience and LOS.
Table 13 Nursing Key performance indicators

<table>
<thead>
<tr>
<th>Month</th>
<th>Ward</th>
<th>Nursing Indicators</th>
<th>Staffing Indicators</th>
<th>Patient Experience</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Suction</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Documentation</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment in 24 hours</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned vs Actual</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall/Fatality Rate</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA/PATCH Assessment</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Incidents</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall/Fatality Rate (Average YR)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDR</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Coleman Unit, Jackson Burrows Ward
6.3 London Irish Ward

The London Irish Ward is presently 10 months opened, located on the second floor of the new Stanmore Building. The ward specialises in caring for the complex spinal surgical patients, urological patients normally following a spinal cord injury, patients.

LIW opened to 22 beds on 8th December 2018 with the help of Duke of Gloucester Ward seconded staff. On 28th February the ward opened to 28 beds and has supported as hoc increases to 28 / 30 patients depending on skill mix, availability of bank and agency and staff from short stay following closures. The plan to open to 32 beds has very much been impacted by our ongoing and present vacancy level at band 5 seconded by an increase in long term sickness and staff on maternity leave.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budgeted FTE</th>
<th>Actual FTE</th>
<th>Vacant FTE</th>
<th>% Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Band 2</td>
<td>15.52</td>
<td>14.6</td>
<td>0.92</td>
<td>5.93%</td>
</tr>
<tr>
<td>Nurse Band 3</td>
<td>2.0</td>
<td>2.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nurse Band 5</td>
<td>19.66</td>
<td>9.35</td>
<td>10.31</td>
<td>52.44%</td>
</tr>
<tr>
<td>Nurse Band 6</td>
<td>5</td>
<td>6</td>
<td>-1.00</td>
<td>-20.00%</td>
</tr>
<tr>
<td>Nurse Band 7</td>
<td>1.00</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Data source: pulled from finance & ESR

<table>
<thead>
<tr>
<th>Table 15 Required V’s Actual CHPPD</th>
</tr>
</thead>
</table>

Table fifteen identifies the number of shifts that meet or fell below the required CHPPD for the month of July 2019.
Table 16 Temporary Staffing

Data source: E-roster: 1/6/19 - 31/7/19

In addition to the high vacancy factor among the Registered Nurses, there have been 3xRN on Maternity Leave and 3xRN on Long Term Sickness. This has led the drive for agency nurse requirement and is booked in advance to ensure patient safety. Keeping the bed base at 22 capacity has ensured that the skill mix between Substantive RN to Agency is 76:24.

Table 17 Acuity Split (July 2019)

The London Irish ward have the largest range of patients within the RNOH, a number of these are level 1a Unstable with a greater potential to deteriorate or level 1b dependent on nursing care to meet most or all of the activities of daily living.
Table 18 Acuity review results

<table>
<thead>
<tr>
<th>London Irish</th>
<th>RN WTE</th>
<th>HCA WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCT multipliers**</td>
<td>21.4</td>
<td>9.2</td>
</tr>
<tr>
<td>Professional judgment *</td>
<td>28.49</td>
<td>18.14</td>
</tr>
<tr>
<td>Triangulation</td>
<td>24.95</td>
<td>13.67</td>
</tr>
</tbody>
</table>

*Not including band 7

**Due to the change in ward only one SNCT data collection has been used to calculate the SNCT, the Shelford group recommends a minimum of three before reducing staffing.

6.4 DHON Comments & Recommendations

- The present activity is reflective of 26 beds out of 32 bed base.
- Present vacancy at Band 5 level is 10.31 WTE. Recruitment initiatives are underway with the support of DHON, ward manager from short stay and trust recruitment lead.
- The ward has experienced the highest level of long term sickness / maternity leave over the last 5 months. Presently all long term sick staff have returned full time and maternity staff are returning over the next few months up to Feb 2020.
- We identified the acuity was not always reflective of the level of dependency from our spot checks. Feedback and training followed this.
Table 19 Nursing Key performance indicators

<table>
<thead>
<tr>
<th>Month</th>
<th>Nursing Indicators</th>
<th>Staffing Indicators</th>
<th>Patient Experience</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pressure Ulcers</td>
<td>Falls</td>
<td>Sickness Rate</td>
<td>Complaints</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>1</td>
</tr>
</tbody>
</table>

|       | Hand Hygiene       | Monthly Staffing    | Planned vs Actual  | F&R Response Rate|
|       | 100%               | 60%                 | 60%                | 60%              |

|       | NEWS/PEWS Assessment | Clinical Incidents | Bed Occupancy | F&R Recommendation (Average TTO) |
|       | 100%                | 30                  | 100%          | 100%              |

|       | Likely: 94%         | Unlikely: 1.4%       |                 |                  |

|       | Safety (Ward number: Home Free Care) |                  |                 |                  |
|       | 100%                |                    |                 |                  |

London Irish Ward
7.0 Medicine & Therapies Division

7.1 Spinal Cord Injury Centre (SCIC)
The SCIC cares for newly injured Spinal Cord Injury (SCI) patients, and those admitted for SCI rehabilitation and those second admission episodes called ring fence beds.

SCIC was previously assessed on its acuity for only 24 beds, however the SCIC is now a 30 bedded centre after opening of the expansion wing to an additional 6 beds.

After AMU closed four Tissue viability patients and one ring fenced bed were absorbed to make up the 30 beds.

<table>
<thead>
<tr>
<th>Table 20 Spinal Cord Injury Centre (SCIC) Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Nurse Band 2</td>
</tr>
<tr>
<td>Nurse Band 3</td>
</tr>
<tr>
<td>Band 3</td>
</tr>
<tr>
<td>Nurse Band 5</td>
</tr>
<tr>
<td>Nurse Band 6</td>
</tr>
<tr>
<td>Nurse Band 7</td>
</tr>
</tbody>
</table>

Data source: ESR

Table 21 Required V’s Actual CHPPD

Table twenty one identifies the number of shifts that meet or fell below the required CHPPD for the month of July 2019. After internal transfers had been exhausted a number of these shifts had been put out to temporary staffing.
Data source: E-roster: 1/6/19 -31/7/19

Calculation of current vacancies is 26% vacancies rate this reflects the assigned bank and agency usage for the period in question. This is mainly driven by band 5 and Band 2 vacancies.

Table 23 Patient Acuity (July 2019)

The Shelford model identifies all patients with a spinal injury as level 1b and therefore does not take into account the complexity of the patients. During the November 2018 review the ward cared for very few level 3 patients, previous reviews have included a larger percentage of level 2 patients. On examination it is found that there were patients with higher needs not captured. We have noted the staff on the unit are not correctly capturing the data. Some education and teaching will be given to all staff to ensure data is captured correctly in the future, particularly around respiratory patients I.E Level 3 or level 2.

Table 24 SNCT V Professional Judgment

<table>
<thead>
<tr>
<th>SCIC</th>
<th>RN WTE</th>
<th>HCA WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCT multipliers</td>
<td>23.8</td>
<td>23.8</td>
</tr>
<tr>
<td>Professional judgment*</td>
<td>31.00</td>
<td>30.27</td>
</tr>
<tr>
<td>Triangulation</td>
<td>27.4</td>
<td>27.03</td>
</tr>
</tbody>
</table>

*Not including band 7
Table 24 has been calculated using two SNCT (March & July 2019) as previous reviews have been based on different/lesser bed base.

7.2 DHON Comments & Recommendations
Due to recent high rates of vacancies at B5 trained nurse level, both nationally and within SCIC, a clinical review of trained versus untrained ratios was undertaken with the senior nursing team on SCIC and in collaboration with the DDoN and DON. It was agreed that we would change the HCA configuration within budget to ensure advanced levels of competencies and developmental opportunities were given to the HCA workforce. This ensured safety and effectiveness on SCIC while B5 recruitment continued slowly. The posts included more B3 posts and the creation of B4 Senior Rehab Assistant posts. These proved very easy to recruit to and allowed the HCA work force to progress upwards and facilitate very junior B2s to be easily recruited. This facilitated the opening of the new expansion wing with 6 additional beds being used.

This review is in keeping with the national service specification for complex neurological rehabilitation. A change/drop in the SN posts would lead us to be under this confirmed 50:50 trained versus untrained ratio.

Table 24 shows that the triangulation is less than the current budgeted amount due to limitation with the safer nursing care tool. The tool does not completely represent the varied SCI acuity and its multiple complexities (eg we are the only department in the Trust that takes ventilator assisted high level tetraplegics outside of intensive care. To do this there is a need to have a high concentration of skill in the workforce hence the increased HCA advanced roles to support the trained nurse input).

Therefore the professional judgment is more accurate to ensure safe and effective management of this client group. The professional judgement is in line with our current budget and this is what we would recommend remains static.
Table 25 Nursing Key performance indicators

- **Nursing Indicators**
  - Falls: Falls and date not allowed
    - Graph showing percentage over months.
  - Nursing Documentation
  - Nutritional Assessment in 24 hours
  - NEWS/PEWS Assessment
  - Clinical Incidents
  - Bed Occupancy
  - Hand Hygiene

- **Staffing Indicators**
  - Sick Leave Rate
  - Planned vs Actual
  - F&B Response Rate

- **Patient Experience**
  - Complaints

- **Infection Control**
  - E coli

Additional notes:
- Spinal Injury Unit
- Likely 65% Unlikely 2.2%
7.3 Jubilee Rehab ward

Jubilee Rehab Centre is specialist 22 bedded mixed sex rehabilitation adult unit with a multidisciplinary approach to patient care on a Monday to Friday basis. It supports patients with long term/complex conditions – i.e. chronic pain problems, EDS, Hypermobility syndrome, CRPS, POTS, multiple joint dislocation etc. The programmes offered are based on individual patient’s assessments and needs prior to admission. All programs offered aims to encourage independence, support patients and provide them with life changing skills to help manage the various health conditions. Inpatient assessment and treatment programmes are tailored to individual patient's needs.

In addition the unit supports other departments while it is fully established but not fully occupied including the outpatient ambulatory intravenous therapy clinic for Metabolic/Rheumatology and provides pre-operative iron infusion service for the CSSD division.

Table 26 Jubilee Rehab Ward Budget

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budgeted FTE</th>
<th>Actual FTE</th>
<th>Vacant FTE</th>
<th>% Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Band 2</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nurse Band 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Band 5</td>
<td>6.4</td>
<td>6</td>
<td>0.3</td>
<td>4.76%</td>
</tr>
<tr>
<td>Nurse Band 6</td>
<td>2</td>
<td>1.8</td>
<td>0.20</td>
<td>10.00%</td>
</tr>
<tr>
<td>Nurse Band 7</td>
<td>1.00</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Data source: ESR

Table 27: Required v's Actual CHPPD

Table twenty seven identifies the number of shifts that meet or fell below the required CHPPD for the month of July 2019.
Table 28 Temporary staffing

Jubilee Rehab unit is virtually fully established. At times due to scheduling the number of beds being used may not be at full capacity therefore the beds are utilised for theatre/day case patients hence staffing needs are modified to reflect capacity. When required staff are redeployed to other wards to ensure patient safety and quality of care are maintained in other depleted areas of the Trust. Subsequently the demand to use bank and agency is low.

Table 29 Patient Acuity (July 2019)

The July 2019 review predominantly identified patients having a level 0 acuity, previous reviews have included a number of level 1b patients that required support with enhanced psychological needs and sometimes patients that have a high risk of falls when they are inpatients.

Table 30 SNCT results

<table>
<thead>
<tr>
<th>JRH</th>
<th>RN WTE</th>
<th>HCA WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCT multipliers</td>
<td>7.7</td>
<td>3.4</td>
</tr>
<tr>
<td>Professional judgment *</td>
<td>10.10</td>
<td>5.13</td>
</tr>
<tr>
<td>Triangulation</td>
<td>8.9</td>
<td>4.3</td>
</tr>
</tbody>
</table>

*Not including band 7
7.4 DHON Comments & Recommendations
At present the ward is virtually fully established and temporary staffing usage is the best in the Trust therefore we are not recommending any changes to the current ward establishments. The SNCT and the ‘Bottom up review’ / Professional judgment that takes into account the nursing demands that are not captured in the SNCT have shown that we are within safe staffing levels and that to continue to maintain our high standards of care the nursing establishment should remain unchanged. The triangulation calculations are reflective of what the budget already has allocated and we will be happy for this to remain static.
Table 31 Nursing Key performance indicators

Nursing Indicators

- Falls
- Sickness Rate
- Complaints

Staffing Indicators

- Hand Hygiene

Patient Experience

Infection Control

Rehabilitation Unit

Appendix 3 - Monthly Staffing
8.0 Private Care Division

8.1 Private Care Divisions
Private Care (PC) at the RNOH has now located to level 4 of The Stanmore Building (TSB). PC now consists of 18 single ensuite rooms and two fived bedded day case bays. There are in total 28 beds on Private Care, currently the unit is established to 18 beds therefore TCI’s are monitored to ensure the numbers stay within establishment and the roster is flexed to mirror the business of the unit.

Private Care outpatient and pre-operative assessment services are now located on what was Phillip Newman Ward. This consists of 6 rooms used for pre-operative assessment, outpatient clinics, outpatient physiotherapy and outpatient clinical assessments such as blood tests, wound reviews and health assessments. This is staffed from the same establishment as Private Care inpatients on level 4.

As a national centre of excellence patients seen on this unit may be admitted for varied types of orthopaedic surgeries which require the nursing staff to have a diverse experience of orthopaedic conditions.

There is an expectation of five star customer service by both the patient and the consultant which shapes the culture of private healthcare. The patient sees choice of time, date of treatment and choice of consultant as two of the main benefits of private care. The patient expects consultant led care and the consultant expects a level of personal service from the hospital. Patients are made aware prior to admission that the staff ratios are set in line with the NHS safer staffing guidance.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budgeted FTE</th>
<th>Actual FTE</th>
<th>Vacant FTE</th>
<th>% Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Band 2</td>
<td>6.22</td>
<td>5.61</td>
<td>0.61</td>
<td>9.81%</td>
</tr>
<tr>
<td>Nurse Band 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Band 5</td>
<td>20.01</td>
<td>14.34</td>
<td>5.67</td>
<td>28.34%</td>
</tr>
<tr>
<td>Nurse Band 6</td>
<td>5</td>
<td>5</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nurse Band 7</td>
<td>1.00</td>
<td>1.00</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Data source: E-roster (pulled from Finance & ESR)
Table 33 Private Care Required v’s Actual CHPPD

Table thirty three identifies the number of shifts that meet or fell below the required CHPPD for July 2019. As this is timeframe incorporates the settling in period this will continue to be monitored closely.

Table 34 Temporary staffing.

Data source: E-roster: 1/6/19 - 31/7/19

As inpatients and outpatients are now located separately this impacts on staffing levels and availability on level 4.

Private Care supports the NHS service by allowing them to utilise any empty beds on the unit in TSB, therefore where necessary temporary staff may be booked to ensure safe staffing levels.
Table 35 Patient Acuity

Data source: Safcare

Table 35 Identifies the patient acuity for July 2019, previous reviews have identified a larger variation in patient acuity with higher percentage scoring a level 1b.

Table 36 SNCT Results

<table>
<thead>
<tr>
<th>PPU</th>
<th>RN WTE</th>
<th>Band 2 &amp; Band 3 WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCT multipliers **</td>
<td>10.8</td>
<td>4.65</td>
</tr>
<tr>
<td>Professional judgment Ward</td>
<td>25.50</td>
<td>10.33</td>
</tr>
<tr>
<td>Triangulation</td>
<td>18.15</td>
<td>7.49</td>
</tr>
</tbody>
</table>

*Not including band 7

**The SNCT multiplier does not take into account the nurse’s required to run the outpatient clinic. The professional judgment for the PPU Outpatient department is 2.46 WTE RN.

8.2 DHON Comments & Recommendations

We are currently reviewing the establishment following the move to TSB. This includes reviewing the band 2 HCA posts to band 3 CSW posts to allow some flexibility between clerical support and clinical support.

As the inpatient and outpatient facilities are now geographically separated the review will look at whether slightly more senior support is required to oversee the running of the outpatient facility on a daily basis. This may mean reviewing the allocation of band 6 staff across both areas.
Table 37 Nursing Key performance indicators

<table>
<thead>
<tr>
<th>Month</th>
<th>Ward</th>
<th>Nursing Indicators</th>
<th>Staffing Indicators</th>
<th>Patient Experience</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment in 24 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEWS/PEWS Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Incidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFQ Response Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecoli</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Private Care Ward
9.0 Children’s Outpatients, imaging & Access Division

Table 38 Budget & Vacancy

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budgeted FTE</th>
<th>Actual FTE</th>
<th>Vacant FTE</th>
<th>% Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Band 2</td>
<td>8.21</td>
<td>6.64</td>
<td>1.57</td>
<td>19.12%</td>
</tr>
<tr>
<td>Nurse Band 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Band 5</td>
<td>20.86</td>
<td>12.93</td>
<td>7.93</td>
<td>38.02%</td>
</tr>
<tr>
<td>Nurse Band 6</td>
<td>6.56</td>
<td>3.61</td>
<td>2.95</td>
<td>44.97%</td>
</tr>
<tr>
<td>Nurse Band 7</td>
<td>2.90</td>
<td>3.10</td>
<td>0.20</td>
<td>6.90%</td>
</tr>
</tbody>
</table>

Data source: ESR

<table>
<thead>
<tr>
<th>Coxon</th>
<th>RN WTE</th>
<th>HCA WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional judgment</td>
<td>28.52</td>
<td>7.81</td>
</tr>
</tbody>
</table>

9.1 DHON Comments & Recommendations
The trust is currently in the process of introducing the Shelford group’s paediatric tool and the next 6 monthly report will incorporate this data. The ward currently uses the RCN model of paediatric nursing to ensure safe staffing.
10.0 Throughput

Table 41 indicates the throughput (bed occupancy of individual wards.

### Table 41

<table>
<thead>
<tr>
<th>Month</th>
<th>Adolescent/Coxen Ward</th>
<th>Duke of Gloucester Ward</th>
<th>Jackson Burrows Ward</th>
<th>London Irish Ward</th>
<th>Rehabilitation Unit</th>
<th>RNOH Private Care</th>
<th>Short Stay Unit</th>
<th>Spinal Unit</th>
<th>The Coleman Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-19</td>
<td>53.6%</td>
<td>92.2%</td>
<td>87.6%</td>
<td>97.9%</td>
<td>54.8%</td>
<td>44.4%</td>
<td>89.9%</td>
<td>76.8%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>61.6%</td>
<td>93.4%</td>
<td>77.2%</td>
<td>101.4%</td>
<td>64.8%</td>
<td>46.4%</td>
<td>82.2%</td>
<td>83.7%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Mar-19</td>
<td>63.2%</td>
<td>92.4%</td>
<td>77.1%</td>
<td>100.4%</td>
<td>65.2%</td>
<td>51.4%</td>
<td>83.5%</td>
<td>88.0%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Apr-19</td>
<td>56.8%</td>
<td>91.7%</td>
<td>64.5%</td>
<td>93.6%</td>
<td>61.8%</td>
<td>30.2%</td>
<td>71.7%</td>
<td>88.1%</td>
<td>90.5%</td>
</tr>
<tr>
<td>May-19</td>
<td>55.1%</td>
<td>94.5%</td>
<td>75.8%</td>
<td>99.4%</td>
<td>73.3%</td>
<td>40.9%</td>
<td>79.9%</td>
<td>85.5%</td>
<td>85.7%</td>
</tr>
<tr>
<td>Jun-19</td>
<td>64.2%</td>
<td>91.5%</td>
<td>77.9%</td>
<td>90.1%</td>
<td>67.0%</td>
<td>39.8%</td>
<td>80.2%</td>
<td>86.9%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Jul-19</td>
<td>84.8%</td>
<td>96.5%</td>
<td>74.5%</td>
<td>90.9%</td>
<td>59.9%</td>
<td>48.7%</td>
<td>80.1%</td>
<td>81.8%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Aug-19</td>
<td>73.4%</td>
<td>87.8%</td>
<td>65.2%</td>
<td>96.2%</td>
<td>71.1%</td>
<td>43.4%</td>
<td>65.6%</td>
<td>74.1%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Sep-19</td>
<td>68.5%</td>
<td>92.9%</td>
<td>75.9%</td>
<td>101.8%</td>
<td>84.4%</td>
<td>47.7%</td>
<td>79.4%</td>
<td>85.3%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Oct-19</td>
<td>66.5%</td>
<td>97.6%</td>
<td>81.9%</td>
<td>97.8%</td>
<td>88.5%</td>
<td>51.3%</td>
<td>86.5%</td>
<td>88.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Total</td>
<td>64.8%</td>
<td>93.0%</td>
<td>76.2%</td>
<td>96.9%</td>
<td>69.4%</td>
<td>44.5%</td>
<td>80.2%</td>
<td>83.2%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

Source: Insight Bed Capacity, Usage report

11.0 External Bench Marking

The model hospital enables us to bench mark ourselves against our peers (other orthopaedic hospitals) and other London Trusts. Table forty four identifies that our CHPPD is above our peers but the lowest in comparison to other London Trusts.
10.1 Conclusion
At this time the DHON for London Irish and Duke of Gloucester are currently monitoring the staffing numbers closely, with the DHON for Duke of Gloucester recommending an increase in RN.

Due to the fluctuation in bed base and throughput (table 41) it has been a challenge confidently predict a safe staffing requirements as the SNCT is based on lower bed capacity than the Professional judgment.

The impact of vacancies is impacting on the feel within the clinical areas. Work is currently underway to recruit into these post but this is a National / International Issue.

**Report date:** 11/11/19

Report compiled by: Karen Mannion; Project Nurse / lead for Implementation of safe staffing Tool, Divisional Heads of Nursing (DHON) and Dr Julie-Anne Dowie, Head of Nursing on behalf of Professor Paul Fish, Director of Nursing.
# Appendix A

## Expectations 1-10 (NQB, 2013)

<table>
<thead>
<tr>
<th>Expectation</th>
<th>RNOH Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation 1:</strong> Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.</td>
<td>Clinical Quality Review Group Performance Committee Staffing Reports to Board Balanced scorecard</td>
</tr>
<tr>
<td><strong>Expectation 2:</strong> Processes are in place to enable staffing establishments to be met on a shift to shift basis.</td>
<td>eRostering for bank/agency management Escalation protocol Rostering policy Shift-by-shift reporting system</td>
</tr>
<tr>
<td><strong>Expectation 3:</strong> Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.</td>
<td>Shelford Group (2014) Bottom-up (professional judgement)</td>
</tr>
<tr>
<td><strong>Expectation 4:</strong> Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns.</td>
<td>Policies and procedures Employee assistance programme Listening event Visible posters display management team by department</td>
</tr>
<tr>
<td><strong>Expectation 5:</strong> A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.</td>
<td>The Director of Nursing and Finance Director works in partnership to undertake the establishment reviews</td>
</tr>
<tr>
<td><strong>Expectation 6:</strong> Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.</td>
<td>Supervisory ward leaders Centralised budget for managing long term leave Establishments allow for study leave, annual leave and short-term sickness.</td>
</tr>
<tr>
<td><strong>Expectation 7:</strong> Boards receive monthly updates on workforce information and staffing capacity and capability, and is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery review.</td>
<td>Monthly report presented to Board 6 monthly report presented to Board</td>
</tr>
<tr>
<td><strong>Expectation 8:</strong> NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.</td>
<td>Boards in every ward displaying up to date staffing information</td>
</tr>
<tr>
<td><strong>Expectation 9:</strong> Providers of NHS services take an active role in securing staff in line with their workforce requirements.</td>
<td>Recruitment strategy Organisational development strategy Link to local LETB</td>
</tr>
<tr>
<td><strong>Expectation 10:</strong> Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.</td>
<td>Commissioners presented with staffing papers as required Senior nursing representation at review meetings</td>
</tr>
</tbody>
</table>
Overview

- Workforce Performance:
  - Turnover and Exit Data Review
  - Balanced Scorecard

- Staff Experience
  - WRES Targets and Equality Actions Project
  - Staff Survey

- Education Update
  - Funding overview
  - TNA and Study Leave Process
Workforce Performance
The Committee discussed a report which provided analysis and trends for the financial year April 2018 to March 2019, with particular emphasis on staff who left the Trust in the first year of service.

Out of 211 leavers in 2018/19, a total of 90 staff (42.7%) left within the first year of joining the Trust. The top three reasons given for leaving are relocation, promotion, and work/life balance. These three reasons have consistently been the top three over the past three years of providing the turnover report. However, 25 staff left without stating a reason.

In response the Trust is seeking to establish clearer career pathways to replace flat structures and to create more opportunities for career development and progression within the organisation.

In addition to all other ongoing engagement interventions, The Trust is looking to introduce an induction/onboarding plan that includes a discussion or a review with new staff post probation or at month 9 as an intervention to engage in a two way feedback – it is called a ‘stay chat’ in some organisations.
Workforce Performance

Balanced Scorecard:

• The Committee discussed the current balanced scorecard, which showed the agency usage for October had decreased month on month. This was the fifth drop in a row and a 10% decrease since the start of the financial year.

• Other areas of note included:
  – After a four month trend of increasing appraisal compliance, October has seen a 3.4% decrease in the compliance rate
  – The compliance rate for Core Skills remains within the tolerance and is static
  – The retention rate has also remained static and has been on or above target for the last four consecutive months
  – The sickness absence percentage has dropped to 3.2% just above Trust target, although remains within Trust threshold
  – The vacancy rate has continued its downward trend and has fallen for the third month in a row. It was within 1% of the Trust's target of 9.5%
Staff Experience
WRES Targets and Equality Actions Project:

- Following the NHS Workforce Race Equality Standard (WRES) leadership strategy being published at the beginning of 2019, the Trust has now received aspirational targets for bands 8a-VSM BME recruitment.

- The Committee discussed the fact that the Trust has a 55%/45% White/BME split in its staffing but that this ratio is not replicated at the highest levels of the Trust.

- Research shows that organisations that have diverse leadership are more successful and innovative than those that do not. Employees who feel valued are more likely to be engaged with their work and diversity at senior levels increases productivity and efficiency in the workplace. Such organisations are better placed to reduce health inequalities in our diverse communities and leads to better patient care, satisfaction and outcomes.

- The Committee went on to discuss the proposed Equality Actions Project detailed in the following slides.
Equality Achievement Project

Underpinning Principles:

• Projects informed by best practice and methodologies with proven success records
• Staff representatives (from Equality Achievement Network) will sign off all plans
• National expertise in Equality and Inclusivity will be sought to review the project and plans

4 key areas of focus:

• Recognition and representation from ‘Board to Ward’
• Making real change for our staff now
• Improving capability and leadership in relation to equality and inclusivity
• Telling everyone that it matters and what is being done
Equality Achievement Project

• Recognition and representation
  • Meaningful and definitive Trust Board discussion and support for EA Project
  • ‘Reverse mentoring’
  • Executive Director/Trust Board Champions
  • Strengthen Equality Achievement Network (EAN)

• Make real change, now
  • Values-based recruitment
  • Review shortlisting and interview process to drive up equitable and inclusive recruitment process
  • Review of all conduct cases to ensure consistency of approach – model to be agreed
  • Inclusive Talent Management:
    • Map career pathways for all staff (with a focus on engaging EAN to develop this)

*colours used indicated current progress on this initiative
Equality Achievement Project

• Improving capability and leadership:
  • Integrate ‘Unconscious Bias’ training in Leadership Development Programmes
  • Consider Perspective Taking Training
  • Ensure access to training for Protected Characteristic staff:
    • Stepping Up Programme
    • Ready Now
    • Race Equality Expert Programme

• Telling everyone that it matters and what is being done
  • Diversity Festival
  • Communicate our plans to our staff – include national requirements WRES, WDES and EDS2
Background - Education at RNOH

The Education Committee reports into the Workforce and Organisational Development Committee. Four years ago the Trust had a range of funding streams but with no appropriate governance and was not aligned to the Trust’s strategy in relation to ensuring staff could be appropriately trained and educated to deliver the best patient care and staff experience. It was at this time that the Education Committee was established and it focuses on the provision of training, development and education for our staff in the organisation using the resources and funding available.

Nursing students and nurse education is managed by the Director of Nursing’s team and through the Education Committee. AHP education is also overseen ultimately by the Education Committee but managed primarily at a local level. Medical education is overseen by the Director of Medical Education and supported by the Medical Education team (0.5 band 8a and 1 x band 4) and is overseen by the Medical Education Committee which reports into the Education Committee.

The Committee does not oversee education provided by UCL or the relationship with UCL.

The Education Centre team is made up of a Band 3 and Band 5 who focus on generating income and facilitating the running of the centre. The team are focused on reviewing and developing the range of convenor courses, with multidisciplinary teams responsible for their delivery and often led by Consultants.

The Learning and Development team (0.5 band 8a, 1 x band 5, 1 x band 3) organise training courses, CPD and apprenticeships. Approximately £50k CPD is invested in mentorship and preceptorship for nurses and a further £100k is allocated for teams to spend locally.
Education Update

Funding Allocation & Study Leave Process:

- The Committee reviewed a presentation discussed at Education Committee outlining the use of the study leave budget to date. The report showed that the use of funding is not equally used across the Trust although it is allocated on a headcount basis.

- There was a discussion about whether there is a better way to allocate funding going forward at Education Committee and a revised approach was then presented to the WOD Committee for discussion and approval.

- The proposal includes the suggestion that funding be allocated on a 2 year basis, that Trust funding is released ahead of HEE funding (which normally is confirmed and allocated in Q2) and that the TNA be used more clearly to drive training activity. This proposal was approved and will go back to Education Committee.
1 Key drivers of forecast variance – M5

Chart 1 - Control total vs. 19/20 ‘as-is run rate’

Chart 2 - Forecast position vs. M5 ‘as-is run-rate’

Chart 1 illustrates the 19/20 control total and what the run rate would have been had it not been for three key elements bridging the gap:
- £4,977k CIP target
- £1,214k gain from insourcing and other service developments
- £1,436k income gap which allowed us to get to the control total

Chart 2 illustrates the forecast position and corresponding run rate once taking into account the changes to the three key elements:
- £3,156k forecast CIP achievement
- £325k gain from insourcing and other service developments
- £0k of the income gap achieved
## Mitigations:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Scheme Name</th>
<th>Scheme Type</th>
<th>Scheme Lead</th>
<th>19/20 (£) Impact</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>RP1</td>
<td>Reduce medical agency spend</td>
<td>Run-Rate</td>
<td>DoWOD</td>
<td>£55,000</td>
<td>Reduced spend in M6. Run rate adjustment processed, to be tested further.</td>
</tr>
<tr>
<td>RP2</td>
<td>Reduce transcription costs</td>
<td>CIP</td>
<td>COO</td>
<td>-</td>
<td>Potential quality issues with current service being explored.</td>
</tr>
<tr>
<td>RP3</td>
<td>Reduce Medical Note storage costs</td>
<td>CIP</td>
<td>Cauldricott, Info Governance</td>
<td>-</td>
<td>Destruction costs offset by reduced storage cost in year one. Following which annual saving approx. £42,000.</td>
</tr>
<tr>
<td>RP4</td>
<td>Review income provisions</td>
<td>Balance Sheet</td>
<td>Director of Finance</td>
<td>£305,000</td>
<td>Assumed 100% CQUIN achievement in Q1/2 and released prior year income gain. Review of NON NHS debt.</td>
</tr>
<tr>
<td>RP5</td>
<td>Review non pay spend run-rate assumption</td>
<td>Run-Rate</td>
<td>Director of Finance</td>
<td>-</td>
<td>Updated methodology applied to month 6 forecast.</td>
</tr>
</tbody>
</table>
## Mitigations (cont.):

<table>
<thead>
<tr>
<th>Ref</th>
<th>Scheme Name</th>
<th>Scheme Type</th>
<th>Scheme Lead</th>
<th>19/20 Impact</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>RP6</td>
<td>Review Grip and Control Checklist</td>
<td>Financial Governance</td>
<td>Executive Team</td>
<td>-</td>
<td>Ongoing</td>
</tr>
<tr>
<td>RP7</td>
<td>Remove Outsourcing</td>
<td>CIP</td>
<td>COO/DoF</td>
<td>-</td>
<td>Analysis of current arrangements completed. Next steps to be agreed.</td>
</tr>
<tr>
<td>RP8</td>
<td>Private Care contribution</td>
<td>Run-Rate</td>
<td>Director of Finance</td>
<td>-</td>
<td>No change to month 5 forecast. Adverse income variance £271,000.</td>
</tr>
<tr>
<td>RP9</td>
<td>Insourcing</td>
<td>Run-Rate</td>
<td>COO</td>
<td>£118,000</td>
<td>19/20 Outturn income forecast updated.</td>
</tr>
<tr>
<td>RP10</td>
<td>Interpreters</td>
<td>CIP</td>
<td>Director of Nursing</td>
<td>N/A</td>
<td>Options for service delivery being considered. If agreed, changes likely to be introduced in 20/21.</td>
</tr>
</tbody>
</table>
### Mitigations (cont.):

<table>
<thead>
<tr>
<th>Ref</th>
<th>Scheme Name</th>
<th>Scheme Type</th>
<th>Scheme Lead</th>
<th>19/20 Impact</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>RP11</td>
<td>Rationalisation of prosthesis</td>
<td>CIP</td>
<td>MD/DoF</td>
<td>-</td>
<td>Progressing in 19/20 however expected benefit in 20/21.</td>
</tr>
<tr>
<td>RP12</td>
<td>Review of additional sessions</td>
<td>Run Rate</td>
<td>COO</td>
<td>-</td>
<td>Analysis of current arrangements being undertaken.</td>
</tr>
<tr>
<td>RP13</td>
<td>Bolsover street - parking spaces</td>
<td>CIP</td>
<td>Director of Estates/DoF</td>
<td>N/A</td>
<td>Director of Estates liaising with solicitors as to feasibility. Unlikely to impact 19/20.</td>
</tr>
<tr>
<td>RP14</td>
<td>Stop non clinical non pay spend</td>
<td>Run Rate</td>
<td>Director of Finance</td>
<td>-</td>
<td>Not yet implemented. Remains option for consideration.</td>
</tr>
<tr>
<td>RP15</td>
<td>VAT Efficiency - agency</td>
<td>Run Rate</td>
<td>DoWOD</td>
<td>-</td>
<td>Remains option for consideration.</td>
</tr>
</tbody>
</table>
Forecast position for 19/20 (based on M6)

KEY ASSUMPTIONS

1) PSF & FRF – Assume on plan for Q1 & Q2, Q3 & Q4 is expected to register an adverse variance against plan resulting in £10,094k PSF and FRF foregone income in the final two quarters. Phasing of deficit not tested.

2) CIP - The CIP target for 19/20 is £4,977k and forecast is c.£3,456k (assumes £300k stretch to current identified).

3) Insourcing - £1,004k forecast against a plan of £1,234k for 19/20 and the assumed contribution margin is 24.4% (based on 18/19 PLICS data). A clearer picture is expected to emerge around November.

4) NHS income – This is based on the YTD income extrapolated according to working days, then assumptions on 18/19 business planning and also divisional intelligence on expected activity changes have been overlayed accordingly. It is assumed that NHS activity has a contribution margin of c.13.5% (based on 18/19 PLICS data).

5) Private Care – Divisional forecast of £7,414k which represents a £253k adverse variance against the £7,685k plan for 19/20. It is assumed that Private Care activity has a contribution margin of c.20.4% (based on 18/19 PLICS data).

6) Block contract – as it stands the Trust is expected to benefit from the NHSE block contract by £757k. If activity was to increase there would be a deterioration to the position due to the corresponding cost increase with no income gain.

7) Spend on medical equipment supplies and services – run rate increased by £1,202k due to higher spend in M4, M5 and M6 which is likely to be more representative of spend going forward, and accruals on non-pay are also being reviewed.
### Control total movement reconciliation

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>EXPECTED</th>
<th>FORECAST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTROL TOTAL EXCLUDING PSF &amp; FRF</strong></td>
<td></td>
<td>(17,391)</td>
</tr>
<tr>
<td>Insourcing contribution loss</td>
<td>(115)</td>
<td></td>
</tr>
<tr>
<td>Private Care contribution loss</td>
<td>(55)</td>
<td></td>
</tr>
<tr>
<td>CIPs unachieved</td>
<td>(1,521)</td>
<td></td>
</tr>
<tr>
<td>Income gap</td>
<td>(1,436)</td>
<td></td>
</tr>
<tr>
<td>Cost impact of bank change on pay</td>
<td>(185)</td>
<td></td>
</tr>
<tr>
<td>Cost impact of medical pay inflation</td>
<td>(433)</td>
<td></td>
</tr>
<tr>
<td>Net finance cost movements</td>
<td>(198)</td>
<td></td>
</tr>
<tr>
<td>Delays in business planning service developments/contribution assumptions</td>
<td>(623)</td>
<td></td>
</tr>
<tr>
<td>Other activity/run rate movements</td>
<td>(14)</td>
<td></td>
</tr>
<tr>
<td><strong>ADJUSTED FORECAST TO M12</strong></td>
<td></td>
<td>(21,971)</td>
</tr>
</tbody>
</table>

1) Insourcing - The plan submitted to NHSI assumed £1,234k revenue, the Trust is now expecting to generate £1,004k at 24% contribution, therefore resulting in the adverse variance against the plan. A more clearer picture is expected to emerge in November.

2) Private care – Plan was to generate £7,685k, this has now been revised downward to £7,414k at 20% resulting in a net adverse contribution loss of £52k.

3) CIP - The CIP target for 19/20 is £4,977k and forecast is as per the CIPs identified at c.£2,656k.

4) Income gap – balance between the control total and the Trust plan, this was clearly identified as a risk in business planning submission to NHSI. The Trust does not expect to generate the additional £1,436k.

5) Cost impact of bank change on pay – the Trust has discovered that not all bank staff had been receiving minimum wages and therefore pay is expected to be backdated and also staff are to be paid the higher rate going forward. The figure is still subject to being finalised

6) Cost impact of medical pay inflation – updated medical pay inflation assumptions for 19/20 received in August

7) Net finance cost movements – combination of Q1 and Q2 PSF & FRF funding not received resulting in greater drawdown of RSL and therefore higher interest. Similarly we are expecting to forego Q3 and Q4 PSF & FRF which will also result in additional drawdown of RSL. Finally assumptions on finance costs were also revised upwards in-year compared to business planning

8) Delays in business planning service developments – significant delays in particular to the Neurology/FARS business case and limb reconstruction business case etc. resulting in lower contribution
Risks to delivery:

- Winter pressures
- Unplanned workforce changes
- Insourcing work not yet commissioned
- CIP stretch £300,000.
Financial Recovery - MTFP:

- Private Care growth
- Case Mix change – repatriation of complex work.
- Underlying tariff impact
- Theatre inventory system
- Outpatient models of care
- Workforce reviews
External Support and Programs of Work:

- Corporate services review
- NCL Orthopaedic Hub
- Dedicated financial recovery resource
Draft 2019/20 Forecast
(as at M8)

December 2019
1 Forecasting position for 19/20

Forecast – 19/20

### KEY ASSUMPTIONS

1) **PSF & FRF** – Assume on plan for Q1 & Q2, Q3 & Q4 is expected to register an adverse variance against plan resulting in £10,094k PSF and FRF foregone income in the final two quarters.

2) **CIP** – The CIP target for 19/20 is £4,977k and forecast is c.£3,339k (assumes £200k stretch to current identified).

3) **Insourcing** – Forecast reflects 30 patients from Birmingham at locally agreed tariff. No further Belfast/Dublin work.

4) **NHS income** – This is based on the YTD income extrapolated according to working days, this has been adjusted to reflect activity changes advised by the Head of Elective access and divisional intelligence.

5) **Private Care** – Divisional forecast of £7,414k which represents a £253k adverse variance against the £7,685k plan for 19/20. It is assumed that Private Care activity has a contribution margin of c.20.4% (based on 18/19 PLICS data).

6) **Block contract** – based on the activity projections outlined above the Trust is expected to over perform NHSE block contract by £819k.

7) **Spend on medical equipment supplies and services** – run rate adjustment applied (£305k)

8) **Reflects full release of NHS commissioner provisions other than current known disputes.**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL INCOME</td>
</tr>
<tr>
<td>TOTAL PAY</td>
</tr>
<tr>
<td>TOTAL NON-PAY</td>
</tr>
<tr>
<td>OPERATING SURPLUS/(DEFICIT)</td>
</tr>
<tr>
<td>NET FINANCE COST + OTHER GAINS &amp; LOSSES</td>
</tr>
<tr>
<td>SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR</td>
</tr>
<tr>
<td>ADD BACK ALL I&amp;E IMPAIRMENTS/(REVERSALS) REMOVE CAPITAL DONATIONS/GRANTS I&amp;E IMPACT</td>
</tr>
<tr>
<td>ADJUSTED PERFORMANCE</td>
</tr>
<tr>
<td>REMOVED Q1 &amp; Q2 PSF &amp; FRF</td>
</tr>
<tr>
<td>ADJUSTED PERFORMANCE EXCLUDING PSF &amp; FRF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>ANNUAL BUDGET (£000’s)</th>
<th>EXPECTED FORECAST</th>
<th>VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL INCOME</td>
<td>171,381</td>
<td>159,902</td>
<td>11,479</td>
</tr>
<tr>
<td>TOTAL PAY</td>
<td>97,705</td>
<td>97,832</td>
<td>(127)</td>
</tr>
<tr>
<td>TOTAL NON-PAY</td>
<td>74,561</td>
<td>75,472</td>
<td>(910)</td>
</tr>
<tr>
<td>OPERATING SURPLUS/(DEFICIT)</td>
<td>(885)</td>
<td>(13,402)</td>
<td>12,517</td>
</tr>
<tr>
<td>NET FINANCE COST + OTHER GAINS &amp; LOSSES</td>
<td>(1,294)</td>
<td>(1,554)</td>
<td>260</td>
</tr>
<tr>
<td>SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR</td>
<td>(2,179)</td>
<td>(14,956)</td>
<td>12,777</td>
</tr>
<tr>
<td>ADD BACK ALL I&amp;E IMPAIRMENTS/(REVERSALS) REMOVE CAPITAL DONATIONS/GRANTS I&amp;E IMPACT</td>
<td>0 (316)</td>
<td>0 (351)</td>
<td>667</td>
</tr>
<tr>
<td>ADJUSTED PERFORMANCE</td>
<td>(1,863)</td>
<td>(15,307)</td>
<td>13,444</td>
</tr>
<tr>
<td>REMOVED Q1 &amp; Q2 PSF &amp; FRF</td>
<td>0 (5,434)</td>
<td>0 (351)</td>
<td>667</td>
</tr>
<tr>
<td>ADJUSTED PERFORMANCE EXCLUDING PSF &amp; FRF</td>
<td>(17,391)</td>
<td>(20,741)</td>
<td>(3,350)</td>
</tr>
</tbody>
</table>
## Control total movement reconciliation

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>EXPECTED FORECAST</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTROL TOTAL EXCLUDING PSF &amp; FRF</td>
<td>(17,391)</td>
</tr>
<tr>
<td>Insourcing contribution gain</td>
<td>732</td>
</tr>
<tr>
<td>CIPs unachieved</td>
<td>(1,638)</td>
</tr>
<tr>
<td>Income gap</td>
<td>(1,436)</td>
</tr>
<tr>
<td>Cost impact of medical pay inflation</td>
<td>(433)</td>
</tr>
<tr>
<td>Net finance cost movements</td>
<td>(260)</td>
</tr>
<tr>
<td>Delays in business planning service developments/contribution assumptions</td>
<td>(623)</td>
</tr>
<tr>
<td>Premises costs lower than expected</td>
<td>324</td>
</tr>
<tr>
<td>Other activity/run rate movements</td>
<td>(17)</td>
</tr>
<tr>
<td>ADJUSTED FORECAST TO M12</td>
<td>(20,741)</td>
</tr>
</tbody>
</table>

1) **Insourcing** - The plan submitted to NHSI assumed £1,234k revenue for Belfast activity, the Trust is expecting to generate £511k resulting in the adverse variance against the plan. However this is offset with Birmingham activity which is forecast to generate income of £1822k.

2) **CIP** - The CIP target for 19/20 is £4,977k and the forecast is £3,339k.

3) **Income gap** – balance between the control total and the Trust plan, this was clearly identified as a risk in business planning submission to NHSI. The Trust does not expect to generate the additional £1,436k.

4) **Cost impact of medical pay inflation** not captured in plan.

5) **Net finance cost movements** – combination of Q1 and Q2 PSF & FRF funding not received resulting in greater drawdown of RSL and therefore higher interest. Similarly we are expecting to forego Q3 and Q4 PSF & FRF which will also result in additional drawdown of RSL. Finally assumptions on finance costs were also revised upwards in-year compared to business planning.

6) **Premises** are expected to be lower than plan following on from the full year opening of The Stanmore Building and lower business rates.
## Likely outturn - £3.35m adverse (exc. PSF/FRF)

<table>
<thead>
<tr>
<th><strong>Upside - £3m adverse</strong></th>
<th><strong>Downside - £3.8m adverse</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Linked to sensitivities around non pay assumptions.</td>
<td>• Risks around block contract. In particular Spinal Cord Injury activity and JRU/Sarcoma.</td>
</tr>
<tr>
<td>• IT compensation payment</td>
<td>• Approach to capitalisation of redevelopment team subject to review due to changes to MSCP/Residences.</td>
</tr>
<tr>
<td>• Potential negotiation of Provider to Provider outsourcing cost</td>
<td>• Requires identification and delivery of additional CIP (£200k stretch to be identified).</td>
</tr>
<tr>
<td></td>
<td>• High variability of non pay costs, difficult to map without e-proc/stock.</td>
</tr>
</tbody>
</table>
Protocol for Changes to an In-Year Financial Forecast

1. Introduction

1.1 NHS providers and commissioners submitted financial plans for 2019/20. These plans were quality impact assessed and signed off by individual boards / governing bodies prior to submission.

1.2 The achievement of financial balance, whilst maintaining the quality of healthcare provision, is a key objective for all organisations. The future success of the NHS depends on clinical commissioning groups (CCGs), direct commissioners (DCs) which includes specialised commissioning, and providers delivering or over achieving the plans that they have signed up to and boards / governing bodies must take organisational and personal accountability for meeting their financial and performance commitments.

1.3 In exceptional circumstances it may be necessary for an NHS commissioner or provider board / governing body to reconsider its planned forecast outurn position. In this event, the primary focus must be the identification and delivery of a recovery plan that demonstrates the mitigating actions being implemented that ensure any proposed adverse revision to forecast outurn is minimised, managed and fully recovered at the earliest possible time.

1.4 To demonstrate the highest standards of governance and for purposes of consistency and transparency, the protocol set out below should be followed by all commissioner and provider boards / governing bodies considering the reporting of a deterioration in the forecast outurn against their planned position for the year. Similar processes will be operated to control directly commissioned services.

1.5 The introduction of this protocol by NHS England and Improvement (NHSE/I) should not be taken by boards / governing bodies as permission to deteriorate financial positions. All reporting revisions must be accompanied by the actions required to return to planned positions.

1.6 The protocol is required to be followed for all deteriorations in positions, it does not apply to improvements in positions, but these should still be communicated and discussed with regional teams in advance of any changes being formally recorded.

2. Protocol

2.1 Revisions to forecast outurns can only be made once a commissioner or provider’s plan for the year has been agreed and only at the quarterly
reporting points in the year and must be made through the standard quarterly reporting process. Where, in exceptional circumstances, a movement is required on a non-quarter-end month, this should only be undertaken with the express agreement of the NHSE/I regional director of finance. Other important considerations are:

- NHSE/I would not expect to see any changes in the first quarter given that this follows closely after the planning process.
- Changes in the final quarter will be looked on as a sign of very poor financial control likely to attract further scrutiny. Where such movements are identified and changes required in months 10 and 11, the protocol process must be initiated as soon as the deviation becomes known.
- The protocol should be used to record all adverse movements from plan regardless of whether an organisation is still within its control total.
- If the protocol process has been invoked for an adverse change in position, any subsequent changes from the revised forecast outturn position will require the process to start again. This would be particularly relevant for an organisation that changes its forecast early in the year and then finds that it has worsened later in the year. A further deterioration will be viewed as very poor forecasting and lack of financial control.

2.2 In advance of formally reporting a forecast outturn variance from plan, commissioners / providers are required to have discussed the financial deterioration with the respective NHSE/I executive regional director and regional director of finance.

2.3 This engagement must be underpinned with a commissioner / provider prepared detailed report that clearly includes details of:

- The key financial drivers for the deterioration;
- An analysis of the underlying causes;
- The actions being taken to address the deterioration and evidenced confirmation that:
  - Relevant partner organisations have been informed of the position and all opportunities for support have been explored and the recovery actions agreed;
  - The senior clinical decision making body within the commissioner / provider has been engaged with and are party to the identification and delivery of the recovery actions;
• Commissioner / provider executive committee, finance committee and board / governing bodies have considered and agree the proposed financial forecast revision and recovery actions.

2.4 This recovery plan described must explicitly reference:

• Details of the additional measures immediately implemented to improve financial control and where applicable working capital/cash management, including capital programme review. This will include all discretionary spend, agency / locum spend, supplies and consumable spend.

• Details of how the commissioner / provider is reviewing:

  • The affordability of planned investments to improve service quality and performance;
  
  • The acceleration of the delivery of productivity opportunities identified by the Carter review and other efficiency programmes;
  
  • The acceleration or extension of quality innovation productivity and prevention (QIPP) schemes and areas such as Rightcare.
  
  • The acceleration of proposals for sub-scale service consolidation or closure;
  
  • The impact on patient safety and experience of recovery actions;
  
  • The demonstration of quarter on quarter improvement in income and expenditure run-rate from the point the revision is submitted and how QIPP, or cost improvement programmes (CIP) delivery is being maximised.

2.5 System review requirements, system level sign off is required to confirm that the position has been discussed and agreed at a sustainability and transformation partnership (STP) level and that all options for mitigation including systems wide solutions have been explored. This should involve the following stages:

• Commissioners / providers must demonstrate that discussions have taken place with partner organisations to resolve any material issues that could affect the partners’ abilities to meet their control totals. There should be an audit trail that shows the partners agreement on the nature and cause of a problem (defined as a deviation from plans) and that the options for mitigation across the system have been properly considered.
• STP partner organisations must have the opportunity to be able to provide peer commentary on the position reached within the organisation. This will ensure there is a system wide understanding of the circumstances leading to a change in planning assumptions.

• Within an integrated care system ICS there may be the added impact that an organisation that cannot meet its control totals, could impact on the provider sustainability fund (PSF) and commissioner support fund (CSF) of all partners. In these circumstances the ICS will need to decide whether there are any system-wide solutions that could be triggered to provide mitigation for the affected organisation’s financial pressures. This should be brokered and approved by the ICS.

2.6 When a formal revision to forecast outturn under this protocol is made through the national reporting process, it must be accompanied by a board assurance statement (BAS) signed by the commissioner / provider chair, accountable officer / chief executive, chief financial officer / director of finance, and audit committee chair in respect of the organisation’s adherence to this protocol and their commitment to the delivery of the recovery plan. Additionally, STP sign off is required, this will be the signature of the STP leader or finance lead. This statement will be addressed to the chair and chief executive of NHSI/E and will be formally reported to that organisation’s board.

2.7 The regional team will notify organisations how they wish the BAS to be submitted. Organisations are required to liaise with regional teams early in the process and well in advance of any monthly or quarterly reporting deadlines. Monitoring arrangements will be determined by the executive regional director to ensure that focus and delivery is maintained.

NHS England and NHS Improvement