## Public Board Meeting

| Appendix 1: Balanced Scorecard for July 2019 (Item 6b) |
| Appendix 2: August Board Assurance Framework (Item 7) |
| Appendix 3: Medical Revalidation – Annual Board Report (Item 9) |
| Appendix 4: X-ray and Imaging Department visit (Item 10c) |
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:
- Indicator on: Target
  - Month and Overall Status calculation:
    - Month: Actual vs Month Target/Month Amber Threshold
    - Overall: YTD Actual vs YTD Target/YTD Amber Threshold

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
- YTD Average

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
OVERALL COMMENTARY

Clinical Quality:

Access to Service:

All cancer access standards were achieved in June. The 62 day referral to treatment target, 31 day first treatment and 31 day subsequent treatment were all met with 100% performance. Performance against the two week wait target was above trajectory with a performance of 96.4%. The notable improvement in performance against the 62 day referral to treatment target is driven by i) utilisation of straight to test pathway; two of the patients treated were seen on a straight to test basis, reducing the overall length of the diagnostic portion of the pathway which allowed them to be treated within target and ii) greater pathway scrutiny to ensure that patients referred to RNOH on a 2WW referral are referred out for treatment before day 38. As a result of the new reallocation rules introduced in April, referring a patient on to the treating Trust before/after day 38 in their pathway has even greater effect on performance and there has been an continued focus on ensuring patients are transferred as quickly as possible to ensure they receive treatment in a timely manner.

The diagnostic wait standard continues to be compliant in June, with a performance of 99%. At present, there is not any statistically significant variation against this performance target.

In June, the Trust achieved 88.96% against the Referral to Treatment standard. The Trust has outperformed the trajectory for every month of 19/20 so far. The total number of backlog pathways dropped from 695 in May to 679 in June. There has been a shift in performance as the last seven months have been below the median. This shift is due to consultant vacancies, the ongoing commitment to reduce the number of cases sent to the independent sector and the reduction in uptake of additional theatre lists. Additionally, the Trust improved the process of requesting inter provider transfer forms for tertiary referrals at the beginning of 2019 and as a result, has found some of these patients come with extensive existing RTT waits which RNOH inherits. This is an important change for patients as we are ensuring we capture their full length of wait but it has impacted the Trust’s RTT performance by more than 0.5%. Despite this shift below the median, the Trust has improved RTT performance by a further 0.24% in June.
It was set out in the 2018/19 Refreshing NHS Plans guidance that the size of the Trust RTT waiting list should be no higher at the end of the financial year than at the beginning of the year and, where possible, it should be reduced. This expectation continues into 2019/20. The total waiting list size in March 2019 was 5896 so this is the benchmark for the 2019/20 year. There was a small reduction in pathways in June; from 6159 in May to 6149.

Whilst below 92%, the Trust is performing similarly when compared with other standalone specialist orthopaedic trusts (RNOH 89%, ROH 88.3% and RJAH 90.6%). For T&O specifically, RNOH performs at 86.6%, materially better than mean 83.8% (England) and 82.2% (London). (June comparison data).

Workforce:

Current Performance: - The budgeted establishment now matches the financial ledger increasing the established WTE by 5WTE. As expected the effect of this was that the vacancy rate would increase, which it did by 0.3%, but continues to remain within the Trust threshold.
- The retention rate is up for a fourth month in a row by 1.6%. That is a 3.1% increase over the last three months and the Trust is now above target.
- There has been a 9% increase in appraisal compliance rate for July. At just under 80% this is the highest rate this year.
- The agency usage for July has decreased by 1%, although we are still exceeding target for the fourth consecutive month.
- The compliance rate continues to improve month on month. This is the eleventh consecutive month of improvement in the compliance rate, and the third month within the target threshold. This month over 1000 training interventions were delivered, of which 33% was completed by e-learning, although this is slightly lower than last month, the general trend is to an increase in e-learning completions as a proportion of core skills completions.
- Sickness has remained static for a third month in a row, although remains within Trust threshold.
- Temporary staffing as a percentage of total workforce, has continued at 8% for July. This is now below target for the fourth consecutive month.

Risks Issues: - Despite the positive increase in appraisal compliance it is important for managers to continue to work with staff to complete appraisals in a timely way. Appraisals meetings are considered essential interactions between managers and their staff.
- To ensure that we continue to support and encourage staff to complete core training, especially at this time during the summer months.
- Band 5 Staff Nurse vacancies in the Trust remain challenging.

Actions this month: - To offer career clinics to staff offering professional career advice to hope to help retain staff.
- The Learning & Development Team continue to promote the opportunities and support available to complete Core Skills Training via e-learning and to
work with subject matter experts and other key stakeholders to promote e-learning. This is part of a broader plan to grow e-learning completions as the most efficient means of completing most of the Core Skills training courses.

- We continue to move towards providing agencies with access to the bank staff system so they book staff quicker and more efficient reducing administrative volume.
- To assess any incremental increase in the Bradford scores of staff to identify any trends that could assist with supporting managers and staff with sickness absence issues.
- We are organising a bank promotional day in September to encourage substantive and agency staff to join the Trust bank. Communications have been sent for the new NHSC A&C rules that start on the 16th September.

Digital Services:

The Clinical Coding team continues to maintain their KPIs above target. Notes not being available on NoteOn in the early part of the month where patients are treated at the end of the month will always impact on the 3rd working day deadline. This is because of the process, and mutually agreed turnaround time, for the scanning of notes externally. This has not had any financial impact as these are either coded by the mid-month flex or at the very latest by the freeze date.

There was no loss of service for any of our Non Clinical Systems.

Despite two outages the target was met for the availability of Clinical Systems. There was an overnight outage for the Nurse App. The on call team responded and were able to get the system back quickly. Further investigatory work and other corrective actions were taken the following morning. The underlying issue which impacted the availability has been fixed by the supplier. Some downtime was also experienced for the Inpatient Management Application. This again was quickly resolved and the underlying issue affecting the service corrected.

There were issues caused by the upgrade of C-Scribe to the latest version. Whilst the application was running there was significant impact on the users as the application was performing very slowly and occasionally crashed. The issues causing this have now been rectified but it had a longer than expected impact on the users. Further issues raised by the users have also been fixed giving the application some stability and further fixes are being released and tested. A lessons learned meeting has been scheduled. The main issue was the volume of users. Whilst a significant amount of testing was
carried out by both the project team and the users it is extremely difficult to stress test applications. We are working with the supplier to see if there are any mechanisms to carry out volume testing.

The target for Infrastructure availability was met again for this month. However there was another outage for our Virtual Desktop environment. Resources are now focussing on putting further resilience in place to prevent failures of this service impacting on the users. A small printer outage occurred but was resolved quickly with minor user impact.

The C-Scribe performance issues impacted on the number of outstanding calls at the end of the month and this substantially exceeded the target. Despite the volume of tickets raised it is pleasing to note that the SLA performance met its target and the customer satisfaction performance was maintained at a very high level.

Mandatory submissions failed to meet its target but was maintained within tolerance. One return was not submitted on time as it hadn’t appeared on a submission list. NHS Digital have been contacted to establish how this happened.

This month the appraisal target was met after slipping below target last month. The Mandatory training target has continued to be met across the year.

Estates:

These indicators are quarterly and not due to report this month.

Finance Reports:
Please see Finance Director’s report for further information.
<table>
<thead>
<tr>
<th>Clinical Quality</th>
<th>Status</th>
<th>Status</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>Financial YTD</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;E – Patients who would recommend the Hospital - Effective</td>
<td>95.2%</td>
<td>94.0%</td>
<td>&gt;= 97.0%</td>
<td>&gt;= 95.0%</td>
<td></td>
<td>2h Caring</td>
<td>within Threshold</td>
<td></td>
<td></td>
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<td>16</td>
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<tr>
<td>2. Paed F&amp;E – Patients who would recommend the Hospital</td>
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<td>90.3%</td>
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<td>&gt;= 95.0%</td>
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<td>2h Caring</td>
<td>within Threshold</td>
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<td></td>
<td>16</td>
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<tr>
<td>3. Complaints - Rate per 1000 bed days - Effective</td>
<td>3.1</td>
<td>3.2</td>
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<td>&lt;= 1.7</td>
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<td>4. Mixed Sex Accommodation Breaches - Effective</td>
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<td>5. Length of Stay - Effective</td>
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<td>83.8%</td>
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<td>&gt;= 83.5%</td>
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<td>6. Discharges in Time for Lunch - Effective</td>
<td>8.6%</td>
<td>8.5%</td>
<td>&gt;= 11.1%</td>
<td>&gt;= 9.1%</td>
<td></td>
<td>1a Effective</td>
<td>within Threshold</td>
<td></td>
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<td>18</td>
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<tr>
<td>7. Discharge Experience - Effective</td>
<td>90.5%</td>
<td>88.9%</td>
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<td>&gt;= 90.0%</td>
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<td>2h Caring</td>
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<td>8. Patient Perception of Nurse Staffing Levels - Effective</td>
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<td>96.4%</td>
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<td>9. Never Events - Safe</td>
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<td>10. Clinical Incidents - Rate per 1000 bed days - Safe</td>
<td>51.1</td>
<td>54.1</td>
<td>&gt;= 40</td>
<td>&gt;= 30</td>
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<td>11. Paediatric Clinical Incidents - Rate per 1000 bed days</td>
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<td>16</td>
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<td>&gt;= 30</td>
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<td>12. % of Clinical Incidents with Significant Harm (all patients) - Safe</td>
<td>1.8%</td>
<td>3.1%</td>
<td>&lt;= 1.5%</td>
<td>&lt;= 3.0%</td>
<td></td>
<td>2h Safe</td>
<td>within Threshold</td>
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<td>13. Rate of Incidents with Feedback to Reporter - Safe</td>
<td>71.8%</td>
<td>46.0%</td>
<td>&gt;= 75.0%</td>
<td>&gt;= 60.0%</td>
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<tr>
<td>14. Safety Thermometer - RNOH Acquired Harms - Safe</td>
<td>2.9%</td>
<td>0.8%</td>
<td>&lt;= 5.0%</td>
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<td>15. Trips and Falls - Rate per 1000 Bed Days</td>
<td>2.93</td>
<td>3.79</td>
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<td>&lt;= 5.60</td>
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<td>2h Safe</td>
<td>Target met</td>
<td></td>
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## Balanced Scorecard

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<tr>
<th>Clinical Quality</th>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
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<th>Page</th>
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</thead>
<tbody>
<tr>
<td>16. Pressure Ulcers (Grade 1 &amp; 2) - Safe</td>
<td>2</td>
<td>4</td>
<td>&lt;= 3</td>
<td>&lt;= 5</td>
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<td>Target met within Threshold</td>
<td></td>
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<td>PF</td>
<td>23</td>
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<td>17. Pressure Ulcers (Grade 3 &amp; 4) - Safe</td>
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<td>23</td>
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<td>18. Pressure Ulcers (Device Related) - Safe</td>
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<td>&lt;= 6</td>
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<td>19. Planned vs Actual Staffing - Nursing</td>
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<td>97.0%</td>
<td>100.0%</td>
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<td>Target met within Threshold</td>
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<td>PF</td>
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<td>20. Mortality Rate - Safe *</td>
<td>0.3%</td>
<td>0.3%</td>
<td>&lt;= 1.0%</td>
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<td>Target met within Threshold</td>
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<td>21. Clostridium Difficile - Infection</td>
<td>0</td>
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<td>Target met within Threshold</td>
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<td>PF</td>
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<td>22. Gram Negative Blood Stream Infection</td>
<td>3</td>
<td>2</td>
<td>&lt;= 4</td>
<td>&lt;= 5</td>
<td></td>
<td>2h Effective</td>
<td>Target met within Threshold</td>
<td></td>
<td></td>
<td>PF</td>
<td>26</td>
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<tr>
<td>23. Hand Hygiene</td>
<td>96.9%</td>
<td>98.0%</td>
<td>&gt;= 98.0%</td>
<td>&gt;= 95.0%</td>
<td></td>
<td>2h Safe</td>
<td>Target not met within Threshold</td>
<td></td>
<td></td>
<td>PF</td>
<td>26</td>
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<tr>
<td>24. Paediatric Hand Hygiene</td>
<td>92.5%</td>
<td>96.0%</td>
<td>&gt;= 98.0%</td>
<td>&gt;= 95.0%</td>
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<td>2h Safe</td>
<td>Target not met within Threshold</td>
<td></td>
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<td>PF</td>
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<td>Access to Services</td>
<td>Status YTD</td>
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<td>Amber Threshold</td>
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<tr>
<td>25. Referral to Treatment Open Pathways *</td>
<td>88.6% 89.0%</td>
<td>&gt;= 92.0%</td>
<td></td>
<td></td>
<td>2h Responsive</td>
<td>Target not met</td>
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<tr>
<td>26. Paediatric Referral to Treatment Open Pathways *</td>
<td>95.4% 96.2%</td>
<td>&gt;= 92.0%</td>
<td></td>
<td></td>
<td>2h Responsive</td>
<td>Target not met</td>
<td></td>
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<tr>
<td>27. Diagnostic Waits *</td>
<td>99.4% 99.0%</td>
<td>&gt;= 99.0%</td>
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<td>2h Responsive</td>
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<tr>
<td>28. Cancer 2 Week Wait Standard *</td>
<td>93.4% 96.4%</td>
<td>&gt;= 93.0%</td>
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<td>2h Responsive</td>
<td>Target not met</td>
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<tr>
<td>29. Paediatric Cancer 2 Week Wait *</td>
<td>100.0% 100.0%</td>
<td>&gt;= 93.0%</td>
<td></td>
<td></td>
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<td>Target not met</td>
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<tr>
<td>30. Cancer 31 day diagnosis to first treatment standard *</td>
<td>94.9% 100.0%</td>
<td>&gt;= 96.0%</td>
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<td></td>
<td>2h Responsive</td>
<td>Target not met</td>
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<tr>
<td>31. Cancer 31 day wait for subsequent treatment standard *</td>
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<td>32. Cancer 62 day standard referral to treatment standard *</td>
<td>82.1% 100.0%</td>
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<tr>
<td>33. Clinical Letters Completed on Target</td>
<td>76.9% 71.6%</td>
<td>&gt;= 80.0%</td>
<td>&gt;= 75.0%</td>
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<tr>
<td>34. Clinic Percentage On Time Starts</td>
<td>91.3% 93.3%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 88.0%</td>
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<td>Target not met</td>
<td></td>
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<tr>
<td>35. Theatre Capacity/ Session Uptake</td>
<td>87.8% 90.0%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 84.0%</td>
<td></td>
<td>2h Responsive</td>
<td>within Threshold</td>
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<td></td>
<td></td>
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<tr>
<td>36. Intra-session Theatre Utilisation</td>
<td>85.2% 89.6%</td>
<td>&gt;= 85.0%</td>
<td>&gt;= 80.0%</td>
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<td>2h Responsive</td>
<td>Target not met</td>
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<tr>
<td>37. Children’s HDU Utilisation</td>
<td>59.0% 90.0%</td>
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<td>&gt;= 40.0%</td>
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<td>Target not met</td>
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<tr>
<td>38. Contact Centre Incoming Telephone Call Responsiveness</td>
<td>87.0% 85.9%</td>
<td>&gt;= 80.0%</td>
<td>&gt;= 75.0%</td>
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<td>2h Responsive</td>
<td>Target not met</td>
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<tr>
<td>39. Non-Contact Centre Incoming Telephone Call Responsiveness</td>
<td>73.4% 70.9%</td>
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<td>&gt;= 60.0%</td>
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<td>2h Responsive</td>
<td>Target not met</td>
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<tr>
<td>Workforce</td>
<td>Status YTD</td>
<td>Status Month</td>
<td>Month Target</td>
<td>Amber Threshold</td>
<td>Financial YTD</td>
<td>Trust Objective &amp; CQC Domain</td>
<td>Summary VTD/Month</td>
<td>Forecast</td>
<td>DQA</td>
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<tr>
<td>40. Established Posts (Wte)</td>
<td>1596</td>
<td>1594</td>
<td>&lt;= 1617</td>
<td>&lt;= 1642</td>
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<td>1d Well-led</td>
<td>Target met</td>
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<tr>
<td>41. No of Staff WTE (excl. bank and agency)</td>
<td>1408.3</td>
<td>1415.2</td>
<td>&lt;= 1365.0</td>
<td>&lt;= 1390.0</td>
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<td>1d Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
<td></td>
<td>38</td>
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<tr>
<td>42. Vacancy Rate (%)</td>
<td>11.7%</td>
<td>11.2%</td>
<td>&lt;= 9.5%</td>
<td>&lt;= 11.5%</td>
<td></td>
<td>1d Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
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<td>39</td>
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<tr>
<td>43. Retention Rate</td>
<td>87.0%</td>
<td>88.7%</td>
<td>&gt;= 88.5%</td>
<td>&gt;= 87.5%</td>
<td></td>
<td>1d Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
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<td>39</td>
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<tr>
<td>44. Temporary Staffing as a % of Total Workforce</td>
<td>8.2%</td>
<td>8.0%</td>
<td>&lt;= 10.0%</td>
<td>&lt;= 11.0%</td>
<td></td>
<td>1d Well-led</td>
<td>Target met</td>
<td></td>
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<tr>
<td>45. Agency as a % of Temporary Staffing Usage</td>
<td>24.3%</td>
<td>23.0%</td>
<td>&lt;= 30.0%</td>
<td>&lt;= 33.0%</td>
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<td>1d Well-led</td>
<td>Target met</td>
<td></td>
<td></td>
<td></td>
<td>40</td>
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<tr>
<td>46. Appraisal rates</td>
<td>74.5%</td>
<td>79.1%</td>
<td>&gt;= 92.0%</td>
<td>&gt;= 82.0%</td>
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<td>1d Well-led</td>
<td>Target not met</td>
<td></td>
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<tr>
<td>47. Medical Staff Appraisal (%)</td>
<td>96.5%</td>
<td>94.0%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 92.0%</td>
<td></td>
<td>1d Well-led</td>
<td>Target met</td>
<td></td>
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<tr>
<td>48. Core skills training compliance (%)</td>
<td>86.0%</td>
<td>87.2%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 85.0%</td>
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<td>1d Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
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<td>42</td>
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<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>1d Well-led</td>
<td>Target not met</td>
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## Research & Innovation

<table>
<thead>
<tr>
<th>Research &amp; Innovation</th>
<th>Status YTD</th>
<th>Month YTD</th>
<th>Month Target</th>
<th>Amber YTD</th>
<th>Financial YTD</th>
<th>Trust Objective &amp; CQI Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
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<tr>
<td>50. Research - Protocol violations and deviations</td>
<td>1</td>
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<td>0</td>
<td>&lt;= 2</td>
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<td>4l Well-led within Threshold Target met</td>
<td></td>
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<td>IH</td>
<td>44</td>
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<td>51. Research - Recordable adverse events</td>
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<td>&lt;= 3</td>
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<td>4l Well-led within Threshold Target met</td>
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<td>IH</td>
<td>44</td>
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<td>52. Patient Follow Up Visits</td>
<td>468</td>
<td>107</td>
<td>&gt;= 40</td>
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<td>4l Well-led Target met Target met</td>
<td></td>
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<td>IH</td>
<td>45</td>
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<tr>
<td>53. Research - Projects Submitted per Month</td>
<td>4</td>
<td>3</td>
<td>&gt;= 3</td>
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<td>4l Well-led Target met Target met</td>
<td></td>
<td></td>
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<td>IH</td>
<td>45</td>
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<td>54. Research - New patients recruited</td>
<td>115</td>
<td>26</td>
<td>&gt;= 25</td>
<td>&gt;= 20</td>
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<td>4l Effective Target met Target met</td>
<td></td>
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<td>IH</td>
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<td>Digital</td>
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<tr>
<td>55. Coding Completeness (end of 3rd working day)</td>
<td>90.3%</td>
<td>93.2%</td>
<td>&gt;= 85.0%</td>
<td>&gt;= 80.0%</td>
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<td>1g Effective</td>
<td>Target met</td>
<td></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></td>
<td>1g Effective</td>
<td>Target met</td>
<td></td>
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<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></td>
<td>1g Effective</td>
<td>Target met</td>
<td></td>
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<tr>
<td>58. Mandatory Submissions Compliance</td>
<td>99.4%</td>
<td>97.5%</td>
<td>100.0%</td>
<td>&gt;= 95.0%</td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. Clinical System Availability</td>
<td>99.9%</td>
<td>99.9%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td></td>
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<tr>
<td>60. Non-Clinical System Availability</td>
<td>100.0%</td>
<td>100.0%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>61. Infrastructure Availability</td>
<td>99.9%</td>
<td>99.8%</td>
<td>&gt;= 99.0%</td>
<td></td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>62. Number outstanding IT Service Desk Calls at month end</td>
<td>205</td>
<td>301</td>
<td>&lt;= 200</td>
<td>&lt;= 220</td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td></td>
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<tr>
<td>63. Service Level Agreement Achieved</td>
<td>96.1%</td>
<td>95.0%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 90.0%</td>
<td></td>
<td>2j Effective</td>
<td>Target met</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>64. Customer Satisfaction</td>
<td>96.8%</td>
<td>97.0%</td>
<td>&gt;= 90.0%</td>
<td>&gt;= 85.0%</td>
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<td>Responsive</td>
<td>Target met</td>
<td></td>
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<tr>
<td>65. Digital Services Appraisal Rate</td>
<td>92.6%</td>
<td>92.4%</td>
<td>&gt;= 92.0%</td>
<td>&gt;= 82.0%</td>
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<td>1d Well-led</td>
<td>Target met</td>
<td></td>
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<tr>
<td>66. Digital Services Mandatory Training compliance</td>
<td>98.8%</td>
<td>99.3%</td>
<td>&gt;= 95.0%</td>
<td>&gt;= 85.0%</td>
<td></td>
<td>1d Well-led</td>
<td>Target met</td>
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## BALANCED SCORECARD

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<tr>
<th>Estates</th>
<th>Status YTD</th>
<th>Status Month</th>
<th>Month Target</th>
<th>Amber Threshold</th>
<th>Financial YTD</th>
<th>Trust Objective &amp; CQF Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>72. Infrastructure and Building Availability (Quarterly)</td>
<td>&gt;= 99.0%</td>
<td>&gt;= 98.0%</td>
<td></td>
<td></td>
<td>1c</td>
<td>Safe</td>
<td>Not due this mth</td>
<td>MAM</td>
<td>55</td>
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<td>73. Six Facet Property Appraisal (Quarterly)</td>
<td>&lt;= 534.00</td>
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<td></td>
<td></td>
<td>1c</td>
<td>Safe</td>
<td>Not due this mth</td>
<td>MAM</td>
<td>55</td>
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## Balanced Scorecard

### Finance Reports

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<tr>
<th>Metric Description</th>
<th>Status YTD</th>
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<th>Month Target</th>
<th>Amber Threshold</th>
<th>Financial YTD</th>
<th>Trust Objective &amp; COQ Domain</th>
<th>Summary YTD/Month</th>
<th>Forecast</th>
<th>DQA</th>
<th>Lead</th>
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<tbody>
<tr>
<td>67. Finance and Use of Resources Risk Rating</td>
<td>3.0</td>
<td>3.0</td>
<td>&gt;= 3.0</td>
<td></td>
<td></td>
<td>1g Well-led</td>
<td>Target met</td>
<td></td>
<td></td>
<td>HW</td>
<td>57</td>
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<tr>
<td>68. Liquidity Metric</td>
<td>8.7</td>
<td>8.7</td>
<td>&gt;= -63.0</td>
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<td></td>
<td>Well-led</td>
<td>Target met</td>
<td></td>
<td></td>
<td>HW</td>
<td>57</td>
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<tr>
<td>69. Normalised I&amp;E Margin</td>
<td>-8%</td>
<td>-8%</td>
<td>&gt;= -1%</td>
<td></td>
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<td>Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>HW</td>
<td>58</td>
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<tr>
<td>70. Performance against I&amp;E Control Total</td>
<td>1.40%</td>
<td>1.40%</td>
<td>0.00%</td>
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<td>Well-led</td>
<td>Target met</td>
<td></td>
<td></td>
<td>HW</td>
<td>58</td>
</tr>
<tr>
<td>71. Agency Metric - performance against NHS Ceiling</td>
<td>2%</td>
<td>2%</td>
<td>&lt;= -11%</td>
<td></td>
<td></td>
<td>Well-led</td>
<td>Target not met</td>
<td></td>
<td></td>
<td>HW</td>
<td>59</td>
</tr>
<tr>
<td>SR</td>
<td>Strategic Objectives</td>
<td>Strategic Risk Description and change in Current Risk Rating</td>
<td>Inherent Risk</td>
<td>Current Risk Aug 2019</td>
<td>Target Risk</td>
<td></td>
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<tr>
<td>SR1 (AN)</td>
<td>Deliver targeted improvements in clinical excellence</td>
<td>The Trust faces increasing challenges recruiting and retaining medical staff.</td>
<td>16</td>
<td>12</td>
<td>4</td>
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<tr>
<td>SR2a (PF)</td>
<td>Deliver targeted improvements in High Quality Care</td>
<td>Capability and capacity of clinical and non-clinical staff to undertake improvement in the quality of care.</td>
<td>12</td>
<td>12</td>
<td>6</td>
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<tr>
<td>SR2b (PF)</td>
<td>Deliver targeted improvements in High Quality Care</td>
<td>National, regional and local workforce pressures in relation to recruitment, retention and development of clinical professionals, including nurses, doctors and allied health professionals.</td>
<td>20</td>
<td>15</td>
<td>10</td>
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<tr>
<td>SR3 (LD)</td>
<td>Deliver targeted improvements in activity levels, access and unlocking capacity</td>
<td>Insufficient theatre, bed or clinic capacity to achieve planned activity levels.</td>
<td>20</td>
<td>12</td>
<td>8</td>
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<tr>
<td>SR4 (TN)</td>
<td>Deliver a culture of improvement</td>
<td>Staff lack confidence, motivation, resource and capacity to embrace opportunities for improvement.</td>
<td>12</td>
<td>9</td>
<td>6</td>
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<tr>
<td>SR5 (TN)</td>
<td>Deliver the VAL-YOU (organisational development) programme to improve retention and staff experience</td>
<td>Failure to improve staff experience as a result of capacity and resource in relation to bullying and harassment and equality, diversity and inclusion 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.</td>
<td>20</td>
<td>16</td>
<td>4</td>
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<tr>
<td>SR6 (TN)</td>
<td>Deliver the Recruitment and Retention programme to recruit and develop a workforce of appropriately skilled and engaged staff</td>
<td>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.</td>
<td>20</td>
<td>12</td>
<td>8</td>
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<td>SR7 (MM)</td>
<td>Enable the site redevelopment</td>
<td>Failure or delay in completing WDZ land sale by August 2021.</td>
<td>25</td>
<td>20</td>
<td>10</td>
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<td>SR8 (MM)</td>
<td>Deliver the site redevelopment projects</td>
<td>Awaiting approval of Accommodation OBC from NHSi.</td>
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<td>20</td>
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<tr>
<td>SR</td>
<td>Strategic Objectives</td>
<td>Strategic Risk Description and change in Current Risk Rating</td>
<td>Inherent Risk</td>
<td>Current Risk Aug 2019</td>
<td>Target Risk</td>
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<tr>
<td>SR9 (SP)</td>
<td>Implement Digital Strategy</td>
<td>Inability to implement the objectives set out in the Trust’s digital strategy.</td>
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<td>16</td>
<td>12</td>
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<tr>
<td>SR10 (HW)</td>
<td>Exploit equipment provision to enhance care and Trust operations</td>
<td>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 sub-standard service to our patients with potentially unreliable and technically inferior diagnostic imaging equipment.</td>
<td>9</td>
<td>9</td>
<td>2</td>
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<tr>
<td>SR11 (HW)</td>
<td>Achieve financial stability</td>
<td>The national tariff, based on average reference costs, does not adequately recompense RNOH for the complexity of NHS work undertaken resulting in a significant underlying deficit.</td>
<td>20</td>
<td>16</td>
<td>8</td>
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<tr>
<td>SR12 (TN)</td>
<td>To deliver world class musculoskeletal research and education</td>
<td>Failure to deliver a strategic review will prevent the RNOH delivering world class neuro musculoskeletal research and education.</td>
<td>15</td>
<td>12</td>
<td>3</td>
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<tr>
<td>SR13 (RH)</td>
<td>Lead national programmes to improve NHS sustainability</td>
<td>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.</td>
<td>12</td>
<td>9</td>
<td>6</td>
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<tr>
<td>SR14 (RH)</td>
<td>Undertake a leadership role where appropriate and relevant in regional setting of Sustainability and Transformation Programmes</td>
<td>STP unable to approve pre-consultation business case process.</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR15 (TN)</td>
<td>Coordinate RNOH and RNOH Charity strategies</td>
<td>Failure of sufficient executive leadership, integration and coordination with RNOH Charity CEO and Trustees will result in aims and objectives of Trust strategy.</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
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</tbody>
</table>
The Royal National Orthopaedic Hospital NHS Trust Board Assurance Framework

2019-20
### Strategic Risk Description:

The Trust faces increasing challenges recruiting and retaining medical staff. RNOH has experienced difficulty recruiting to non-consultant posts in orthopaedics, anaesthetics, paediatrics and urology. National trainee numbers have declined. Individual units have struggled to recruit to posts, which has negatively impacted on night time cover and out of hours care. Current arrangements to manage this do not deliver robust operational control for the Trust. Budgetary pressures have increased as a result of agency and bank staff utilisation. Historical contractual arrangements require updating. These circumstances combine to apply significant challenges to the effective delivery of a safer clinical workforce.

### 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.

### Gaps in control:

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Progress Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Safer Staffing Improvement Programme - Wide range of projects addressing the range of issues</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>b) Increased governance/oversight of NCHD workforce</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>c) Increased governance over new and existing provider and commissioned supplementary clinical services</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>d) Increase utilisation of adaptive tools and technologies for temporary staff management and information flow to assist continuity and clinical handover</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>e) MD (Responsible Officer) report to Trust Board re: Staffing and Training requirements</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>f) WDO report to Trust Board re: Non-Consultants, Safer Staffing Strategy Meeting to consider other models (physicians, prescribing pharmacists, specialist nurses etc.)</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>g) GMC Guidance re: staffing for emergencies</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
<tr>
<td>h) SSIP report to IPS</td>
<td>Aresh Nejad</td>
<td>In progress</td>
</tr>
</tbody>
</table>

### Action Plan to Address Gaps

**Lead:** Aresh Nejad

- **Due date:** 01-Oct-19

---

**Positive Assurance Review Date**

<table>
<thead>
<tr>
<th>Risk Open Date</th>
<th>Executive Lead/ Risk Owner</th>
<th>Risk Review Date</th>
<th>Lead Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-18</td>
<td>Aresh Nejad</td>
<td>Sep-19</td>
<td>Aresh Nejad</td>
</tr>
</tbody>
</table>

---

**Lead Committee:**

- **Aresh Nejad - risk owner (1)**

---

**Positive Assurance Review Date**

<table>
<thead>
<tr>
<th>Positive Assurance (1st, 2nd or 3rd time)</th>
<th>Positive Assurance Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-25</td>
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<tr>
<td>8-12</td>
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<td>4-6</td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td></td>
</tr>
</tbody>
</table>

---

**Strategic Aim:**

Best patient care in the NHS

**Strategic Objective:**

Deliver targeted improvements in clinical excellence

**Controlled by:**

- **The Royal National Orthopaedic Hospital NHS Trust Board Assurance Framework 2019-20**
<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.)

**Strategic Objective:**
Deliver targeted improvements in High Quality Care

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

<table>
<thead>
<tr>
<th>Risk Open Date:</th>
<th>Oct-18</th>
<th>Lead Committee:</th>
<th>Quality Committee:</th>
</tr>
</thead>
</table>

**Risk Review Date:**

**Executive Lead/ Risk Owner:** Paul Fish

**Lead Committee:** Quality Committee

**Effects:**

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

**Inherent Risk:**
Inadequate improvement activity to improve quality of care by poorly designed or executed improvement activity

**Residual/ Current Risk:**
Inadequate improvement activity to improve quality of care by poorly designed or executed improvement activity

**Target Risk:**

**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.

**Lead:**
John Bateson

**Status:**
Not Yet Started/In Progress/Complete

**Action:**
Introduce an improvement recognition award at the annual staff awards

**Positive Assurance Review Date**

**Appendix 2.4 -**

Page 20 of 52
### Risk Key
- Extreme Risk: 15-25
- High Risk: 8-12
- Medium Risk: 4-6
- Low Risk: 1-3

#### Strategic Objective

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

#### Strategic Risk Description

**National, regional and local workforce pressures in relation to the recruitment, retention and development of clinical professionals including nurses, doctors and allied health professionals.**

**Causes:**
- In excess of 40,000 vacancies for Registered Nurses in the NHS in England
- Uncertainty in relation to Brexit and the supply and retention of EU nurses
- Increased demand across the NHS for RN posts in the aftermath of the Francis report
- Reduced applications for undergraduate nursing programmes with the removal of the nursing bursary
- Reduced number of HCA’s being trained as nurses with the removal of financial support from HEE
- Challenges recruiting to NCHD posts at the RNOH

**Effects:**

**Inherent Risk:**

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
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<td>$3</td>
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<tr>
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**Residual/Current Risk:**

<table>
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<tr>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
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<tr>
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<td>1</td>
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**Target Risk:**

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
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<td>1</td>
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<tr>
<td>Medium</td>
<td>$10</td>
<td>1</td>
<td>10</td>
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</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 intervention, Legal challenges, etc.

**Steps in Control:**

- Where are we failing to put controls/systems in place. Where are we failing in making them effective
- Where are we failing to put controls/systems in place. Where are we failing in making them effective

**Steps in Assurance:**

- Effective controls in place and based rationale that appropriate assurances are available.
- Effective controls in place and based rationale that appropriate assurances are available.
- Effective controls may not be in place and assurances are not available to the Board.

**Action Plan to Address Gaps**

- Monitoring compliance monitored weekly via bank and agency meeting and monthly via divisional performance reviews
- Effective controls in place and based rationale that appropriate assurances are available.
- Effective controls in place and based rationale that appropriate assurances are available.

**Strategic Objective**

**Deliver targeted improvements in High Quality Care**

**Risk Open Date:** Oct-18

**Lead Committee:** Quality Committee

**Risk Review Date:** Oct-19

**Executive Lead/Risk Owner:** Paul Fish

**BAF REF No:** SR2b

**Source of Risk:** (External Environment, Risk Register, Strategic Objective, Board or Committee, etc.)
Strategic Objectives:
Deliver targeted improvements in activity levels, access and unlocking capacity

- e) Detailed nursing recruitment and retention action plan; review of pain management gap plans and potential reduction in anaesthetic sessions by pain consultants in short term as easier to backfill
- b) Sherman Building; building maintenance programme
- c) Regular review of referral criteria and Directory of Service
- d) POA review, implementation of SOPs
- e) Outpatient model of care improvement programme

Failing in making them effective

- a) Workforce Dashboard, monthly monitoring of Care Hours Per Patient Day (CHPPD) (2); monitoring via ATTF (2) and CPAG spending review (2)
- b) Final Survey (3), CPAG spending review (3)
- c) AITF reporting (1)
- d) Model Hospital (2)
- e) Model Hospital (3)


Risk Key

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

Controls:
(Preventive, Corrective, Directive or Detective)

- Insufficient theatre, bed or clinic capacity to achieve planned activity levels.
- High levels of FU OP activity
- Reduced opportunity to maximise IP activity through fixed bed capacity
- Demand / capacity mismatch: growth in waiting times
- Inability to extend theatre template to 3-session day
- Pathway delays; short notice cancellations and wasted theatre time

Total Score:
Forward
b) POA case for investment to address backlog and provide sufficient capacity going forward
A
20
Dec-19
Lucy Davies, CEO / Luke Martin, GM

In progress

Risk Review Date: 05/09/2019

Positive Assurance Review Date: 05/09/2019

G

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

Affirmative control thought to be in place but assurances are unclear and/or/weak.

Affirmative control may or may not exist 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>
</tr>
</thead>
<tbody>
<tr>
<td>a) Develop programme to review and address FU New OP ratios</td>
<td>Lucy Davies, CEO / Luke Martin, GM</td>
<td>Apr-20</td>
<td>In progress</td>
</tr>
<tr>
<td>b) POA case for investment to address backlog and provide sufficient capacity going forward</td>
<td>Lucy Davies, CEO / Luke Martin, GM</td>
<td>Dec-19</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Appendix 2.6 - SR3
BAF_2019-20_LD
Appendix 2.6 - SR3
BAF 2019-20_DEV
### Risk Key

<table>
<thead>
<tr>
<th>Level</th>
<th>Score</th>
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<tbody>
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<td>15-25</td>
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<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>

### Strategic Objective

- **Strategic Risk Description:** Staff lack confidence, motivation, resource and capacity to embrace opportunities for improvement.

- **Strategic Aim:**
  - Deliver a culture of improvement

- **Strategic Objective:**
  - Deliver a culture of improvement

- **Causes:**
  - a) Lack of resources - funding or staff within improvement function to deliver annual objectives
  - b) Improvement training included in staff induction
  - c) Improvement strategy will need to be adjusted to ensure targets are met

- **Effects:**
  - a) Extreme Risk
  - b) Inadequate improvement activity to improve quality of care, quality of staff experience, financial savings and infrastructure improvements
  - c) Poorly designed or executed improvement activity
  - d) Lack of recognition of improvement activity

- **Inherent Risk:**
  - 3

- **Residual/ Current Risk:**
  - 3

- **Target Risk:**
  - 3

### Controls: (Provenance, Committee, Directive or Detective)

- **Assurances on Control:**
  - Positive Assurance: (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 Date:**
  - Not Yet Started/In Progress/Complete

### Progress Update

**Action:**

**Lead:**

**Due date:**

**Progress Update:**

**Status:**

- Effective control in place and Board satisfied that appropriate assurances are available.
- Positive Assurance Review Date
- Positive Assurance: (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 KPIs are in their infancy and will always be limited in scope and ability to give a fully detailed understanding of improvement culture progress.
- Effective control thought to be in place but assurance are uncertain and/or insufficient.
- Effective controls 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>
<th>Low Risk</th>
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<tbody>
<tr>
<td>Value</td>
<td>15-25</td>
<td>8-12</td>
<td>4-6</td>
<td>1-3</td>
</tr>
</tbody>
</table>

### Strategic Aim:
Deliver the VAL-YOU (organisational development) programme to improve retention and staff experience

### Strategic Objective:
Deliver the VAL-YOU (organisational development) programme to improve retention and staff experience

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

### BAF REF No:
SR5

### Risk Open Date:
Executive Lead/ Risk Owner
Tom Nettel

### Risk Review Date:
Lead Committee:

### Lead:

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<tr>
<th>Effects</th>
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<th>Likelihood</th>
<th>Total Score</th>
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<tbody>
<tr>
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<tr>
<td>Residual/ Current Risk</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Target Risk</td>
<td>2</td>
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<td>4</td>
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</table>

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

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

### Gaps in Control
- Where we are failing to put controls in place. Where are we failing in making them effective
- Access to training based on funding and internal/external capacity to provide
- Capacity within WOD team to lead and deliver the objectives

### Action:
- Lead: 
- Due date: 
- Status: Not Yet Started/In Progress/Complete

---

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

Appendix 2.8 - SR5_BAF_2019-20_TN

Page 24 of 52
<table>
<thead>
<tr>
<th>Risk Key</th>
<th>Extreme</th>
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<tbody>
<tr>
<td></td>
<td>15-25</td>
<td>8-12</td>
<td>4-6</td>
<td>1-3</td>
</tr>
</tbody>
</table>

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

**Strategic Aim:**
Deliver the Recruitment and Retention programmes 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.

**Effects:**
- Quality of care, quality of staff experience, financial savings and infrastructure improvements will not be delivered
- Increased incidents of perceived bullying, harassment and discrimination
- Increased vacancy, sickness and turnover rates
- Inability to achieve ‘Outstanding’ rating and loss of ‘Good’ rating
- Increased clinical incidents

**Assurances on Control**
Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.
Positive 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.

**Positive Assurance:**
- Draft and submit business case for investment in medical resourcing, resourcing function, e-rostering for medical staff and ANP investment in commercial partner for provision of bank staff and direct engagement models
- Deliver the Recruitment Process Improvement Project by 31 March 2020
- 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

**Action Plan to Address Gaps**
- Action: [Details of action plan]
- Lead: [Name of lead responsible]
- Due date: [Due date for action]
- Progress Update: [Status of action plan]

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

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

**BAF REF No.:** SR6

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

**BAF REF No.:** SR6

**Risk Open Date:**
- Executive Lead: Tom Nettel

**Risk Review Date:**
- Lead Committee: [List of lead committees]

**Risk Movement**
- Total Score: 20
- Target Risk: 8

**Inherent Risk:**
- 5
- 4

**Residual/Current Risk:**
- 4
- 3

**Positive Assurance Review Date**
- [Date of positive assurance review]
### Risk Key

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

### Strategic Risk Description

Failure to sell WDZ land by August 2021.

**Causes:**
- Lack of Market appetite
- Land value not achieved
- Deal complicated by trying to meet accounting treatment test
- Business Cases to enable vacant possession not approved (MSCP and Staff Accommodation)
- Inability to repay loan

**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.

**Assurances on Control (Positive Assurance: Reports, Audits, Dashboards, Minutes, Positive Surveys, External evidence etc.)**

<table>
<thead>
<tr>
<th>Inherent Risk</th>
<th>Residual/Current Risk</th>
<th>Target Risk</th>
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<tbody>
<tr>
<td>5</td>
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**Positive Assurance**
- Positive Assurance (1st, 2nd or 3rd line)

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

**Green**
- Monitor and review risk register
- Monitor progress of providing vacant possession

**Amber**
- Monitor and review risk register
- Monitor progress of providing vacant possession

**Red**
- Monitor and review risk register
- Monitor progress of providing vacant possession

**Action Plan to Address Gaps**

- Where appropriate de-risking activities have been carried out, such as vendor due diligence to provide more certainty and improve the attractiveness of the site to potential purchasers.
- Obtain prescriptive rights over Warren lane access.
- Where market value has been achieved and the site is deemed to be suitable for a new development.
- Effective control is in place and Board satisfied that appropriate assurances are available.
- Effective controls may not be in place and assurances are not available to the Board.

**Positive Assurance Review Date**
- Monthly

**Effective control is in place and Board satisfied that appropriate assurances are available.**
- Value provided by Deloitte Sale being monitored by land sale short life working Group and Redevelopment Programme Board
- Trust Board
- Monthly

**Impact**
- Failure or delay in completing WDZ land sale by August 2021.
- Improved infrastructure
- Annual Objectives
- Disposal of western development zone by August 2021

**Strategic Objective:**
- Enable the site redevelopment

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

**Positive Assurance Review Date**
- Monthly
### Strategic Objective:
Deliver the site redevelopment projects

#### Annual Objectives:
1. Have an approved business case for staff accommodation
2. Have an approved full business case for the multi-story carpark
3. Agree a development provider for Patient Step Down Facility
4. Complete the P&O building enabling infrastructure work

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

### Risk Open Date:
04-Sep-19

### Risk Review Date:

#### Lead Committee:
Redevelopment Programme Board

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

#### Assurances on Control
- Positive Assurance
- Negative Assurance

### Gaps in Control

<table>
<thead>
<tr>
<th>Reason</th>
<th>Positive Assurance Rating</th>
<th>Reasonable Assurance Rating</th>
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<td>(A, B, C)</td>
<td>(C, A, B)</td>
</tr>
<tr>
<td>Where there is no direct control of risk</td>
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</table>

#### Action Plan to Address Gaps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Due Date</th>
<th>Progress Update</th>
</tr>
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</table>

We are in very regular communication with NHSI. Raised at STP Estates Board. DoF written to NHSI.

NHSI recognise their involvement in this delay.

### Strategic Risk Description:
Awaiting approval of Accommodation OBC from NHSI.

- NHSI have stated that our business case is robust however it would be off balance sheet. NHSI wish to see it as off balance sheet. 'Modular' model and obtain accounting treatment advise from auditors which has been done however does not achieve an off balance sheet position. NHSI are now pursuing this with DH and HM Treasury. NHSI wish to identify a model for providing staff accommodation which is off balance sheet which they then roll out nationally. Unfortunately the RNOH are test case. The RNOH OBC has now been with NHSI for 15 months.

- All the staff accommodation can be located away from the WDZ. The WDZ cannot be sold with vacant possession. The Trust are due to repay the short term loan for the construction of the WDZ by August 2021 and is to use the capital receipt from the WDZ sale for this purpose. The Trust cannot commence procurement of the staff accommodation until the OBC is approved. The procurement process, design, planning, construction will take approx 30 months to complete and we are currently 23 months away from August 2021. This project can therefore no longer be accomplished within the necessary timeframe.

- NHSI have stated that our business case is robust however it would be on balance sheet and NHSI wish to see it as off balance sheet. NHSI have insisted that we pursue a land-lease model and obtain accounting treatment advise from auditors which has been done however does not achieve an off balance sheet position. NHSI are now pursuing this with DH and HM Treasury. NHSI wish to identify a model for providing staff accommodation which is off balance sheet which they then roll out nationally. Unfortunately the RNOH are test case. The RNOH OBC has now been with NHSI for 15 months.

- Until the staff accommodation can be located away from the WDZ, the WDZ cannot be sold with vacant possession. The Trust are due to repay the short term loan for the construction of the WDZ by August 2021 and is to use the capital receipt from the WDZ sale for this purpose. The Trust cannot commence procurement of the staff accommodation until the OBC is approved. The procurement process, design, planning, construction will take approx 30 months to complete and we are currently 23 months away from August 2021. This project can therefore no longer be accomplished within the necessary timeframe.

We have no direct control of NHSI. We have no direct control of NHSI.

We have no direct control of NHSI.
**Executive Lead / Risk Owner:**  Saroj Patel

### Strategic Objective: Implement Digital Strategy

#### Strategic Risk Description:

- **Inability to implement the objectives set out in the Trust’s digital strategy.**

#### Controls:

- **Amber Risk**
  - **Inherent Risk:**
  - **Target Risk:**
  - **Residual / Current Risk:**

#### Assurances on Control:

- **Positive Assurance:**
  - Reports to the Executive and Digital Committee and the minutes of these meetings (1st, 2nd or 3rd line)

#### Action Plan to Address Gaps

| Action | Lead | Due Date | Progress Update | Remarks
<table>
<thead>
<tr>
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</table>

#### References

- **SR9 BAF REF No:**
- **SR9**
<table>
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<tr>
<th>Risk Level</th>
<th>Score</th>
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<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>

**Strategic Objective:**
- **Explicit equipment provision to enhance care and Trust operations**

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

**BAF REF No:** SR10

**Risk Open Date:** 01.09.19
**Executive Lead/Risk Owner:** Hannah Witty

**Risk Review Date:**
**Lead Committee:** STRIDE (Strategic Imaging Development) Governance Group

<table>
<thead>
<tr>
<th>Effects</th>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent Risk</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Residual Current Risk</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Target Risk</td>
<td>1</td>
<td>2</td>
<td>2</td>
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</tbody>
</table>

**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 technologically inferior diagnostic imaging equipment.

**Gaps in Assurance:**
Where effectiveness of control to be in place but assurances are uncertain and/or insufficient.

**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 control may not be in place and assurances are not available to the Board.

**Action Plan to Address Gaps**

**Lead:**

**Due date:**

**Progress Update:**

**Status:** Not Yet Started/In Progress/Complete

---

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

Improved infrastructure

**Annual Objectives**

(a) Deliver annual Diagnostic Imaging replacement programme (DIRP) to ensure existing services are maintained and upgraded with current technology in line with Imaging Strategy.

(b) Deliver and finalise additional opportunities for developing imaging capacity and capability to meet current demand, reduce out-sourcing and support NLP Diagnostic Imaging provision.

---

**Strategic Aim:**
Exploit equipment provision to enhance care and Trust operations

**Strategic Objective:**
Exploit equipment provision to enhance care and Trust operations

**Causes:**
- Insufficient confidence of year-on-year funding in the context of the overall investment needs the Trust has.

**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.

**Positive Assurance Review Date**
- a) The STRIDE Group will continue to meet throughout the year and funding will be identified as an agenda item.
- b) NED involvement has begun with an informal review of the STRIDE Options paper written by Mike Giles and Luke Martin. This will be formally presented to the Board in October where ongoing NED involvement and support will be officially invited. From this a strategy in line with positive assurance will be developed.

- It is also an annual/ongoing agenda consideration and challenge for CAPSAG in consideration and context of the Trust’s broader priorities.

---

**Gaps in control:**
Where are we failing to put controls/systems in place. Where are we failing in making them effective.

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

---

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

**Positive Assurance Review Date**

1st October 2019
### Strategic Objective:

Achieve financial stability

### Annual Objectives:

- Influence national payment mechanisms in conjunction with the National Orthopaedic Alliance to ensure complexity is factored into agreed payment mechanisms by 31 March 2020.
- Delivery of £7.6m Private Care income target within budgeted resource by 31 March 2020.
- 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.
- Development of a Board approved Medium Term Financial Plan including a financial strategy for sustainability by 30 September 2019.

### Risk Key

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

### Risk Open Date:

Sep-19

### Executive Lead / Risk Owner:

Hannah Witty

### Risk Review Date:

Monthly

### Lead Committee:

Finance Committee

### Progress Update:

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

### Action Plan to Address Gaps

- Support and drive NOA tariff engagement to ensure shared objectives with EWG to influence tariff change
- Director of Finance - 30-Dec-19
- Update of top loss making procedures underway to inform NOA-EWG discussions. CEO attendance at EWG-NHSE&I tariff meetings.
- In progress
- Model Hospital training to SLT to add identification of efficiency opportunities through benchmarking data
- Director of Finance - 30-Nov-19
- Sessions booked with RJAH MH specialist to provide training and share learning.
- In progress
- PCD refresh of growth strategy, including risks and opportunities
- Director of Finance, PCD GM - 30-Dec-19
- Modelling underway, including case for additional theatre. Possible external support needed.
- In progress
- Medium Term Financial Plan, plan for sustainability and five year efficiency plan
- Director of Finance - 30-Sep-19
- JPPP Board review 18 Sept, plan for sustainability including efficiency plans to follow (end Nov 19)
- In progress

### 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.)

### Residual / Current Risk:

- Inherent Risk: 4
- Residual / Current Risk: 4
- Target Risk: 4
- Total Score: 20

### Risk Mitigation:

- Expected financial deficit continues to run with an unsustainable underlying deficit, control totals are not met and revenue support loans continue to be required to fund NHS activity.

### Strategic Risk Description:

The national tariff, based on average reference costs, does not adequately reimburse RNOH for the complexity of NHS work undertaken resulting in a significant underlying deficit. RNOH does not have sufficient mitigations in place in the form of non-NHS income growth or efficiency plans to address this deficit. RNOH expects to reforecast to not fit financial plan in 2019/20.

### Consequence:

- Cashable savings
- Growth of non-NHS income
- Underlying deficit
- Revenue support loans
- Deficit, control totals are not met

### Likelihood:

- Monthly

### Outcome of internal audit review of controls (3)

- Unqualified external audit opinion, including VfM (3)
- Internal audit - agreed points during the year
- External audit - annual
## Strategic Risk Description:
Failure to deliver a strategic review will prevent the RNOH delivering world class neuro musculoskeletal research and education.

### Causes:
- a) Lack of resources - funding, systems or staff within RNOH develop a vision and objectives, programme plan and milestones
- b) Lack of commitment, knowledge and skills from staff including Trust Board, senior leadership team and amongst staff
- c) Lack of time within work schedule to undertake annual objectives

### Effects:
- a) Improvements in quality of care will not be delivered
- b) Loss of academic partnerships and potential further academic partners
- c) Loss of funding and inability to take advantage of funding opportunities for research and education
- d) Inability to achieve "Outstanding" rating and loss of "Good" rating; sustainability/ viability of organisation as national and international specialist centre questioned
- e) Increased vacancies and turnover

### Control Settings:
- a) Significant ongoing progress w Nursing and AHP research
- b) Effective management and oversight of education funds via Education Committee

### Gaps in control:
Where are we failing to put controls/systems in place. Where are we failing in making them effective

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

### Action Plan to Address Gaps:
- a) REI governance structure is not fully established
- b) Understandable lack of buy in to overall plan
- c) Absence of agreed funding and programme/project management resource

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

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

### Risk Movement:
 ![Risk Movement](image-url)
Executive Lead/ Risk Owner

Total Score:

3

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

3

a) SHC Sub-Committee of the Board is still developing and so fully effective assurance to Board is not yet in place.
b) Difficulties in achieving clear agreement with NHS I on future leadership, governance, structures and funding, particularly from April 2021.

c) Internal Audit of GIRFT recruitment processes and expenses.

g) Difficulties in achieving clear agreement with NHS I on future leadership, governance & Culture - Reporting to September GIRFT Board and September RNOH Strategy & Sustainability Committee.

a) Strengthening of RNOH Governance 2019-20: Inclusion of SHC in Strategy, Aims, Objectives and BAF monitoring. Establishment of Stanmore Health Consulting Sub-Committee of Strategy & Sustainability Committee to agree clear purpose, aims, objectives and delivery plans for SHC.
b) NHS I / RNOH joint review and investigation of GIRFT Leadership, Governance & Culture - Reporting to September GIRFT Board and September RNOH Strategy & Sustainability Committee.
c) Internal Audit of GIRFT recruitment processes and expenses.

a) Major SHC Projects (e.g. GIRFT England) are delivering on Key Performance Indicators as at September 2019 - e.g. numbers of front line visits, national specialty reports produced, data and information feed into Model Hospital, evidence of improvements in GIRFT identified quality of care outcomes metrics across all GIRFT specialties with significant associated financial benefits to NHS.
b) External Reviews and Reports of key “think tanks” (Kings Fund and NHS Providers) provide positive assurance on GIRFT methodology very positive and in the public domain.
c) Many examples of Trust by Trust, Specialty by Specialty improvements facilitated by GIRFT methodology leading to large numbers of requests for additional support.
d) 2018 NHS I Internal Audit Report (Green) and 2019 GIRFT RNOH Internal Audit Report (Partial Assurance) give examples of positive assurance and practice on GIRFT internal controls processes including governance and recruitment processes.
a) NHS I/RNOH Joint Review / Investigation into governance and culture May - September 2019 identified need to invest in leadership development and organisational development within GIRFT and enhanced NHS I oversight arrangements. 

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### 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>
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<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 Aims of the RNOH.</td>
<td>Rob Hurd and Rachel Yates</td>
<td>31st December 2019</td>
<td>SHC Sub Committee now evolving with monthly meetings - Board engagement session to be scheduled in the Autumn.</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>
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</table>
# Strategic Risk Description:

**STP unable to approve pre-consultation business case process.**

<table>
<thead>
<tr>
<th>Causes</th>
<th>Effects</th>
<th>Risk Rating</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Total Score</th>
</tr>
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<tbody>
<tr>
<td>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.</td>
<td>Inability to progress with recommendations for the new clinical service model for orthopaedics in the NCL STP.</td>
<td>Inherent Risk: 4</td>
<td>2</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Residual/Current Risk: 4</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Target Risk: 3</td>
<td>2</td>
<td>6</td>
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### Controls: (Preventative, Corrective, Directive or Detective)

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

### Positive Assurance

Controls: (Preventative, Corrective, Directive or Detective)

**SR14**

### Positive Assurance Review Date

**Patients and staff continue to raise concerns around impact on transport if some local hospital sites no longer provide inpatient elective orthopaedics.**

### Action Plan to Address Gaps

- **Engagement events have been arranged targeting specific concerns raised around AMP involvement and transport issues raised.**
  - Lead: Rob Hurd
  - Due date: 01-Mar-20
  - Progress Update: Events scheduled as part of Autumn engagement and consultation events
  - Status: In progress
### Strategic Objective:
Coordinate RNOH and RNOH Charity strategies

**Annual Objectives:**
(a) Share and agree Trust Strategic Aims and Objectives that will be supported by the RNOH Charity’s Strategy by 1 November 2019.
(b) Support delivery of relevant Trust Strategic Aims and Objectives through Charity support and grants by 31 March 2020.

**Cause:**
- 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

**Inherent Risk:**
- Consequence: 2
- Likelihood: 4
- Total Score: 8

**Residual/Current Risk:**
- Consequence: 2
- Likelihood: 3
- Total Score: 6

**Target Risk:**
- Consequence: 2
- Likelihood: 1
- Total Score: 2

**Controls:**
- Positive Assurance (1st, 2nd or 3rd line) Controls: Preventative, Corrective, Directive or Detective

**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

**Gaps in control:**
- Where we are failing to put controls/systems in place. Where we are failing in making them effective

**Support delivery of relevant Trust Strategic Aims and Objectives through Charity support and grants by 31 March 2020 not yet delivered.**

### Action Plan to Address Gaps

**Action:**
- See controls.

**Lead:**
- Tom Nettel

**Due date:**
- Not Yet Started/In Progress/Complete

**Progress Update:**
- Not Yet Started/In Progress/Complete

**Status:**
- Not Yet Started/In Progress/Complete
A Framework of Quality Assurance for Responsible Officers and Revalidation


NHS England and NHS Improvement
A Framework of Quality Assurance for Responsible Officers and Revalidation


Publishing approval number: 000515

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.
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Section 6 – Summary of comments, and overall conclusion .................................................................10
Section 7 – Statement of Compliance ...................................................................................................11
Introduction:

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

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

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

- **Board Report template:**

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

  Whereas the previous version of the Board Report template addressed the designated body’s compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance¹. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer, and
c) act as evidence for CQC inspections.

- **Statement of Compliance:**

  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.
Designated Body Annual Board Report

Section 1 – General:

The board executive management team of the Royal National Orthopaedic Hospital can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.
   - Date of AOA submission: 14th May 2019
   - Action from last year: None required.
   - Comments: None required.
   - Action for next year: None required.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.
   - Action from last year: None required.
   - Comments: Medical Director is the Trusts Responsible Officer.
   - Action for next year: None required.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.
   - Yes
   - Action from last year: None required.
   - Comments: The Medical Director has appointed a Deputy Responsible Officer and has administrative support provided by the Medical Education team to carry out the responsibilities of the role.
   - Action for next year: None required.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.
   - Action from last year: None required.
   - Comments: The Medical Resourcing team work closely with the Medical Education team to keep the prescribed connection list up to date.
   - Action for next year: None required.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.
   - Action from last year: None required
   - Comments: The following policies are in place:
     - Revalidation and Appraisal Policy
### Section 2 – Effective Appraisal

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

   **Action from last year:** None required.
   **Comments:**
   **Action for next year:** None required.

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

   **Action from last year:** None required.
   **Comments:**
   **Action for next year:** None required.
3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board’s approval (or by an equivalent governance or executive group).

| Action from last year: None required. |
| Comments: Yes – Revalidation and Appraisal policy. |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: There are a total of 25 trained medical appraisers. 7 consultants have expressed an interest to become appraisers in 2019/20. |
| Action for next year: Annual new and refresher training to be held for new and current appraisers. |

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

| Action from last year: None required. |
| Comments: |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: An external audit took place in 2018/19 with recommendations suggested for improvement. The audit included a review of the current appraisal system, ‘Allocate’ which was deemed suitable and relevant for appraisal and revalidation. |
| Action for next year: None required. |

**Section 3 – Recommendations to the GMC**

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2 http://www.england.nhs.uk/revalidation/ro/app-syst/
2 Doctors with a prescribed connection to the designated body on the date of reporting.
1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

| Action from last year: None required. |
| Comments: The Deputy Responsible Officer meets with the Medical Education Manager fortnightly to review under notice doctors on GMC connect to ensure timely recommendations are made. |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: The Responsible Officer and/or Deputy Responsible Officer confirms with the doctor the reasons for recommendations if a deferral or non-engagement recommendation is made. |
| Action for next year: None required. |

Section 4 – Medical governance

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

| Action from last year: None required. |
| Comments: |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: Responding to concerns policy and process flow is in place. |
4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

| Action from last year: None required. |
| Comments: The external audit included a review of the current policies including responding to concerns. |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: |
| Action for next year: None required. |

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

| Action from last year: None required. |
| Comments: |
| Action for next year: None required. |

**Section 5 – Employment Checks**

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

| Action from last year: None required. |

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

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of last year’s actions:
- Ensure policies are reviewed in a timely manner
  The following policies are in place and will be reviewed:
  Revalidation and Appraisal Policy
  Responding to Concerns Process Flow
  Maintaining High Professional Standards
- Carry out an external audit of revalidation processes.
  An external audit took place in 2018/19 with recommendations suggested for improvement.

Current Issues
Ensure there is Lay Involvement in Revalidation.
Review of the Honorary Contracts policy.

New Actions:
- Commence appraiser forums twice yearly
- Annual new and refresher training to be held for new and current appraisers.
- Implement process within the Revalidation and Appraisal policy to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Overall conclusion:
The external audit review provided a satisfactory level of assurance to the RO and RNOH that the appraisal discussion, documentation analysis and personal development plans for Doctors with a prescribed connection is reasonably consistent, supporting the overall Appraisal and Revalidation process.

It is accepted that the appraisal inputs and outputs vary in quality. There currently is not a formal Appraiser Forum and one will be set up to communicate information generally and to share anonymised poor and good examples of inputs and summaries for consideration and learning. This would be very beneficial in improving communication and quality.
The RO and his team have discussed involving a GMC Layperson and how that would influence the way Doctors would feel about the quality outputs they had provided if that were the case.

Overall it is clear the Trust is meeting the requirements of revalidation in line with NHS England Core Revalidation standards.

Section 7 – Statement of Compliance:

The Board executive management team – of the Royal National Orthopaedic Hospital has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
Mr Rob Hurd, Chief Executive

Official name of designated body: Royal National Orthopaedic Hospital

Name: Mr Rob Hurd Signed: _ _ _ _ _ _ _ _ _ _
Role: Chief Executive
Date: _ _ _ _ _ _ _ _ ___
### Department Profile:

The X-ray and Imaging is located in two separate areas on the Stanmore site, both being within the main ‘slope’ building. It provides X-ray and Imaging services for all of RNOH Stanmore, both inpatient and outpatient.

*The X-ray department includes three x-ray machines, all of which use the latest digital technology, avoiding the need to process ‘films’. Completed X-rays are transferred securely to the respective patient’s records. These new machines are fast and reliable and can now ‘stitch’ complex X-rays where a single X-ray would not be sufficient. Stitching together multiple X-rays offers a more detailed view of the area in question.*

In addition, the department has small mobile machines, which can be used when patients are not able to be brought into the department. The department also offers ultrasound scanning and other specialised services such as Pedcat scanning for feet and ankles. We outsource this latter service to a private company that visits site once a week.

The Imaging Department has two MRI Scanners and a CT scanner. A new MRI scanner was installed in March 2019 and is already giving ever-improving service.

### Observations

#### Patient Experience

The X-ray department is located towards the bottom of the slope and Imaging is located at the top of the slope. The departments were quiet on the day we visited. Whilst this meant that it was not appropriate to speak directly to patients, we were able to see all the operational areas without interfering with ongoing patient activity.

Both X-ray and Imaging are well signposted on the main through-road and off the main slope corridor of the hospital*.

The main X-ray area can become very busy and at times it is virtually impossible to control the number of patients sent directly from Outpatients. Consequently, when the waiting area in X-ray becomes too crowded to cope with any additional patients, the Outpatients Department has to stop sending any new cases down to the unit until some of the backlog clears. It is hard to see how this can be rectified, given the varying cases that the radiographers have to deal with and the ‘ad hoc’ nature of the referrals from Outpatients. This leads to some patients being seen in a few minutes, with others taking considerably longer, depending on the x-rays requested and the mobility etc. of the individual in question.
CAT and MRI Imaging operate on an appointment only basis and thus, are better placed to deal with patient waiting times.

DNAs (Did not appear) are not too serious but notwithstanding this nuisance, texting is being introduced which should improve matters further.

**The Imaging unit is still not currently able to offer SPECT Scanning** and some 50 patients per month are sent to external units for this process to take place. We understand that when SPECT scanning is carried out off-site, there is a cost to the Trust of around £830 per patient. The capital cost of this facility is expected to be in the order of £1.2m and the current time expectation for sourcing is 2 years, thus the overall revenue cost, meanwhile, to continue sending patients outside as things stand would be some £1m. As it is considered feasible to take in patients from outside as well as treat in-house patients when the machine is installed, **there seems to be quite a persuasive argument for bringing this project forward...**

**Patient Safety**

Within X-ray all three machines have now been upgraded to use Digital Radiography, with the most recent having been commissioned in September 2017. These machines provide greater picture quality but with a reduced dose of radiation. Due to the nature of the treatment and diagnosis, many RNOH patients require regular, and at times repeated, X-rays so the newer equipment reduces overall exposure levels.

In Imaging, the long awaited MRI scanner is up and running and the eagerly awaited SPECT scanner is referred to above.

There were plenty of wall mounted hand wash units available and all those we checked were filled and operational.

Generally, both X-ray and Imaging were tidy throughout although we did note that in X-ray there was a cable trailing from a ‘flow monitor’ in the disabled toilet into a store room on the left, adjacent to the entrance to the toilet. This was referred to in the 2017 report.

In both X-ray and Imaging there was clear signage warning when the rooms were active and prohibiting access at times of radiation.

**Environment**

All three X-ray rooms and machines having been upgraded and the overall result is a bright and welcoming environment with ‘watery’ motives affixed on the both X-ray and MRI walls. These tend to detract from the somewhat claustrophobic environment in the equipment rooms.

There has been some patching carried out to the 3T floor to repair damaged areas. It is not a pretty sight! This was reported in 2017 but no action has been taken!

The Imaging Department could benefit from some minor works and redecorating to improve the waiting environment. For a 1998 building there is an air of tiredness emphasised by soiled ceiling tiles from leaks in the roof. The patient toilet located adjacent to reception is still difficult to access; patients have to pass through two doors and the entrance is cramped. All these deficiencies should
Patient Group Department Visit

be addressed as and when the unit is successful in getting the SPECT scanner.

The staff restroom in X-ray looks less tired than in 2017 with some remedial work having taken place but the floor is still poor. By contrast, the Imaging department staff restroom was bright, clean and tidy.

Patient Services and Amenities

There are waiting areas in both X-ray and Imaging. The X-ray waiting area floor is weird with no attempt made to colour-match repaired patches.

A cold-water machine is available to patients in X-ray.

The Imaging waiting area has a water fountain for patients’ use. In both X-ray and Imaging there is still only a very small selection of reading material available for patients (see 2017 report). It has been claimed that reading material is not wanted but Rachel Mason says otherwise!

There is a paediatric play-area partitioned off in the corner of the X-ray waiting area with a plentiful supply of toys and a TV/Games monitor, awaiting installation, the cost for which has been assessed as £680.

Department processes and procedures

Reception staff are present in both X-ray and Imaging to process patients on arrival.

The booking office is cramped and poorly ventilated.

The staff changing room is cramped with an inadequate number of clothes lockers.

A hoist and an ultra-sound machine has to be stored in a corridor.

In X-ray, at times of high activity, patients are processed according to the type of X-ray required. That is to say, one radiographer will process all those patients requiring a particular type of x-ray, with other radiographers dealing with other requests. This can result in some patients being seen ahead of others already waiting, apparently ahead - but overall, this has been found to be the most efficient way to manage times of high patient throughput (typically when Outpatients is very busy).

*It must be noted that access to both units can be bewildering at weekends if they are being used when other parts of the hospital (eg the OPD) are closed. Consideration must be given to advising such patients who are called to the units at weekends as to how to get to them.

<table>
<thead>
<tr>
<th>Actionable Observations following the 2017 report</th>
<th>Trust action to date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement to the Paediatric waiting area in X-ray (provision of better toys, wall mounted screen or monitor etc. to show TV shows or cartoons)</td>
<td>Done – except for the installation of the monitors (one in Children’s waiting area); one to be installed by the entrance, next to drinking water. Cost £680</td>
</tr>
<tr>
<td><strong>Upgrade to two major items of imaging equipment:</strong></td>
<td>Time frame is 1-2 years – See earlier</td>
</tr>
<tr>
<td>Replace the Gamma Scanner with a new SPECT scanner – See earlier</td>
<td></td>
</tr>
</tbody>
</table>

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### Patient Group Department Visit

<table>
<thead>
<tr>
<th>Task</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replace the existing 1.5 Tesla MRI Scanner which is reaching the end of its serviceable life</td>
<td>Done</td>
</tr>
<tr>
<td>Provision of better reading materials etc. in both waiting areas</td>
<td>Still inadequate</td>
</tr>
<tr>
<td>Remove the redundant Image Processor from the X-ray waiting area</td>
<td>Done</td>
</tr>
<tr>
<td>Attend to doors / entry route to the patient toilet located in the Imaging waiting area</td>
<td>Done</td>
</tr>
<tr>
<td>Refurbish and freshen up the waiting area within the Imaging Department</td>
<td>Still tired. TV monitors need installation. Dull areas need freshening</td>
</tr>
<tr>
<td>Refurbish the staff restroom in X-ray, particularly the sink / kitchen area</td>
<td>In hand but not yet a pretty sight</td>
</tr>
<tr>
<td>Shortage of porters can lead to beds + patients being stacked in corridors</td>
<td></td>
</tr>
<tr>
<td>The Recovery area needs improvement with a separate area for juveniles</td>
<td></td>
</tr>
<tr>
<td>See the three negative comments in <strong>Department Processes</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Additional Comments

We would like to thank Rachel Mason, Edmond Kinene and Jennifer Gibson for their friendly and positive cooperation with us during our visit and for the time they took to guide us through the X-ray and Imaging areas.

It is clear that they and their colleagues contribute enthusiastically to the making of a silk purse out of a sow’s ear that was the RNOH site!

The overriding question is clearly that of the earliest practicable sourcing of the SPECT scanner.
Patient Group Department Visit

Ward Response:

Thank you for visiting us. We would like to receive reading material for both waiting areas if this can be provided. The installation of the aerial for the TV would also help to mollify x-ray waiting times.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Job title:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rachel Mason</td>
<td>Imaging Manager</td>
<td>24/07/19</td>
</tr>
</tbody>
</table>