The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 11.01.2023

MEETING
11 January 2023 09:30

PUBLISHED
11 January 2023

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	11/01/23		09:30
1. Welcome			09:30
1.1. Apologies		All	
1.2. Declarations of Interest		All	
1.3. Minutes from the previous meeting November 2022		Chairman	
1.4. Matter Arising		All	
2. Presentations			09:40
2.1. Patient Story with Julie Hibbs		Chief Nurse and Patient Safety OfficerOfficer	
2.2. Transition Service Presentation with Sarah Ford		Chief Nurse and Patient Safety Officer	
3. Chairman / CEO Update		Chief Executive Officer	10:10
3.1. Communications and Engagement Strategy			
4. Board Assurance Framework and Corporate Risk Register		Acting Trust Secretary	10:30

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	11/01/23		09:30
5. Quality and Safety			10:40
5.1. Chief Nurse and Patient Safety Officer Update		Chief Nurse	
5.2. IPR Exception Report		Chief Nurse and Chief Medical Officer	
5.2.1. IPC Improvement Plan			
5.2.2. CQC Patient Experience Survey			
5.3. Chief Medical Officer Update		Chief Medical Officer	
5.4. Chair Report from Quality and Safety Committee		Non Executive Director	
BREAK			11:25
6. People and Workforce			11:40
6.1. IPR Exception Report			
6.2. Freedom to Speak Up Q2 Report		Chief Nurse and Patient Safety Officer	
6.3. Chair Report from People and Culture Committee		Non Executive Director	

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	11/01/23		09:30
7. Performance and Governance			12:00
7.1. Chief Operating Officer Update (verbal)		Chief Operating Officer	
7.2. IPR Exception Report		Chief Operating Officer	
7.3. Long Waiters (Presentation)		Chief Operating Officer	
7.4. Finance Performance Report		Chief Finance and Planning Officer	
7.5. Headline Planning guidance for 23/24		Chief Finance and Planning Officer	
7.6. Chair Report from Finance, Planning and Digital Committee		Non Executive Director	
7.7. Chair Report from Audit and Risk Committee (verbal)		Non Executive Director	
8. Questions from the Governors and Public		Chairman	12:45

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Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Main Entrance	11/01/23		09:30

9. Items to Note:	
9.1. Duty of Candour Annual Report	Chief Nurse and Patient Safety Officer
9.2. Health and Safety Annual Report	Chief Finance and Planning Officer
9.3. NICE Guidance Annual Report	Chief Medical Officer
9.4. Human Tissue Act Annual Report	Chief Medical Officer
9.5. Freedom to Speak Up Annual Report	Chief Nurse and Patient Safety Officer
9.6. Workforce Equality Annual Report	Chief People Officer
10. Any Other Business	All
10.1. Next Meeting: 1 March 2023	

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Harry Turner ☎ 01691 404358
Chairman

BOARD OF DIRECTOR – PUBLIC MEETING
2 NOVEMBER 2022 AT 9.30AM, BOARD ROOM AT RJAH
MINUTES OF MEETING

Present:

Harry Turner	Chairman	HT
Paul Kingston	Non-Executive Director	PK
Martin Newsholme	Non-Executive Director	MN
Chris Beacock	Non-Executive Director	CB
Penny Venables	Non-Executive Director	PV
Sarfraz Nawaz	Non-Executive Director	SN
Stacey Keegan	Chief Executive Officer	SK
Craig Macbeth	Chief Finance and Planning Officer	CM
Sara Ellis Anderson	Chief Nurse and Patient Safety Officer	SEA
Ruth Longfellow	Chief Medical Officer	RL

In Attendance:

David Gilburt	Associate Non-Executive Director	DG
Denise Harnin	Chief People Officer	DH
Jacqueline Barnes	Director of Improvement and Quality	JB
Mary Bardsley	Acting Trust Secretary (minutes)	MB
William Greenwood	Lead Governor	WG
Martin Bennett	Public Governor	MBe
Victoria Sugden	Stakeholder Governor	VS
Katrina Morphet	Public Governor	KM

MINUTE NO	TITLE
02/11.01	**APOLOGIES** Apologies were noted from John Pepper and Martin Evans.
02/11.02	**APOLOGIES MINUTES OF THE PREVIOUS MEETINGS** 07 September 2022 - the minutes were agreed as an accurate reflection of the meeting and therefore approved by the Board of Directors.
02/11.03	**MATTERS ARISING** There were no further items to be tabled for discussion.
02/11.04	**DECLARATION OF INTERESTS** DG informed the Board that he has been offered and accepted a role as Non-Executive Director and Chair of the Audit Committee at the University Hospital in Liverpool. It was noted that DG will commence the role in December 2022 and will step down as Associate Non-Executive Director at the Trust.
02/11.05	**GUARDIAN OF SAFE WORKING HOURS – MR CHRIS MARQUIS** RL introduced Mr Chris Marquis, Guardian of Safe Working Hours and explained the information is overseen by the People and Culture Committee. Chris joined the meeting to provide further details on his role as guardian for the Trust, exception reporting the Trust the overall responsibility the Trust has. HT thanked Chris for joining the meeting and the Trust was commended for having no exception reports since 2016 (since the safe working hours was implemented) CB queried the challenges faced in relation to committed trainees who would like to stay at work beyond their allocated time. CM explained that overall junior doctor training has decreased due to covid which has been difficult and therefore it has been a challenge to manage their theatre time as they are keen to support. CM continued to explain that consultants are supportive and help manage trainee time well. It has been unfortunate that the junior doctors have missed out on three years of training however the Trust is continuing to support.

	MN queried the Trusts capacity for junior doctor uptake. CM explained that there are a set number and posts available. The Trust struggles to fill the spines posts however the surgical services side the rota is usually full. The Trust would be able to take more junior doctors if there was an increase workforce. On behalf of the Board, HT thanked Chris for his leadership and commitment to the role.
02/11.06	**CHAIR AND CEO UPDATE** HT provided the following update: • NOA awards – congratulated the Trust in receiving 2 awards relating to the path of positivity and the green plan • The Trust Secretary interviews are scheduled to take place on Monday • Statutory role of the ICS has now been in place for 5 months. It is an inclusive system which will continue to develop. The Trust are keen to continue to support the System as is noted as a valued member. • Board to Board session – positive feedback has been received from the System regarding the session which took place in October. The Integrated Care Board were impressed with the organisation and noted the module is being used with other providers. **SK provided the following update:** • Publication of results of adult inpatient survey – the Trust rated high for patient experience and cleanliness. Food has been rated the highest 16 times out of 17 times in previous report. There is a requirement to focus on improvement. • NOA Awards – delighted to gain 2/3 awards – congratulations to all who were shortlisted • The Senior Leader continue to have a focus on the impact of cost of living for staff members. Some actions which are been implemented to support include, free hot drinks, free breakfast, reduced price for a meal at lunch time. • NHS leadership event – member of the ICB and Trusts CEO attended the event. Presentations were delivered from Amanda Pritchard and the national team, noted a focus on the long-term plan for the NHS and current challenges including workforce, recruitment, and retentions. • September Health Hero – Gill Edwards, Cook was nominated for her support with the diverse menu which is offered. Well done, Gill! • October Health Hero - Melanie Roberts, Medical Secretary was nominated for her resilience, kindness, and attitude. Congratulations Melanie! On behalf of the Board, SK thanked JB for her support throughout the IPC challenges and changes which have been faced.
02/11.07	**CORPORATE RISK REGISTER** The report is presented to the Board for information and ensure oversight of the current 8 live risks with a rating of 15 or more. It has been agreed that the process for reviewing the register will be via the Trust Performance and Operational Improvement Group following a review from the delivery units. • 1 risk has a rating of 20 (2653) relating to Theatre staffing and impact on operational delivery • 1 new risk has been registered relating to potential Industrial Action • 1 risk has increased (2793) – relating to the provision of Consultant Microbiologist due to current Consultant Microbiologist being off sick A further action is to ensure the register is added to the workplan for each assurance committee. It will be placed at the beginning of the agenda to support with discussion and reflection throughout the meeting similar to the setup of the Board. CB asked for the three risk ratings to be included in future meeting to support with the background of the risk. DG noted that it was pleasing to see a potential consultant microbiologist, good to see this is being considered through alternative organisations

	SN highlighted that the recruitment and workforce risk should be to be aligned to the People and Culture Committee with a note to be presented to the Finance, Planning and Digital committee for oversight. MN added that the Chair for each assurance Committee attends the Audit and risk Committee and therefore supports the links and cross cover between the meetings. HT encouraged the Committees to ensure time is allocated at the end of each meeting to reflect upon the risks aligned to the meeting to ensure they are current.
02/11.08	**ENGLISH VETERANS' AWARD** SK presented Lieutenant Colonel Carl Meyer, Consultant Orthopaedic Surgeon with the prestigious English Veteran Awards. On behalf of the Board, SK congratulated Lt Col Meyer who has been recognised for his amazing efforts. Lt Col Meyer responding with the following statement "Caring for our veteran patients is a huge priority for the hospital and the care we provide will only be enhanced with our new dedicated facility which is opening soon."
QUALITY AND SAFETY	
02/11.09	**CHIEF NURSE AND PATIENT SAFETY OFFICER UPDATE** SEA provided the following update: • Covid/Flu vaccination programme progress is slower than anticipated across the organisation with several actions being taken to encourage uptake. Flu is currently at 39.5% - approximately 10% behind where we were this time last year. Covid Booster is currently at 38.6%. • October was Freedom to Speak Up (FTSU) Month introducing our newly appointed FTSU champions and an opportunity to raise awareness making speaking up business as usual across the organisation. FTSU training is being rolled out and the Board have further training planned this afternoon. • The Trust received excellent 2021 Adult Inpatient Survey results • October saw the return of our PLACE audits; overall feedback was positive with all wards have either maintained or improved their overall score from 2019. • Patient Safety Incident Response Framework implementation plan launched in October by our Patient Safety Specialists with key stakeholder training sessions and focus groups. HT queried if there have been any changes to the PLACE audits following IPC issues. SEA explained that environmental scores have been increased and there is a noted a decreased in dementia. The Trust is liaising with the League of Friends to gain support on mural within the ward(s)
02/11.10	**INTEGRATED PERFORMANCE REPORT (QUALITY AND SAFETY)** The following key points were highlighted: • There were no serious incidents or never events reported in September • Th Trust declared a Never Event in October relating to retained foreign object, part of an oxford knee tibial implant introducer had been retained and confirmed on the patient post op x ray. The patient is progressing well and no evidence of harm. • A serious incident was also declared in October under the category of patient requiring intervention from another healthcare professional to prevent harm from occurring. • Surgical site infections are being reported as 8 for Q2 July-Sept. SN thanked the Trust for sharing the retention on forging object briefing with the Board in good time. HT queried whether the Trust is an outlier in relation to surgical site infections. The Trust confirmed yes for the hips but no knee or spines. Further work is to be undertaken to the strengthen the governance process following the IPC issues. CB reassured the Board that this is frequently discussed at the Quality and Safety Committee.
02/11.11	**NEAR MISS ANNUAL REPORT** The report has been presented and approved at the Quality and Safety Committee and is presented to the Board for oversight and noting. The report provides a summary of the categories of near miss incidents reported. There has been an overall decrease in the total number of near miss incidents reported across the Trust, some of this is through to be related to the pauses in activity due to the pandemic.

	Further work is to be completed in relation to the patient safety strategy to learn from near miss incidents going forwards and encouraging staff to report these. Following a query regarding the blood transfusion incident, it was confirmed that a cross match was not available on the day. There was no harm to the patient. Highlighting the overall decrease in near misses, the board discussed the possibility of a culture shift and asked for assurance on staff member not reporting near misses. MC explained that the reduction correlates with the overall reduction in activity across the Trust within the reporting period. SEA confirmed that action from the learning is shared with patient safety committee. CB highlighted the importance of the near misses and incorporating into the patient safety strategy. HT suggested a heat map is compiled to display the seriousness of the information and therefore consider the potential for harm in high-risk areas.
02/11.12	**PATIENT SAFETY ALERT ANNUAL REPORT** The report has been presented and approved at the Quality and Safety Committee and is presented to the Board for oversight and noting. The report summaries the number of safety alerts received between April 21 and March 22 of which 11 out of the 46 were National Patient Safety Alerts. All relevant actions were completed within deadlines. It was agreed at QS Committee that an effective auditing process would evidence ongoing compliance and give the Board further assurance. CB recognised the full audit of compliance on the trust sheet but queried how does the Trust know patient safety alert reached the correct person before asking for consideration to be given to the overall governance loop.
02/11.13	**CONTROLLED DRUGS ANNUAL REPORT** CD annual report for 21/22 for noting giving assurance on compliance with The Controlled Drugs (Supervision of Management and Use) Regulations 2013. Approval has been sought from the Quality and Safety committee. The report provides a summary of incidents reported in relation to controlled drugs with no Sis reported, a total of 22 reported incidents over the 12-month period. It was noted that the Trust has been compliant with CQC requirements, CD Lin submissions, CD audit completion, CD storage requirement and CD legislation. SK queried – does the Trust audit pharmacy usage of controlled drugs, are there systems and process in place to identify what is ordered into the Trust? SEA confirmed that stock audits are embedded and completed monthly. SK noted the good practice in place.
02/11.14	**CHIEF MEDICAL OFFICER UPDATE** RL provided an update on the following: • Digital portfolio has been realigned to the Chief Medical Officer • There has been an amber alert for blood • Noted the national shortage of doctors • GGI – clinical effectiveness, actions being taken to support the recommendation. This is to be supported by Andrew Roberts.
02/11.15	**LEARNING FROM DEATHS Q3 REPORT** There have been 3 deaths in the period, 2 of which were expected. Following a review of the deaths to support with learning, it was noted that the care the patients received has been noted as good. RL confirmed that the end-of-life care group establishes and link in with local hospice to support transfers. In relation to the 1 unexpected death, an investigation is being completed. There have been no concerns in relation to the care provided. A formal debrief to discuss learning points is to be scheduled. HT asked for a review of the report to enhance the learning noted within the reviews/investigations to provide further assurance to the Board. RL explained that following a debrief the staff had a no issues to raise, the process is in place and fit for purpose.
02/11.16	**CLINICAL AUDIT ANNUAL REPORT** RL highlighted the following:

	• The Trust continue to be involved in national audits - 9 have been completed for the reporting period • NICE guidance are reviewed to see if they are relevant to the Trust • Sharing learning from audits via forum and meeting • Risk – software is dated and not fit for purpose CB commented that he was pleased that the Trust has oversight, the structure of the report is expected to be changed to include learning. Following a query, RL confirmed the timeline for implementing the nee software is within 2023. DG asked for the actions to be updated before being published on the website. ACTION: action plan to be updated ahead of publication.
02/11.17	**CHAIRS' ASSURANCE REPORT – QUALITY AND SAFETY COMMITTEE** CB highlighted the following key points to the Board: • Discussion took place regarding delayed transfer of care and the impact on potential harm through the spinal injuries unable to get to the ward as there is a noted increase in numbers HT noted that this is a bigger issue for acute trusts who are required to deal with multiple counties and countries. MC explained that within the System, Shropshire Community Health has taken a lead for patient flow and there have been noted improvements in relationships between wards and the system hub which is supported the patient flow. SK suggested this is a KPI which is reported to Board as there has become and increased focus upon the challenges faced. SK confirmed there is a robust escalation process internally and within the ICS in relation to delays. It was noted that issues are relating to social care capacity. PK suggested the Trust consider new ways of working and how to manage differently in the future, is there an alternative design. MC explained that the Trust is currently considering having 5 beds at a local care home to support an expansion withing the area and therefore will increase MCSI capacity. • Assurance level low relating to safeguarding training. It was confirmed that there have been data quality issues and being monitored through the Safeguarding Committee.
02/11.18	**IPC IMPROVEMENT PLAN** The paper provides a summary and overview of progress against the improvement plan is in the pack and happy to take any questions. The letter following Kirsty Morgan's visit in September confirms the improvements seen and noted the changes are now becoming embedded into the Trusts processes. The Trust is now assessed as Green on the NHSE IPC matrix. The Trust self-assessment against our formal undertakings that were issued is also included for information. The Improvement Review Meeting held last Thursday agreed verbally that the formal undertakings had been met and could be removed and the letter to confirm this is awaited. SEA delivered the presentation which was given at the last performance meeting for oversight. PV thanked SEA for the comprehensive update and commended the green rating. The Trust has completed a lot of improvement withing a short time. Following PV query, SEA confirmed that the recommendations within the letter will be embedded into the overarching improvement plan. MN highlighted the high turnover rate and queried if the IPC team attend the induction meetings? SEA confirmed that IPC champions support new starters to ensure the background information is shared for greater oversight and understanding.
02/11.19	**IPC Q2 REPORT** This new format of the quarterly IPC report has been presented at IPCQAC and is shared with the Board for noting. SEA highlighted the following: • Cleanliness scores remain consistent with Q1 performance and local and national targets have been maintained. • 3 HCAI's reported in Q2 (1 CDIFF, 1 E-coli and 1 MSSA) • 8 SSI (5 Hips and 3 Knees) have been reported for the quarter

	• Demonstrable improvement in IPC training compliance noted and feedback from IPCQAC to add further narrative on any hot spots of non-compliance will be added to future reports • 8 outbreaks declared for Q2, 7 of which relate to COVID-19 and 1 MRSA outbreak.
02/11.20	**CHAIRS' ASSURANCE REPORT – IPC QUALITY ASSURANCE COMMITTEE** Items not discussed elsewhere within the meeting were noted as follows: • recognised the team effort for the IPC agenda • Following the last improvement review meeting a formal letter is expected. • A desktop review has been completed of all evidence provided against the actions. • The Trust is being rated as Green against the NHSE matrix which is a testament to the work being completed • Awareness of risks were noted • Formal undertakings are to be removed JB thanked the Board for welcoming her as the improvement director for the Trust. HT thanked JB for support not to underestimate the work which has been completed. HT explained that the desired outcome from the review would be an exemplar for other organisations. PV congratulated the Trust on the improvement noted within training data, highlighting the difficulties in completing training on top of the usual day to day work and staffing level pressures – highly commend the work which has been completed.
PEOPLE AND WORKFORCE	
02/11.21	**INTEGRATED PERFORMANCE REPORT – PEOPLE AND CULTURE COMMITTEE** DH highlighted the following key messages: • Sickness turnover and vacancy rates all show an increase • Sickness related to short term illnesses - flu and some covid related. • The people service business partners continue to support managers with staff on long term sick • Retention is a focus area for the department and ensuing managers are supported in the process • Exit interviews process being reviewed and keeping in touch discussions are to be implemented • Agency core target is based on national targets and usages
02/11.22	**GUARDIAN OF SAFE WORKING HOURS – Q2 REPORT** Following on from the presentation earlier in the meeting, RL highlighted the following: • 4 foundation doctors posts are to commence • The guardian has submitted a request for admin support • There have been no fines or exceptions reported
02/11.23	**CHAIRS' ASSURANCE REPORT – PEOPLE AND CULTURE COMMITTEE** PV provided an update on the Chairs report: • A continued focus on recruitment and retention with the target to improve recruitment timelines. A detailed action plan is required on a retention plan • Performance data – triangulation between the sub committees and ensure the workforce data is being shared in FPD • Additional support for international recruitment is required • The Committee received a deep dive into special leave • Further assurance from the consultant working group and the recruitment working group has been requested • Noted the current 5 year people plan expires in March 2023, needs to incorporate the system people plan to support collaborative working • Clarity sought on the role of the committee in relation to approving policies. HT confirmed that an assurance committee are to scrutinize the policies and recommend approving to the Board. DG suggested that a policy for policies to be compiled and share with the committees for oversight. DG and MB to work together to develop policy for policies.

	SN noted that a lot of work is around the workforce and queried the people services team capacity. The Trust need to ensure the team is adequality resourced to implement the changes and action identified. DH confirmed a review of the people services team is being completed. SN encouraged the Trust to focus on EDI. There are recommendations within the internal audit report which are soon to be completed.
02/11.24	**INTEGRATED PERFORMANCE REPORT** MC highlighted the following messages: • Reviewing the KPIs for the Board • specific deep dive on a rolling basis for the FPD committee • A industrial action and planning group has been established • Focus on longest waiting patients - demand and capacity modelling to be completed • A theatre productivity workshop is being completed • Overdue Follow Ups – backlog within rheumatology has had less movement than expected and therefore, a revised trajectory is being developed • Diagnostic – improvement noted withing September. The mobile MRI scanning is being delivered to support with the additional capacity • Overall activity – remains challenging for the Trust • Outpatients – concerns noted with underperformance (in particular, within therapies)
02/11.25	**LONG WAITERS' PRESENTATION** MC delivered the presentation the Board, highlighted the key points: • Presentation reported the Trust being 13 behind plan however the Trust is now ahead of plan with the performance continuing to improve. • Bottle neck noted within milestone 2 with diagnostics. HT noted that there is an expectation to discuss the theatre productivity at the Board-to-Board meeting. MC explained that theatre utilisation is being reviewed and the Trust are developing an improved dashboard which will be shared with the Board following discussion at the FPD Committee. MC explained that touch time is being asked to focus on nationally. DG suggested the collection of the start and finish time metrics is to be investigated to provide further assurance that actions are being implemented to use the full theatre capacity. CM explained that the Trusts current challenge related to the number of cases per session running compared to pre-pandemic. The Trust are now completing more complex cases in line with the guidance.
02/11.26	**ELECTIVE RECOVERY SELF-CERTIFICATION** The Trust has completed the self-certification and highlighted the amber rated actions to the Board for information. Following a discussion, MN agreed to be the Non-Executive Lead for theatre utilisation. JB encouraged the Trust to add further detail to the actions implemented to ensure robust information and assurance on governance processes is received. SN commented that the Trust has made good progress with 104 waiters and need to ensure outpatient challenges are highlighted within the report. The Board approved the self-certification.
02/11.27	**FINANCE PERFORMANCE REPORT** CM provided an update on the following: • New Theatre – the Trust is to submit a shortform business case on the new theatre to gain funding from national allocation fund. CM thanked the team for their support in delivering the form as short notice. A decision is expected next week. • Walkabouts in the veterans' centre have been scheduled and the final handover took place on Monday. The official opening is scheduled for in a few weeks' time. • The Trust is back on trajectory in relation to finances. The Trust benefited from the ERF support over the past few months – this is set to continue into the second half of the year • Forward looking challenges relate to the integrated care system financial position, and escalation of this risk. The Trust is considering ways on how to improve and justify the current position. CM confirmed there is a national meeting to review this

	afternoon to consider key drivers. The Trust are expecting to be challenges on agency spending and productivity.
02/11.28	**CHAIRS' ASSURANCE REPORT – FINANCE, PLANNING AND DIGITAL COMMITTEE** SN highlighted other key points which have not been discussed elsewhere within the meeting, these included: • MSK efficiency report – an agency report is being presented to the People and Culture Committee to support in gaining assurance. • Noted the extraordinary meeting which took place to consider the business case form for the new theatre • Workforce remains a key issue which impacts the overall deliverability of the operational and financial plan. PV queried the working practices within therapies department highlighting the downturn in activity. SN confirmed the FPD committee is sighted on the therapies activity and is being monitored. CB noted the 16% shortfall on pre pandemic activity and queried the main barriers. The Trust confirmed an analysis has been completed and it is due to the mutual aid support which was offered in April. This has been main impact, along with a shift with the case mix. It was noted that there are less sessions being completed than pre-pandemic. This is not unique to the Trust and the team is currently looking into improving the efficiency rates. HT queried the second half of the plan and the contributed factors which may influence delivery going forward. The going impact of covid relating to cancellations, shortfall with anaesthetists, willingness of the staff and supporting the wellbeing of staff was noted. The Trust does not wish to rely on staff to complete additional work. MC reminded the Board of the step change within October/November 2019/20. The forecast has been revised and the Trust is over performing against the revised forecast. HT confirmed the confidence that the Board have in the Executive Team to deliver the plans but encouraged them to ask for support if required. CB asked whether the Trust is using the facilities to full capacity? MC explained that there are some issues which are mainly linked to staffing. The Board reaffirmed the impact to which the workforce pressures have upon the activity plans.
02/11.29	**CHAIRS' ASSURANCE REPORT – AUDIT AND RISK COMMITTEE** The following key pointed were noted: • Policy tracker – a review of the policies is required to ensure they have been validated, and allocated to assurance committee for oversight • HFMA self-assessment is a regulatory requirement. There is a 3-stage process which is to be completed by the end of December. An internal audit review has been scheduled and recommendations are tabled for discussion at the January meeting. • Internal audit progress – the first report has been completed and an assurance rated of substantive was noted for the waiting list management process. • Improvements to the risk management process and the actions to mitigate the risk have been noted. This continues to be a working progress however the Committee is please with actions taken to date. • Chair report from IG committee – appointment of the Data Protection Officer was highlighted as a risk however the Trust is currently considering options.
02/11.30	**QUESTIONS FROM THE PUBLIC/GOVERNORS** There were no questions from the public. The Governors shared the following comments: • Assured from the discussion within the Quality and Safety remit, specifically in relation to CB comments relating to learning from near misses which triangulated with a recent patient safety walkabout discussion - good to witness the link between ward and board • Noted the impact on the ICS has at the Trust • Welcomed DH comments regarding the recruitment and retention

	• In relation to supporting delayed discharges, the Trust were reminded of the ETHOS Charity which supports spinal rehab patients to which the Trust agreed to discuss outside of the meeting to offer further oversight and support.
02/11.31	**ANY OTHER BUSINESS** Thank you and best wishes to DG On behalf of the Board and the Trust, HT thanked DG for his continued support over his time with the Trust. It was noted that DG contribution has been invaluable, and the Trust were grateful that he agreed to return to support the Trust when required with corporate memory.
02/11.32	**CLOSING REMARKS** HT thanked everyone for attending the meeting and for their contribution in the discussions.
NEXT PUBLIC MEETING: 11 JANUARY 2023	

SUMMARY OF ACTIONS

REFERENCE/TITLE	LEAD	STATUS
Actions from the Previous Meeting – November 2022		
Clinical Audit Annual Report action plan to be updated ahead of publication.	Chief Medical Officer	Complete – action plan updated

Transition

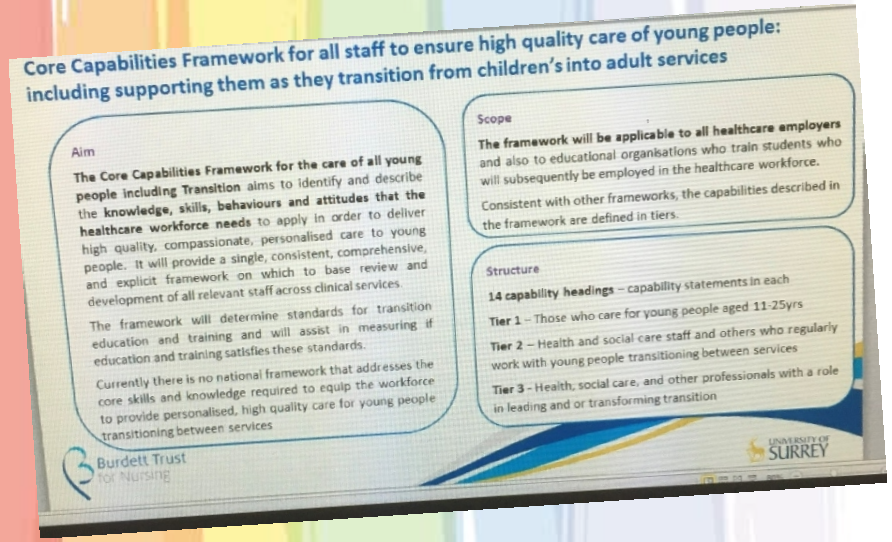
What is Transition in healthcare

- Transition is not a single event, but is a gradual process of supporting a young person and their family through their teenage years and into adulthood, building up their confidence and ability to manage the care and support they need.
- The process involves preparing, planning, educating and empowering the young person about their health and social needs.
- The ready steady go document is utilised as a holistic approach enabling the young person to take charge of their own healthcare needs.

Nice Guidance

- Nice Guidance suggests that RSG is a resource designed to enable high-quality transition across all subspecialties.
- Utilising the RSG programme allows for best practice and benchmarking effective transition.
- Addresses the full range of issues for good transition and facilitates discussion in greater depth where required by the YP, carer or healthcare professionals
- Improves clinical practice and clinical outcomes

The Core Capability Framework



Core Capabilities Framework for all staff to ensure high quality care of young people: including supporting them as they transition from children's into adult services

Aim

The Core Capabilities Framework for the care of all young people including Transition aims to identify and describe the **knowledge, skills, behaviours and attitudes that the healthcare workforce needs** to apply in order to deliver high quality, compassionate, personalised care to young people. It will provide a single, consistent, comprehensive, and explicit framework on which to base review and development of all relevant staff across clinical services.

The framework will determine standards for transition education and training and will assist in measuring if education and training satisfies these standards.

Currently there is no national framework that addresses the core skills and knowledge required to equip the workforce to provide personalised, high quality care for young people transitioning between services

Scope

The framework will be applicable to all healthcare employers and also to educational organisations who train students who will subsequently be employed in the healthcare workforce.

Consistent with other frameworks, the capabilities described in the framework are defined in tiers.

Structure

14 capability headings – capability statements in each

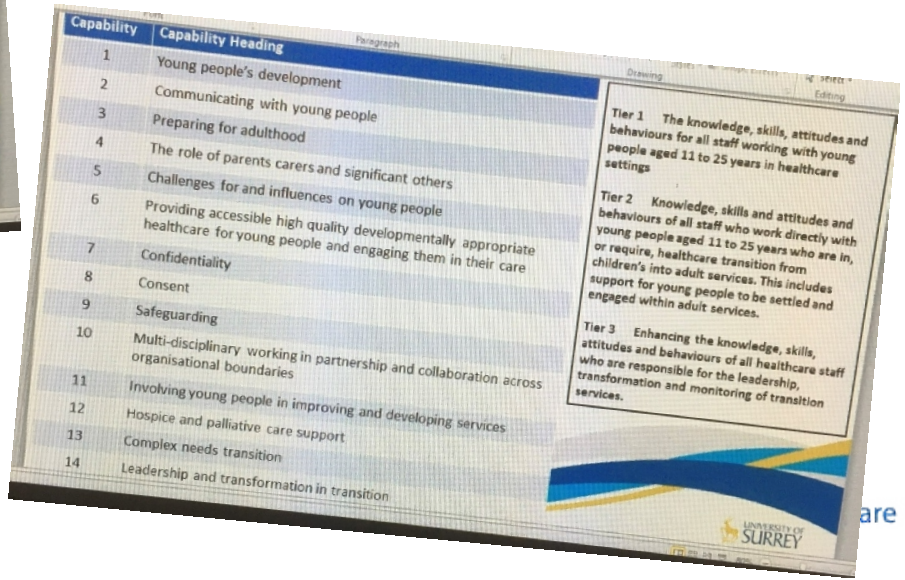
Tier 1 – Those who care for young people aged 11-25yrs

Tier 2 – Health and social care staff and others who regularly work with young people transitioning between services

Tier 3 - Health, social care, and other professionals with a role in leading and or transforming transition

Burdett Trust for Nursing

UNIVERSITY OF SURREY



Capability	Capability Heading
1	Young people's development
2	Communicating with young people
3	Preparing for adulthood
4	The role of parents carers and significant others
5	Challenges for and influences on young people
6	Providing accessible high quality developmentally appropriate healthcare for young people and engaging them in their care
7	Confidentiality
8	Consent
9	Safeguarding
10	Multi-disciplinary working in partnership and collaboration across organisational boundaries
11	Involving young people in improving and developing services
12	Hospice and palliative care support
13	Complex needs transition
14	Leadership and transformation in transition

Tier 1 The knowledge, skills, attitudes and behaviours for all staff working with young people aged 11 to 25 years in healthcare settings

Tier 2 Knowledge, skills and attitudes and behaviours of all staff who work directly with young people aged 11 to 25 years who are in, or require, healthcare transition from children's into adult services. This includes support for young people to be settled and engaged within adult services.

Tier 3 Enhancing the knowledge, skills, attitudes and behaviours of all healthcare staff who are responsible for the leadership, transformation and monitoring of transition services.

UNIVERSITY OF SURREY

are

Mapping – pre services development

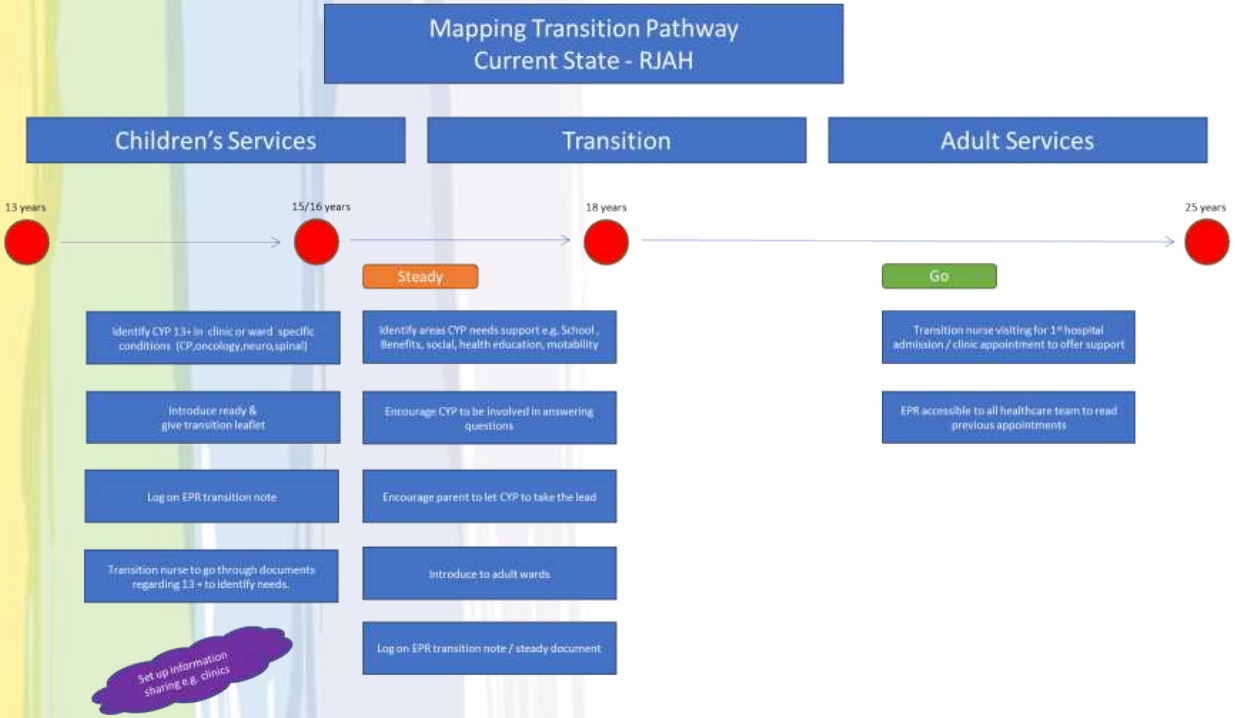
Current situation

- Post – this is a newly developed post to meet the national guidance and to address an informal complaint for a young man transitioning during COVID.
- Temporary post set up 18th July using unused maternity backfill until Mar 23
- Currently funded at 24 hrs per week on a band 6.
- Post holder completed NHSE transitional collaborative last year.
- Post needs job matching with a plan for Band 7 – 30hrs per wk
- Regular support from Nathan Samuels – NHSE west midlands regional nurse advisor for transition (Burdett National Transition trust).
- Networking countywide Transition leads for support and supervision

Current situation

- Pathways for children with Complex health care needs - CP, Spinal Injuries, oncology, neuromuscular
- Clinic contacts recorded on EPR
- Support for adolescents on Adult wards
- SF member of the RDAC - regional driving assessment centre, can now refer young people for assessment free of charge. Self referral =£100
- SF attended sex education conference for young people with disabilities which will help with this role.
- Level 4 safeguarding training complete 2nd Dec

Mapping Now

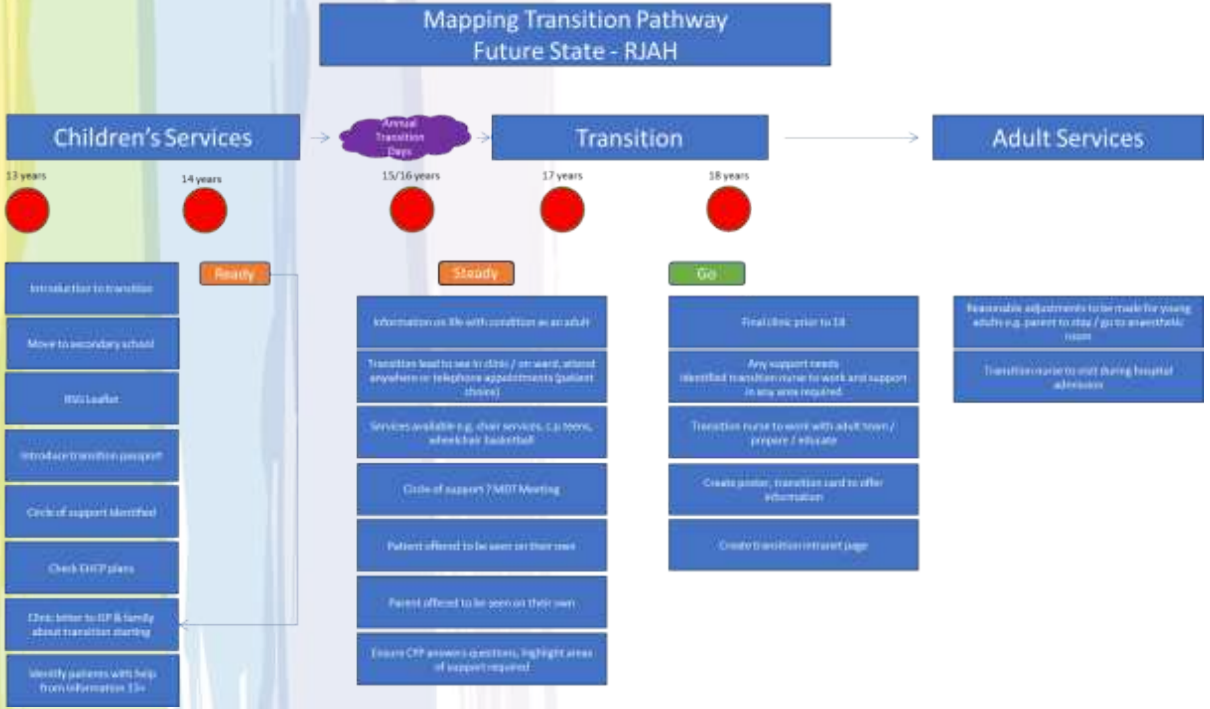


Aspiring to deliver world class patient care

Next steps

- Secure Funding for post
- Finalise Job description and send for job matching
- To encompass the associate safeguarding lead role in this post.
- Attend anywhere clinics to increase number contacts made.
- Last clinic before 18yrs
- Transition page on ‘Percy’
- Transition day.

Mapping for future service



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Patient feedback

- What have you found helpful?
- *“Recognition that transition to adult services is harder on disabled people”*
- *“Information clearly explained and felt comfortable talking”*
- *“learning about all of the services available- my son says this has eased his anxieties”*
- *“we have been so stressed before this, we feel so reassured”*

Patient feedback

- *"it would have been extremely stressful for my 1st adult admission, but Sarah prepared me and made me feel so comfortable"*
- *"Sarah was so patient with us and made us feel so much more relaxed about the future and what will happen"*
- *"Outstanding, Sarah was paramount in keeping us calm and putting **** at ease"*

0. Reference Information

Author:	Stacey Keegan, Chief Executive Officer	Paper date:	11 January 2023
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	5 January 2023
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an update to Board members on key local activities across several business areas not covered within the main agenda.

2. Executive Summary

2.1. Context

This paper provides an update regarding some of the most noteworthy events and updates since the last Board from the Chief Executive Officer.

2.2. Conclusion

The Board is asked to note and discuss the contents of the report.

3. The Main Report

- **Substantive Chief Executive**

This is the first Board meeting where I am here as substantive Chief Executive, after being appointed to the role in December. It's been a huge privilege to lead this Trust during the initial stages of the pandemic and over the last 16 months, where I stepped up as interim CEO on two occasions, and I am delighted that I will now be able to continue in post and build on the great work we have started together. Planning has now commenced for the recruitment to the Chief Nurse and Patient Safety Officer post.

- **Christmas and New Year**

This is our first Board session for 2023. Thank you to all our staff who worked over the Christmas and New Year period. I paid a visit to our staff working on Christmas Day, visiting our clinical and non-clinical areas who were onsite ensuring our patients have the best Christmas possible. I especially had a lovely time on Alice Ward, our dedicated children's ward, where I joined the children opening their Christmas presents.

- **Urgent Emergency Care Pressures**

The Shropshire, Telford and Wrekin system continues to experience significant pressure with high numbers of emergency presentations exacerbated by the fifth wave of Covid-19 and a surge in influenza cases (a picture currently seen across the NHS). This has resulted for Shrewsbury and Telford hospitals (SaTH) in long ambulance waits, overcrowding, corridor care and a further strain on workforce including absence. At RJAH, we have continued to support with SaTHs most clinically prioritised orthopaedic patients including long waits and have recently in December supported further upper limb trauma. Kenyon Ward was opened on the 4th January to pathway one and two medically fit patients from Shropshire Community Trust to support decompression and flow across the system. This capacity is being staffed with support from the Integrated Care Board (ICB).

- **NHS Providers Conference**

In November I attended the two-day NHS Providers conference, with this year's theme being resilience. A focus on resilient services, resilient communities, and resilience for the future. There were a series of roundtables, expert case studies, interactive debates and importantly an opportunity to connect and network with colleagues.

- **Chair and CEO leadership and tackling health inequalities**

This event focused on the role and leadership of NHS Chairs and Chief Executives in tackling and reducing health inequalities which I attended in November. Hearing what initiatives and approaches have been taken across Integrated Care Systems (ICS) and an opportunity to hear from General Sir Gordon Messenger following the publication of the Messenger Review of NHS Leadership.

- **Veterans' Orthopaedic Centre ribbon cutting**

I think the biggest piece of news since the last public Board of Directors meeting is the official opening of the Headley Court Veterans' Orthopaedic Centre – the UK's first dedicated orthopaedic centre for veterans.

The building, which was possible following a £6million donation from The Headley Court Charity, was built by local contractor Pave Aways.

To mark the occasion, a special soft launch ribbon cutting event took place on Remembrance Day, Friday 11 November.

- **First patient treated in the Veterans' Centre**

Following the ribbon cutting ceremony, Thursday 1 December saw Mr Alex Baxter, former Wing Commander in the Royal Air Force from Shrewsbury, became the first patient to be seen in the new centre.

Mr Baxter visited the hospital for a follow-up review after having both hips replaced by Lt Col Carl Meyer. He credits the surgery "gave him his life back" and believes the new centre will be a game-changer for meeting the health and care needs of the veteran community.

- **Pride t-shirt competition**

Back in June, we held a competition encouraging the children of staff to design a Pride themed t-shirt. Our winner was Maggie, the granddaughter of Operating Department Practitioner Roe Walsh.

Maggie's design was inspired by a pride of lions, with a rainbow which represents the strength and unity within the LGBTQIA+ community. Her design has now been turned into a t-shirt, with one of them displaying on the corridor at the hospital. Well done Maggie!

- **Marathon Runners thank**

In December I was delighted to attend Fernhill Hall hosted by Deputy Lieutenant Mrs Veronica Lillis to present certificates and celebrate the enormous achievements and fund raising of all our marathon runners. Over £44,000 was raised for RJAH Charities - Huge congratulations!

- **Award for RJAH finance team**

Congratulations to our Finance Team who have recently been awarded level 3 accreditation in the Future Focused Finance assessment framework.

The Future Focused Finance framework is run by the Healthcare Financial Management Association and was introduced to encourage NHS finance departments to share improvements, knowledge and best practice

- **Health Hero Award**

There have been two winners of the Health Hero Award since our last public Board meeting:

Joanne Caffrey, Sian Williams and Noel Jennings from the Information Department won November's award for their hard work when it comes to providing essential data submissions, relating to waiting lists.

Our December winners were Hayley Lewis, Siobahn Price and Chloe Upton, who all work in the Project Management Office, for their work on the Headley Court Veterans' Orthopaedic Centre project for the past 18 months. Congratulations all!

4.0. Conclusion

The Board is asked to note and discuss the contents of the report.

0. Reference Information

Author:	Chris Hudson Head of Communications	Paper date:	11 January 2023
Executive Sponsor:	Stacey Keegan, Chief Executive Officer	Paper Category:	Strategy
Paper Reviewed by:	People and Culture Committee (Nov. 22)	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the People and Culture Committee and what input is required?

The Board of Directors is asked to consider the communication and engagement strategy.

2. Executive Summary

2.1. Context

This communications and engagement strategy for The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust sets out how the trust will communicate and engage with its audiences, to support the delivery of its vision and strategic priorities.

Communicating and engaging well with our staff, patients and their families, the public and stakeholders is essential for the delivery of safe and effective patient care and is central to the success of the organisation.

2.3. Conclusion

In November the People and Culture Committee were asked to:

- Note the content of the Communications Strategy in so far at it falls within the Committee's remit
- Consider and agree whether assurance can be provided to the Board that this strategy represents a robust approach to both internal and external communications over what is a crucial period for the NHS – both nationally and within our own health system
- Consider whether there are any additional elements that the committee feel should be captured within this strategy document

The People and Culture Committee recommend that the Board of Directors approve the strategy.

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

COMMUNICATIONS STRATEGY

October 2022 - October 2024

Version 1.0

Executive Summary

This communications and engagement strategy for The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust sets out how the trust will communicate and engage with its audiences, to support the delivery of its vision and strategic priorities:

Aspiring to deliver World Class Patient Care

Communicating and engaging well with our staff, patients and their families, the public and stakeholders is essential for the delivery of safe and effective patient care and is central to the success of the organisation.

It's crucial that we communicate clearly, openly, in a timely way and with relevant and helpful information. But one-way communication is not enough – we must establish an engagement approach to ensure that we have an ongoing dialogue with all of our audiences, using their views and the insight gained to continually improve.

We are committed to improving and evaluating how we communicate – with recommendations based on evidence and facts.

This strategy aims to maintain and build our reputation from the inside-out, and make the trust an attractive place to work for our current and potential employees. It recognises the need to listen to patients, the public and other stakeholders, and to put people at the heart of all that we do.

In this strategy, we describe the approach we will take, and the channels we will develop for:

- brand and reputation management
- internal communications and engagement
- external communications and engagement
- campaigns

We have two overarching communications objectives:

1. to ensure that the trust's vision, values and priorities are understood by staff and our stakeholders

2. to ensure that all communications have a response mechanism for conversation and feedback

And five linked to the vision, enhancing the reputation of the trust, ensuring that:

1. our staff feel proud to work here – at the trust and for the NHS

2. there is public pride in our hospital and that patients value our services and staff

3. we celebrate areas of good practice and share across the trust, regionally, and nationally

4. we use communications to support improvement in the trust – both through the quality improvement programme, and through clear and consistent messaging around important issues, for example safety

5. as we share good practice, we will also share examples of compassionate care – not only **what** our staff are doing, but **how** they are doing it

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1. Introduction

The NHS is changing, and the way we communicate is changing.

As technology advances, the way that people expect to receive and interact with information, brands and organisations has changed – and so we must evolve to meet those demands.

Where once people would have limited sources of information about an organisation and had limited response mechanisms, now they have many, and can connect with people all over the world and share views and experiences. Information is, rightly, more open and transparent.

People demand information at the touch of their fingertips, quick responses, and a two-way conversation. They expect 24-7 customer service and will make their views heard publicly – whether we like it or not.

Staff also demand more from their organisation. They receive more information about the trust from external sources, and are not only our core audience, but are active ambassadors for our trust. Academic research shows that each person will directly influence 12 more people (Smythe, Dorward and Reback, 1992). With more than 1,600 staff, that's a lot of reach.

High levels of staff engagement also leads to better patient outcomes and better use of resources – investing our time and energy into staff communications and engagement will benefit patients (NHS Employers, 2013).

As a Trust, we can't always control the information, channels or how our messages are interpreted. But we can, and must, join the conversation as an active participant and provide clear, accessible and consistent information about our services, our priorities and our values.

As an organisation and as a communications team we must meet this expectation head on. Our reputation depends on it – as does the public confidence in our ability to provide high quality, compassionate care.

2. Strategic Context

This Communications Strategy has been written to support the specific needs of the organisation at this moment in time.

Trust Strategy

This communications strategy supports the trust's strategic plan, which is summarised below:

1. We will lead the work to integrate and transform Musculoskeletal (MSK) services across Shropshire, Telford and Wrekin.
2. We will develop our Veterans service to ensure it is established as a centre of excellence.
3. We will optimise the potential of digital technologies to transform the care of patients and their outcomes.
4. We will deliver operational excellence.

It is recognised that the NHS as a whole is moving into a new era with ongoing challenges presented by Covid-19 and the impact of this on the work to recover and restore services.

It is therefore anticipated that the Trust strategy may require review as events unfold and national requirements change to respond to the ongoing challenges.

Mission, Vision and Values

Our stated mission is Caring for Patients, Caring for Staff and Caring for Finances. This is underpinned by our vision: Aspiring to Deliver World Class Patient Care.

Our values set out how we go about delivering that vision. They are the bedrock for everything we do, and are backed up by a set of 25 Signature Behaviours and 11 Cultural Characteristics.

This Communications Strategy sets out how we will support the successful delivery of our Trust's over-arching strategy and how we will continue to do that in a strong values-based fashion.

3. Situation Analysis

Our communications must take into account influences from outside our own organisation – to both ensure that we are communicating correctly and legally, and also to identify, monitor, and plan for emerging and current issues.

Political

- there is likely to be instability for the next few years - our MP won a sensational victory in a shock by-election in 2021, becoming the first non-Conservative to serve the constituency in a lifetime. The current national political stage remains turbulent at the time of writing, meaning we cannot be sure what the future holds.
- building a relationship with our sitting MP should be a priority to ensure her support for our key strategic aims.
- wider implications of EU exit will need ongoing monitoring - for example recruitment and retention, and supply chain - public confidence will need to be maintained

Economic

- RJAH currently in surplus, though that is forecast to change in the coming year
- Tariff for specialist services will impact on our services
- system-wide financial planning likely to continue to impact our financial position
- system focus on reducing spend on orthopaedic surgery

Social

- a growing and aging population with new health challenges
- public pride in the NHS but fear over its future
- importance of openness and transparency
- importance of doing more to make sure Equality, Diversity and Inclusion (EDI) is at the heart of our decision-making process

Technological

- a greater reliance on mobile technology to communicate - internal and external
- medical technology innovations - showcase RJAH as a site of innovation in eg ACI
- huge investment in a new Electronic Patient Record (EPR) – challenges for communications, but also opportunities too, to sell our vision

Legal

- impact of CQC ratings on our reputation
- requirement to meet access and quality targets
- requirement to adhere to stricter accessibility guidelines for communications - ie online accessibility
- Information governance requirements relating to data collection - ie via web forms, cookies etc

Environmental

- The Trust has invested successfully in its estate and has now, of course, secured the funding for the Veterans Orthopaedic Centre
- as a trust we are working to become more environmentally sustainable

4. Audiences

Continuing to engage and build supportive two-way relationships with our audiences is critical to our ongoing success. We have many audiences and each has different priorities, interests and influence over different topics.

As we plan each project, campaign or communication, we will identify priority audiences and, if appropriate, key messages for each.

Internal

- Board – executives and non-executives
- deputies
- staff
- consultants
- nurses
- therapists and scientific staff
- administrative staff
- corporate – ie HR, finance, IT
- facilities – ie porters, cleaners
- volunteers
- trades unions
- friends of the hospital
- charity team
- charity fundraisers

External

- patients
- carers and families
- members
- general public
- local, regional and national media
- local and national politicians
- local community groups
- third sector
- Healthwatch Shropshire
- GPs/PCNs
- regulators – NHSE, CQC
- ICS
- think tanks
- schools and colleges
- prospective employees
- private and 3rd sector providers
- prospective private patients
- Trade Unions

5. Communications principles and objectives

5.1 Principles of communication

Every piece of communication, internally and externally, contributes to our reputation and needs to be consistent with our values. This includes corporate communications and leadership communications. In order to achieve this:

- will be clear, accessible and inclusive – making information available in other formats and languages where requested
- we will use Plain English
- we will be accurate, fair and balanced
- our information will be timely and relevant
- we will target our communications to different audiences
- staff will be first to find out information about the trust – “nothing about us without us”
- all of our activity will be aligned with corporate brand guidelines (visual and tone)
- we will evaluate our activity and be evidence-based in our recommendations

5.2 Our approach

Clear communications and responsive engagement will mean:

- patients have the information they need, when they need it, in an appropriate format
- staff have the information they need to carry out their role
- engaged staff who feel listened to – leading to better staff morale and better patient care
- high levels of public confidence

The Communications Team at RJAH has developed over the last three years, with a real focus on addressing internal cultural challenges and building our online follower base, who in turn have acted as advocates for the organisation.

Going forwards, we will:

- continue to **grow capability** in the comms team – particularly around two-way engagement, use of technology and evaluation
- **plan and prioritise campaigns** and resources according to our organisational priorities and values
- thoroughly **evaluate** all of our activity – using output and outcome measures – so that we can ensure our resources are used in the most effective way
- consider our **succession planning** to ensure a stable service

There are five areas that we will organise communications activity around over the next few years – these are explained in more detail in sections 6-10.

In each section we explain our approach, our communications objectives and a summary of the strategy and tactics we will use to address:

- brand and reputation
- internal communications and engagement
- external communications and engagement
- equality, diversity and inclusion
- campaigns

6. Brand and reputation management

6.1 The NHS identity – and why consistency is important

"The NHS Identity is one of the most cherished, recognised, and trusted brands in the world. When applied correctly and consistently, it evokes exceptionally high levels of trust and reassurance… the single NHS Identity is important to [the public] and deviation from the guidelines creates confusion, mistrust and concern." NHS England

National research shows the importance of a clear consistent use of this brand to ensure clear signposting of NHS services (and therefore quality and values):

"Patients and the public see the NHS as a single, national, unified service and expect and want the NHS Identity to be applied in a consistent and uniform way – it reassures them that they can rely on the quality of the healthcare being provided wherever they access it.

"Overall, there was a strong preference for this [consistent] approach across all groups...seen as clean, crisp, consistent and orderly. There was no ambiguity in the format, and thus in the messaging; this represented a unified approach from a unified organisation. This level of consistency was felt by respondents to make it easier for the public to navigate the NHS system.

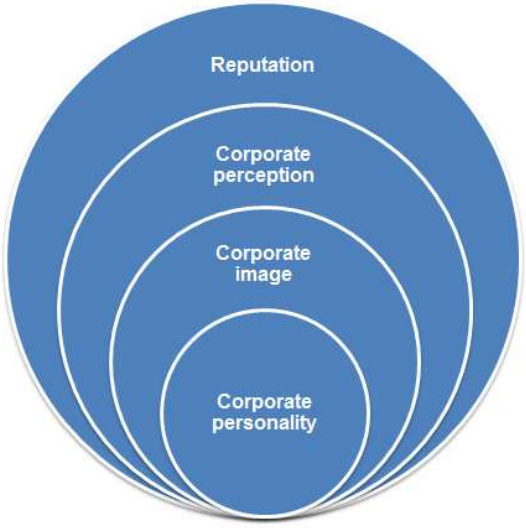
"That is what you would expect from the NHS brand. That's what you'd expect from a quality service – a structured, consistent approach. It's not people doing their own thing

"More consistency of communications and respect for the NHS Identity, less use of colour and additional graphics will help increase clarity for patients."

(NHS Identity Research, 2016)

6.2 Corporate Identity and Reputation

Corporate brand and reputation are built on much more than the visual expression of our logo and materials. The diagram below shows the building blocks of corporate reputation:



Building blocks of the corporate reputation Source: Roper-Fill, 2012, p. 35

- **Corporate personality:** the personality of an organisation – how it actually is, and how it feels to work here
- **Corporate image:** how we project our personality – beyond just the logo and visual elements, this is about how we behave, our service-scape, how responsive we are
- **Corporate perception:** this is a single image that a person holds about the organisation, often based on the last interaction (which could be digital, a letter or a conversation)
- **Corporate reputation:** this is a "photo album" of how people think, feel, and most importantly act in response to an organisation – ie what do they say and do

This clearly shows that reputation begins from inside an organisation and highlights the importance of prioritising strategic internal communications, and creating a culture where staff understand our priorities and live our values. We explore this further in section 8.

How our external audiences perceive us (the corporate perception) must be measured to identify areas of "perception gap" – where the experience of our stakeholders does not match our vision, priorities and values. The communications team will then work with staff and services to help close that gap, including tailoring our internal and external communications.

Existing qualitative evidence points to our organisation having a strong corporate reputation amongst the public at large, and being well loved – both within our local community and further afield. The communications team will look to use that goodwill to tell our story and to build our reputation internally.

We will:

- continue to **embed our vision, values and priorities** into all of our communications, internal and external - and celebrate examples of these being demonstrated
- embed an **issues management approach** to communications – anticipating, preparing for and mitigating potential issues which could impact our reputation
- do more to seek out and celebrate examples of **good practice** – both through internal channels and external and national channels
- highlight our contribution to the **local health system**; raising awareness amongst partners of the important role we play

7. External communications

We will maintain a strong focus on strong external communications, designed to maintain and grow confidence in the care, treatment and experience which patients can be sure of receiving at RJAH.

- To build and maintain an accurate understanding of RJAH services and standards among our key audiences
- To promote RJAH as a high performing place to work, learn, innovate and improve
- To improve awareness of the good practice, achievements, and improvements happening at RJAH, in areas including clinical quality, national performance standards, staff engagement and involvement, and patient experience.

How we will achieve these aims:

Existing/ongoing external communications	How we will raise our game:
1. www.rjah.nhs.uk In October 2022, we launched a new Trust website. This new-look site is mode modern, fully mobile responsive, and meets all accessibility standards.	We will develop the shape, functionality and content in agreement with key stakeholders, including commissioners, partners, regulators, and representatives of patient and other user groups.
2. Social Media The Trust has well established social media platforms on Facebook, Twitter, Instagram and LinkedIn, with a combined following of more than 17,000 people. The tone of these channels is accessible and friendly, and other NHS organisations locally have looked to them as examples of best practice for growing their own channels.	We will continue to grow these channels over the next two years and to work in close partnership with other teams to use our channels in order to support key Trust priorities. This will include recruitment, with more emphasis placed upon paid advertising in order to reach our key demographics. We will use data to drive activity and evaluate effectiveness. We will continue to monitor the social media landscape and continually evaluate our portfolio of platforms to ensure our focus is in the right place to make the most of the resources we have at our disposal.
3. Media relations Newspapers continue to provide a 'go to' place of record for opinion formers about public services, and continue to have significant influence over opinions and confidence in local health and care services. We have a strong working relationship with the main local paper, the Shropshire Star. Broadcast media - regional and national TV and radio, plus specialist stations aimed at communities of interest - remain a highly influential channel for awareness raising. Like traditional media, trade and professional media channels such as *Nursing Times*, *HSJ*, *BMJOpen*, *OT Magazine*, for example, can have an almost disproportionate impact on opinion and reputation, as well as have a significant	We will develop a planned and sustainable schedule of proactive media relations activity across local/community, regional/national and trade/professional media outlets which supports our Trust aims and priorities, celebrating innovative practice, improvements in patient experience, and significant improvements in quality. We will also seek to use this channel for marking milestones in achievement relating to business aims, such as local developments, progress in partnerships, and improvements in regulatory findings.

positive effect on morale and pride.	
4. System working We work closely with our partners within NHS STW, including leading on system communications regarding the MSK Transformation Programme, and the STW People agenda.	We will look to further strengthen working relationships with system colleagues, ensuring RJAH has a voice at system level, while also ensuring an awareness of system challenges and issues influences our own activity.

8. Internal communications and staff engagement

"Executives only know 4% of problems, middle managers 9% and frontline 100% of our problems." **Sidney Yoshida, The Iceberg of Ignorance, 1989**

Our staff are the Trust. Over the last four years, we have put a lot of thought, effort and time into our internal communications channels.

Evidence from staff surveys suggests that this work has made an impact. However, we will always look for ways to improve and to keep up with the ever-changing world of communications. We will evaluate and refresh existing channels, and develop new channels, ensuring that we are prioritising our resources most effectively and reaching the majority of our staff.

We will explore options to use technology better to engage with our staff – and measure engagement.

Our data shows us our Staff Facebook Group is the most popular source of information about the Trust, with more than 80% of our people members of the group. However, we also know this serves to alienate some staff who are not on Facebook or choose not to use it to obtain information about the Trust. We therefore ensure we make use of other platforms, including the new staff intranet, Percy, which was launched in spring 2022.

Face-to-face engagement is 34 times more effective than email *(Bones & Roghanizad, 2017).* We will continue to look for more ways to allow staff to hear from, and engage with, our senior leaders directly – whether through means such as the Chief Executive's Staff Open Forum, or more remotely by increasing our use of video.

However, research shows that an organisation's staff generally prefer to get their information from a line manager so we will focus on supporting our senior leaders and middle managers to communicate more effectively, in particular sharing examples of good practice from teams.

We know that stories which connect with people's emotions are far more likely to be recalled and result in action than simply repeating key messages.

For example, an education programme led by the mental health charity Rethink – which aimed to improve understanding of mental health among medical trainees – found that it was the patients' stories that the doctors remembered six months later rather than the statistics or facts provided. We will put storytelling at the heart of our work, featuring real situations and real people.

We will:

- provide clear, timely and accessible information
- use evaluation to drive the channels we use
- increasingly look for opportunities to target hard-to-reach groups, such as the consultant body, Theatres and the Facilities Team
- improve opportunities for two-way conversations with our staff
- maintain a focus on organisational culture

Activity	Channel and frequency	Current status and future development
Intranet	Digital Ongoing	Our new intranet, Percy, was launched in spring 2022 in partnership with our provider Interact. **Development – we will:** ➢ use this new tool to introduce new collaborative ways of working, using the 'Communities' function on new site. Opportunity to reduce email traffic and better connect staff in and out of work ➢ evaluate effectiveness of new site – qualitative and quantitative data
Weekly Round-up	Email Every Monday	Weekly bulletin filled with a mix of corporate, service, system and staff news. It is well used. **Development – we will:** ➢ link to new intranet content where possible
Staff Noticeboard	Email Ad hoc	Regular bulletin issued as required to keep staff abreast of Trust developments and news. Feedback from staff suggests this has been well received.
Communicate	Email Monthly	A monthly news bulletin, rounding up some of our key news and campaigns. With the support of Medical Illustration, this is a glossy looking publication that is well received. **Development – we will:** ➢ use our Communications Survey to check that this remains a valuable channel for staff
Question Time	Face-to-face/Digital Monthly	This started as a monthly face-to-face briefing with the Chief Exec that has attracted up to 80 people to attend each session. During covid-19 this approach was put on hold, but we made use of the Staff Facebook Group and/or Teams to run virtual sessions instead. We have now moved to a hybrid model to try and make the best of both avenues.

		Development – we will: ➢ build on these sessions but experiment with time and format to prevent audiences dropping too low to make worthwhile ➢ Ensure more director input so that the Chief Executive has more support in delivery
Buddy Scheme	Face-to-face Monthly	All members of the Senior Leadership Team are allocated two or three clinical areas to 'buddy' up with – committing to visit them at least once a month and to champion their issues in SLG discussions. The list of buddy areas is refreshed periodically. **Development – we will:** ➢ build on work done in the covid period to also give SLG members non-clinical areas to align with
Board Walkabouts	Face-to-face Bi-monthly	Members of the Board take part in informal walkabouts on the day of our public Board meetings. These are done in group of three, and with a plan to ensure we cover all departments in the Trust across the year. **Development – we will:** ➢ ensure we amplify these through existing communications channels so that staff know they are taking place ➢ gather feedback from staff to understand how these are being received
Other visibility activity	Face-to-face	Our Chair Harry Turner has launched a 'Chat with Harry' initiative – offering specific units or departments the opportunity to come and speak with him in an informal setting and share their successes and challenges. Our governors, Non-Executive Directors and Senior Leaders also take part in regular patient safety walkabouts. **Development – we will:** ➢ ensure we amplify these through existing communications channels so that staff know they are taking place
Visual content, including: - corridor posters - noticeboards - desktop messages	N/A	The comms team updates patient-facing posters down the main corridor and into the main entrance, ensuring these are up-to-date, and are used for relevant campaigns. **Development – we will:** ➢ develop guidelines to help teams make the best use of their own messageboards

		➢ work with IT to develop ways of making more regular use of desktop banners
Social media – closed and open	Digital Daily	The Trust has established platforms on Facebook and Twitter, and a growing Instagram account that has shown significant growth over the last 12 months. We also have a Staff Facebook Group which is used by around 80% of Trust staff. These are key channels that are at the heart of most of our campaigns. **Development – we will:** ➢ continue to monitor trends in social media, ensuring our content remains relevant and is delivering on its objectives.
Videos and podcasts	Digital Ad hoc	The Comms Team looks to use video at every opportunity, and has a YouTube channel where much of its self-generated content is hosted, as well as a Vimeo account where more high-end content – usually produced by the Medical Illustration team – is hosted. **Development – we will:** ➢ explore opportunities to improve our video offer, for example by producing podcast series. This is something we were actively working on before the coronavirus pandemic hit, and is something we will revisit.
Recognition - Health Hero - Thank You cards - Awards - External	Face-to-face/digital Annual/monthly/ ad hoc	The Trust has a wide-ranging recognition programme. This includes formal awards like the Celebration of Achievement Awards and the Health Hero Award. There are also role specific awards, such as the Dame Agnes Hunt Nursing Medal. There are also less formal processes, including our Thank You cards, which went down well after their launch in 2019. **Development – we will:** ➢ Carry out a review to decide whether to return to our old awards format or build on the Togetherness Week approach adopted in 2022. This will be done via a staff survey and qualitative feedback. ➢ Consider options to refresh our wider offer, including reviewing ways to adapt and improve our Health Hero Award so that it does not get stale after six years in place.
Professional Awareness Days eg AHPs Day, Nurses Day etc	Throughout the year	The communications team works with teams across the Trust to make the most of opportunities to recognise our staff on dedicated awareness days that take place throughout the year.

		These usually involve arranging visits and presentations to teams as well as creating public-facing content – for use on social media – about the work of these teams.

9. Equality, Diversity and Inclusion

Staff Facing

At RJAH, everyone is welcome. Understanding more about each other, and the dates in the calendar that matter most, is a brilliant way to celebrate our diversity and start some great conversations.

That is why we will put the EDI agenda front and centre in our cultural work over the next couple of years, with the aim of supporting the building of knowledge, encouraging of curiosity and forming of allies.

We know that there is more we can do to become a truly inclusive workplace. We will support our Senior Leadership Team and our Improvement Team to build and strengthen our Staff Networks, giving them the tools and the confidence to make an impact. We will work with partners within the Trust, but also within the System People Team, to ensure that staff at RJAH have access to the wide range of system support that is in place to support them alongside our own in-house offers.

We will:

- develop an **EDI calendar** highlighting key dates in the calendar for awareness activities at the Trust
- support and champion our **existing Staff Networks**
- champion the Staff Networks being established at **system level**, encouraging RJAH staff to get involved and make the most of the opportunities they offer (the system LGBTQIA+ group is already chaired by an RJAH employee)
- Work with the Trust's People Team and Improvement Team to identify **gaps in our networks**.
- Support work to **identify an appropriate EDI Lead at RJAH**, so that this important workstream can be given more direction and momentum

Patient Facing

RJAH will work to ensure that equality is a key part of our core business and that we deliver on the duties of the Equality Act 2010 and Human Rights Act 1998 when planning services.

We will take into account the nine protected characteristics in all we do (age, disability, gender and gender reassignment, marriage and civil partnerships, pregnancy and maternity, race including nationality and ethnicity, religion or belief/lack of belief, sex and sexual orientation).

We will ensure all external communications are inclusive and take place through a range of channels that reach all groups, taking into consideration all barriers to communication, including language and access to computers.

The Trust has, in October 2022, launched a new website that is fully compliant with Web Content Accessibility Guidelines (WCAG) 2.1 level AA. It scored 95 out of 100 at launch (against a 'pass' mark of 75) when tested against the standards.

We will:

- work with operational teams to ensure **patients are given a voice** in service change projects
- ensure all Trust communications channels meet all **Accessibility standards** so that no group is disadvantaged when seeking information about the Trust
- ensure the **Trust website** remains compliant with accessibility standards and regularly monitor for changes in those standards

10. Campaigns and projects

We will plan out, across the year, a number of campaigns linked to our priorities. These will be integrated communications campaigns, utilising many channels, with set objectives, milestones, timelines and budgets. Planned campaigns include:

Campaign	Internal/External	Status/development
Annual staff recognition events	Internal and external	We have traditionally run effective staff awards events – both in-person and, during covid, virtually. This year we shifted to a week-long celebration event aimed at recognising all staff without singling out specific individuals or teams. We are in the process of reviewing that week, with a view to making decisions on the right approach to take over the next couple of years.
Annual NHS staff survey	Internal	Working closely with the people directorate, we will use our refreshed internal comms approach to plan a yearly campaign, in phases from sharing results, resulting actions and improvements, and promoting uptake of the next survey. Following record responses in 2019, we will continue to use a competitive element to motivate teams to complete the survey. Response rates remained high in 2020 but dipped in 2021 so we must put renewed focus into this.
Flu campaign	Internal	Sept – Feb Working closely with the flu team, we will learn from previous years and from success at other trusts to build on the campaign each year. This campaign is now aligned with the equally important work of encouraging staff to get their covid boosters.

Recruitment	External	We will work with the people directorate to plan and deliver a recruitment campaign for the trust – from attracting talent, through to refreshing induction and onboarding. We will focus on different phases of the recruitment journey as a campaign phase plan. We will align this with the ICS recruitment campaign.
Private patients – ongoing	External	We will work with existing media partners to promote our private patient offer, and also look to develop and grow dedicated social media channels for this service, in order to keep costs down but raise awareness.

11. Evaluation

We will use the full range of evaluation techniques to measure the effectiveness of our communications activity – with a focus on not only reporting outputs but also measuring outcomes.

We will produce a quarterly report for the executive team on communications activity, coverage and outcomes – focused on our overarching objectives, and highlighting key areas to focus on for the next month.

Each campaign will be evaluated against objectives, and we will use the following overarching methods to track progress:

Internal communications and engagement

- Quarterly staff friends and family test and the annual staff survey
- Annual internal communications survey on channels used and preferred
- Attendance at face-to-face events/meetings
- Intranet usage

External communications and engagement

- Patient experience feedback – friends and family test, online review websites
- Content analysis of social and traditional media
- Qualitative stakeholder feedback
- Website usage and feedback

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	11 January 2023
Executive Sponsor:	Stacey Lea Keegan, Chief Executive Officer	Paper Category:	Governance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board is asked to consider and approve the proposed risks for the Board Assurance Framework (BAF) aligned to the objectives agreed at the meeting on 4 May 2022.

2. Executive Summary

2.1. Context

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

The Board agreed new objectives for 2022-23 on 4 May 2022 and the project initiation documentation for these objectives was presented to the Board on 8 June 2022. As part of this work and through Executive Team discussions headline risks for 2022-23 have been identified and the Board Assurance Framework for 2021-22 has been reviewed for closure or carry forward of risks (where still relevant) were identified and approved by the Board in June 2022.

The Executive Team worked through these and have made considerable revision to the proposed list of risks. Since August 2022, the Executive Team has continually reviewed the risks and work undertaken to align these to the objectives and outline the controls and assurances.

The framework is aligned to each assurance committee for consideration and has recently been tabled for discussion at the Audit and Risk Committee in its entirety (January 2023)

2.2 Summary

Where risks have previously been identified but removed from the BAF, it does not mean that it is no longer a risk that requires action it means that it is a risk that no longer has potential to impact on the delivery of the Trust's objectives. These risks will continue to be managed through the Trust's risk management processes.

For ease of reference the source of assurance ratings used in the BAF are as follows:

Level 0 – It has not been possible to obtain assurance
Level 1 – Assurance obtained at departmental level
Level 2 – Assurance obtained at organisational level i.e supported by HR, Finance etc
Level 3 – External assurance has been obtained through audit / inspection processes

2.3. Conclusion

The Board is asked to consider the framework gaining assurance from the committees.

Board Assurance Framework 2022-23

Trust Objectives 2022-23
1. Developing and Maintaining Safe Services
This objective can be broken down into seven key components, undertake full service reviews, prioritising the development of a specialist knee revision service and securing robust microbiology services in 2022/23, review of funding models and service line reporting to ensure robust financial management, recruiting and retaining staff to ensure we have the right staff, in the right place at the right time, developing equality and inclusion initiatives for patients, developing equality and inclusion initiatives for staff.
2. Develop our Veterans Service to ensure it is established as a centre of excellence
This objective can be broken down into six key components, developing an communications, marketing and branding strategy aimed at enhancing links with key stakeholders, maintain veteran accreditation and explore other relevant accreditation opportunities, identification and utilisation of key recruitment links for the veterans service, roll out of veterans awareness training, sustainable funding model to be agreed to optimise further investment opportunities, programme of review to ensure best use of resource
3. Support MSK integration across the system
This objective can be broken down into six key components, leading the MSK Transformation Board and contributing to the delivery of the transformation programme, standardising pathways and access for patients, levelling up of outcomes for patients across all providers, integrated OD solution for MSK providers in the system, enhancement of non-medical roles, delivery of efficiencies outlined in the ICS plan
4. Optimise the potential of digital technologies to transform the care of patients and their outcomes
This objective can be broken down into three key components, continue to develop patient facing apps to optimise patient outcomes and explore the use of artificial intelligence, programme of education for staff on digital awareness and commence deliver of the next stages of the EPR programme, ensuring processes are reviewed to improve workflows and outcomes
5. Maintaining statutory and regulatory compliance
This objective can be broken down into seven key components, progress towards full compliance with accessible information standard to coincide with EPR programme, maintaining CQC rating, delivery of the IPC improvement programme, compliance with ED&I requirements for both staff and patients, delivery of financial plan and improve system oversight framework rating from SOF 3 to SOF 2

The risks to delivery of the Trust's objectives are detailed on the Board Assurance Framework and presented at Appendix One. Each objective has an identified Assurance Committee for oversight and onward assurance to the Board.

Risk	Headline Risk	Linked Objective(s)	Assurance Committee
1	Effectiveness of engagement with the workforce	1,2,3,4,5	People Committee
2	Workforce capacity and capability	1,2,3,4,5	People Committee
3	ED & I capacity and capability	1,2,3,4,5	Quality and Safety Committee & People Committee
4	Community Infection Prevalence	1,5	Quality and Safety Committee
5	Insufficient capacity to meet demand	1,3,5	Quality and Safety Committee & Finance Planning and Digital Committee
6	IT capacity and functionality to support new ways of working	1,2,3,4,5	Quality and Safety Committee & Finance Planning and Digital Committee
7	Cyber risk (redacted from this document)	1,3,5	Finance Planning and Digital Committee
8	Constrained resources (incorporating system investment restrictions)	1,2,3,4,5	Finance Planning and Digital Committee
9	Delivery of year-on-year efficiencies and productivity gains	1,2,3,4,5	Finance Planning and Digital Committee
10	Compliance with strategic oversight framework	1,4,5	Quality and Safety and IPC Quality Assurance Committee

Board Assurance Framework 2022-23

Effectiveness of engagement with the workforce NEW **BAF 1**

If the engagement with the workforce is not effective there is a risk that opportunities for improvement and innovation will be missed and staff morale will deteriorate with potential to result in loss of staff. Engagement can be hampered by the prioritisation of operational and clinical duties and there is potential for there to be insufficient time given to managers and clinical staff working together.

Risk Rating:

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

Risk Details:

Opened: August 2022

Reviewed Date: December 2022

Source of Risk: Risk assessment

Corporate Risk Register

Controls:

- ✓ Rolling half days
- ✓ Monthly Trust Management Group meeting to include Clinical Leads
- ✓ Staff briefing open to all staff
- ✓ Appointment of COO and strengthened operational team
- ✓ Ward / department buddying by Executive Team
- ✓ Communications and engagement strategy
- ~~✓ Six monthly back to the floor events / virtual visits~~
- ~~✓ Leadership training and bite-sized modules for wider organisation~~
- ✓ Performance framework in place
- ✓ Weekly update from CEO
- ✓ Comms bulletin
- ✓ Q&A sessions with members of the Executive Team
- ~~✓ Staff networks~~
- ✓ Awards/Health Heroes
- ✓ Freedom to Speak up initiative
- ✓ 'Chats with Harry'
- ✓ Exec and NED board day walkabouts

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

- ✓ Medical Advisory Committee overseeing engagement with management
- ✓ Regular updates to People and Culture Committee and the Board
- ✓ NHSE Quarterly System Review Meetings
- ✓ Staff Survey
- ✓ NHS Oversight Framework
- ✓ Oversight from People and Culture Committee
- ✓ Health and Safety Committee oversight of staff health
- ✓ JCGroup partnership working

Gaps In Controls:

C1: Staff experience group not established – consider shared governance model
~~C2: Quality Forum has not adequately replaced MDCAM~~
~~C3: Schwartz Centre Rounds~~
C4: Staff Survey action plan and communications roll out
C5: Leadership training and bite-sized modules for wider organisation

Gaps in Assurance:

A1: Lack of real-time measure of workforce engagement levels (all staff)
A2: Responding to staff concerns in a timely manner

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Review of all staff networks including Staff Experience Group	Chief People Officer	February 2023	Discussed at December EDI Committee
C1	Monthly invite for all new starters to have a hot drink with Executive lead	Chief Nurse/Operating/ People Officer	Feb 2023	To commence in January 2023
C2	MDCAM to be re-established	Trust Secretary / Chief Medical Officer	~~Oct-22~~	~~Agreement has been reached that these should be re-established. Dates being scheduled for the rest of the financial year.~~ Complete – MDCAM dates have been scheduled for 2023.
C3	Schwartz Centre Rounds	Chief Nurse & Patient Safety Officer	~~Dec-22~~	~~Two new facilitators are being appointed.~~

				Complete – Donna St John and Lis Edwards have been appointed (training to be completed)
C4	Staff survey action plan to be re-visited and communication plan is being agreed to encourage responses to 2022 survey	Chief People Officer	~~Oct 22~~ Complete	~~Survey outcomes reported to the Executive team meeting, people committee and wider communications to encourage greater feedback~~ Complete – 'you said we did initiative' completed. Response rate noted as 52%.
C4	Analysis 2022 staff survey results and disseminated	Chief People Officer	Mar 2023	First data sharing planned for early 2023
C4	Developing Listening Events (including staff engagement events)	Chief People Officer	Feb 2023	Produce framework based on 'listening into action'
C4	Quarterly pulse staff survey	Chief People Officer	Feb 2023	Encouraging staff uptake
C5	Development of leadership programme	Chief People Officer	Jan 2023	First cohort to commence in January 2023

Exec Lead

Chief People Officer

Lead Committee

People and Culture Committee

Board Assurance Framework 2022-23

Workforce Capacity and Capability CARRIED FORWARD FROM 2021-22 **BAF 2**

Inadequate succession planning and talent management resulting in gaps in levels of expertise. Risk to staff morale resulting in increased turnover. Inability to increase activity safely to meet national targets resulting in further regulatory scrutiny. Poor patient experience and potential patient safety risks. Lack of innovative roles reduces the potential staff being attracted to the organisation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	2
Likelihood	4	4	2
Total	16	16	4

Risk Details:

Opened: April 2021

Reviewed Date: December 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment plans to target vacancy hotspots
- ✓ Sickness absence management relaunch
- ✓ Staff turnover monitoring including exit interviews and 'itchy feet' conversations
- ✓ Leadership training to support effective management and engagement of staff – compulsory for all managers
- ✓ Business Continuity Plans
- ✓ KPI in place for overtime hours by unit, sickness absence (including reasons)
- ✓ IPR includes breakdown of activity for IJP & OJP at point of delivery
- ✓ Recruitment timeline KPIs
- ✓ Vacancy rates by professional staff group
- ✓ Nursing associate roles now in training
- ✓ Nursing strategy on a page
- ✓ Nominated EPRR Lead appointed
- ✓ Professional Development Review Compliance

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

- ✓ Performance report
- ✓ Safe staffing audits
- ✓ People and Culture Committee oversight
- ✓ Agency usage monitoring
- ✓ Independent review of e-rostering
- ✓ Turnover and sickness absence rates
- ✓ Recruitment working group
- ✓ Quarterly review of Nursing and Midwifery retention tool

Gaps In Controls:

~~C1: Lack of emergency planning and resilience resource~~
~~C2: Nursing strategy implementation Nov 22~~
C3: Unit level workforce plans aligned to operational activity
~~C4: PDR compliance~~
C5: Exit interview completion and themes
~~C6: Sickness themes~~
C7: Review of flexible working and flexible working offering
~~C8: Supernumerary and supervised staff not counted within establishment~~
C9: People Services team resource and capacity
C10: Workforce improvement plan

Gaps in Assurance:

A1: Alignment of workforce to optimise capacity
A2: Workforce plan monitoring triangulated with activity and quality
A3: Succession plan
A4: Talent management strategy
A5: CPD gaps and allowance of time
A6: Recruitment process assurance -line of sight on milestones
A7: Escalation process for staffing rota concerns

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	EPRR resilience review	Chief Operating Officer	~~Dec 22~~ Complete	~~Nominated EPRR officer for RJAH has been confirmed. Ongoing discussion with STW partner regarding the development of system wide EPRR team~~ Nominated EPRR Lead appointed
C2	Nursing strategy implementation	Chief Nurse and Patient Safety Officer	~~Nov 22~~ Complete	Nursing associates rolled out with second cohort recruited and in training

Board Assurance Framework 2022-23

C3, ~~C4,~~ C5, ~~C6, C7, C8~~	Workforce Task and Finish Group to be set up and chaired by CPO and CN&PSO. To include full establishment review of wards.	Chief Nurse and Patient Safety Officer and Chief People Officer	~~Sep-22~~ Complete	~~Update and recommendations presented to People Committee in August 2022.~~ Recruitment Working Group established and reporting to the People and Culture Committee on a monthly basis.
C3	Ward and Theatre establishment review to be complete	Chief Nurse and Patient Safety Officer	Jan 2023	Establishment review to commence in January
A1-A7	Review of workforce assurance	Chief People Officer	~~Sept 22~~ Feb 2023	Additional resource to support the review of people services including people service policies
C7	Review of application of the flexible working policy	Chief People Officer	Feb 2023	
C9	People Services capacity to be reviewed	Chief People Officer	June 2023	Case of need presented to the Executive Team. Agreed to recruit by priority.
C10	Workforce improvement plan – to be considered by the Committee	Chief People Officer	Jan 2023	To be monitored and presented to the People and Culture Committee on a monthly basis

Exec Lead	**Lead Committee**
Chief People Officer	People and Culture Committee

Board Assurance Framework 2022-23

EDI Compliance, delivery, accountability and leadership **CARRIED FORWARD FROM 21-22** **BAF 3**

Potential for non-compliance with statutory and regulatory requirements. Poor staff experience impacting on staff morale and lack of inclusion, sickness absence and turnover. Inability to improve staff survey results. Potential for health inequalities to not be addressed impacting on patient experience.

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: December 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ ED&I Committee members taking ownership to drive the agenda forward
- ✓ ~~Appointment of Chief of People and Culture Officer~~
- ✓ NHS Standard Contract requirements
- ✓ System transformation work (includes consideration of health inequalities)
- ✓ ~~EDS 2022 self-assessment and action plan (in progress)~~
- ✓ ~~Annual ED&I Workforce report and annual report – includes WRES and WDES~~
- ✓ ~~'It's Just Cricket' (BAME), LQBTQIA+ Friends & Women's Network~~
- ✓ Accessible Information Standards - regular reviews
- ✓ PLACE assessments
- ✓ ED&I training (ICS) and Veteran Awareness training
- ✓ Data quality improvement plan including ethnicity and deprivation index
- ✓ Menopause awareness

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

- ✓ Staff surveys/pulse surveys
- ✓ NHSE oversight/ NHS Oversight Framework
- ✓ People and Culture Committee
- ✓ System People Board and establishment of a System People Committee
- ✓ Executive lead in place both for patients and staff
- ✓ ED&I Committee oversight
- ✓ WRES, WDES and EDS 2022 returns
- ✓ Bi-annual report on health inequalities (includes digital exclusion)

Gaps In Controls:

C1: Sustainable ED&I resource to be identified and secured
C2: Health inequalities working group
C3: Talent Management
C4: Annual ED&I Workforce report and annual report – includes WRES and WDES
C5: EDS 2022 self-assessment and action plan (in progress)
C6: 'It's Just Cricket' (BAME), LQBTQIA+ Friends & Women's Network

Gaps in Assurance:

A1: Effectiveness of ED&I Committee
A2: Accessible Information Policy

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	~~Mar 22~~ Complete	Completed – Internal Audit undertaken and presented to People Committee with associated action plan
C1	ED&I resource to be secured	Chief People Officer	~~Oct 22~~ Jan 2023	~~Internal audit undertaken and action plan developed.~~ The Trust are reviewing other options regarding EDI leads
A1, C3	Refresh of ED&I Committee	Chief People Officer	Complete	First meeting EDI relaunch group. EDI Gap Analysis received.
C2	Health inequalities working group to be established	Chief Nurse and Patient Safety Officer	~~Dec 22~~ Jan 2023	Request for RJAH to join Healthy Lives Steering Group (ICS). Nominated staff to join the meeting and terms of reference have been drafted
C4	Annual ED&I Workforce report and annual report – includes WRES and WDES	Chief People Officer	Jan 23	Annual reports to be presented to the People and Culture Committee in December 2022 Publish information on website
C5	EDS 2022 self-assessment and action plan – Complete an assessment against the EDI framework	Chief Nurse and Patient Safety Officer	March 2023	Healthwatch are facilitated patient led workshops in January 2023 as part of the assessment.

Board Assurance Framework 2022-23

A2	Trust to create accessible information policy	Chief Nurse and Patient Safety Officer	February 2023	First draft being compiled
C6	Review of all staff networks	Chief People Officer	February 2023	Discussed at December EDI Committee – proposal to have one inclusion network

Exec Lead	Lead Committee
Chief People Officer	People and Culture Committee and Quality and Safety Committee

Board Assurance Framework 2022-23

Community Infection Prevalence (NEW) — **BAF 4**

Impact on staff absence, increased potential for covid outbreaks, adverse impact on patient safety and patient experience, reputational damage, additional regulatory scrutiny, impact on the capacity of the IPC Team

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: December 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ External support from NHSE/I
- ✓ Alignment to Clinical Governance from 1 April 2022
- ✓ Investment in the IPC team
- ✓ IPC Governance role established
- ✓ Quality Management System
- ✓ IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review
- ✓ Deputy DIPC recruited in partnership with Shropshire Community Trust
- ✓ Increased staff training programme
- ✓ Learning from previous SI's – actions completed
- ✓ Compliance with Covid guidance
- ✓ Sickness policy and communication
- ✓ Risk assessments
- ✓ Flu campaign
- ✓ Covid booster
- ✓ IPC ICS Meeting

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

- ✓ IPC Quality Assurance Committee
- ✓ Increased committee reporting
- ✓ ~~NHSE/I oversight of IPC improvement plan~~
- ✓ External clinical governance review with focus on IPC commissioned
- ✓ People and Culture Committee oversight
- ✓ IPC Board Assurance Framework
- ✓ Flu and Covid Vaccination update report
- ✓ Gap analysis against the hygiene code

Gaps In Controls:

C1: Completion of IPC action plan

~~C2: Community prevalence (outside of Trust's control)~~

Gaps in Assurance:

~~A1: EPRR desktop scenarios and testing business continuity plans~~

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Progress with improvement action plan	Chief Nurse and Patient Safety Officer	~~Oct 2022~~ March 2023	Reported through IPC Quality Assurance Committee. The reporting continues, IPC Quality Assurance Committee has been extended to March 2023. To be aligned to the IPC Quality Assurance Committee
A1	EPRR desktop scenarios and business continuity plan testing	Chief Operating Officer	~~Nov 2022~~ Complete	~~There is an annual assessment process for EPRR, which will run regular desktop exercise in relation to community infection incidents.~~ EPRR desktop exercise completed 09/12/2022 which included IPC – noted as business as usual.
C2	Staff campaign for staying well over winter including flu and covid booster vaccine uptake	Chief Nurse and Patient Safety Officer	~~Oct 2022~~ Complete	Complete - Flu campaign launched in September 2022. Flu vaccination and covid booster continued to be offered to staff. Monitored weekly

Exec Lead

Chief Nurse and Patient Safety Officer

Lead Committee

Quality and Safety Committee / IPC Quality Assurance Committee

Board Assurance Framework 2022-23

Insufficient core capacity to meet demand CARRIED FORWARD FROM BAF 21-22 **BAF 5**

Inability to restore activity levels to that provided pre-Covid resulting in increasing waiting times and poor patient experience. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	4	1
Total	16	16	4

Risk Details:

Opened: November 2020

Reviewed Date: October 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Demand and capacity modelling at local level
- ✓ Monitoring of efficiency KPIs
- ✓ 6-4-2 implemented
- ✓ Recovery programmes in place for Outpatients, Theatres and Diagnostics
- ✓ Weekly tactical restart activity meeting
- ✓ Key restoration of capacity KPIs
- ✓ Weekly meetings for management of delayed discharges
- ✓ Daily dashboards
- ✓ Outpatient room usage report in place

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

- ✓ Monthly Performance Improvement Board oversight
- ✓ Inpatient Survey Performance
- ✓ System and regulatory oversight
- ✓ Internal audit regarding job planning
- ✓ Patient Experience Committee oversight
- ✓ Finance, Planning & Digital Committee oversight
- ✓ Outpatient Transformation Board restored
- ✓ STW Planned Care Delivery Board Oversight
- ✓ System Governance Framework
- ✓ Integrated Performance Reporting
- ✓ Consultant annual leave reporting through People Committee

Gaps In Controls:

~~C2: Potential for Gaps in job planning and governance processes to ensure full capacity utilised~~

C4: Impact on capacity of increasing complexity of cases due to increased waiting times

C7: Implementation of current job planning policy

C8: Inability to meet target for reducing number of patients who no longer meet 'criteria to reside'

C9: Revising STW orthopaedic model

C10: Optimising internal capacity

Gaps in Assurance:

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C4	Establish reporting on impact of complexity and consider mitigating actions	Chief Medical Officer	~~Jul 21~~ ~~Oct 21~~ Jan 22	Complexity review underway with focus on long waiters and P2 patients and establishing the average case per session for these patients. Update to go to Q&S after going through Clinical Effectiveness Committee – first meeting of refreshed Clinical Effectiveness Committee has taken place. Changes to the timeline have been noted due to the changes within the lead for the work
C7	Conversations to take place around review of job plans	Chief People Officer / ~~MDs~~	~~Mar 22~~ Complete	Complete - good progress made with conversations around job plans and being tracked through Trust Performance Board
C7	All job plans to be signed off by e-job planning	Chief Medical Officer	Ongoing	Tracking of this to be looked at so that there is line of sight
C8	Implementation of the 10 best practice initiatives outlined in the Acute Hospital Discharge 100 day challenge	Chief Operating Officer	~~Nov 2022~~ Complete	Complete – implemented the best practice initiatives to the organisation and closer working with the system discharge hub.

Board Assurance Framework 2022-23

C9	Revising STW ~~orthopaedic~~ MSK model	Chief Operating Officer	Feb 2023	Actions related to phase one due to be launched on 01/02 – future phases are to be confirmed
C10	Optimising internal capacity (theatre)	Chief Operating Officer	Dec 2022	Theatre workforce review has been completed. Action plan in place. – **ongoing process.**
C10	Optimising internal capacity (inpatient)	Chief Operating Officer	Jan 2023	Review opportunities to increase day case activity and reduce length of stay.

Exec Lead

Chief Operating Officer

Lead Committee

Finance Planning and Digital Committee

Board Assurance Framework 2022-23

IT capacity and functionality to support new ways of working NEW — BAF 6

Impact on roll out of EPR, inability to adapt to emerging requirements, opportunities of the system constrained by finances, inability to progress with compliance with accessible information standard resulting in inadequately meeting patient needs and poor patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: December 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital Transformation Programme Board in place to review Digital plans, risks and progress including prioritisation.
- ✓ Workforce plan agreed for life of programme
- ✓ Digital Steering Group in place for operational delivery
- ✓ Sub groups as created by Digital Transformation Programme Board to oversee delivery of EPR implementation
- ✓ Digital Strategy and Roadmap in place 2018 – 2023
- ✓ Programme plan in place
- ✓ Outpatient processes to identify and flag patient needs before admission
- ✓ Accessible Information Working Group established
- ✓ Translation and interpretation services available

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

- ✓ ICS Digital Strategy Board
- ✓ Digital Transformation Board oversight reporting to FPD Committee
- ✓ New EPR contract includes ability to meet Data Standard Notices
- ✓ Oversight of Accessible Information Group and Patient Panel

Gaps In Controls:

C1: EPR Solution in development to address accessible information standard compliance but not in place - Proposed go live Mar – Apr 2024

Gaps in Assurance:

A1: Monitoring of additional patient needs to ensure services and facilities are suitable to meet the needs of patients

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
~~A1~~	~~Accessible Information Group / Patient Panel to recommend monitoring metrics~~	~~Chief Nurse and Patient Safety Officer~~	~~Dec 2022~~	
A1	EDS 2022 self-assessment and action plan – Complete an assessment against the EDI framework	Chief Nurse and Patient Safety Officer	March 2023	Healthwatch are facilitated patient led workshops in January 2023 as part of the assessment.
C1	Progress with EPR Solution	Director of Digital	Ongoing	Programme in place with monitoring via Digital Group and FPD

Exec Lead

Chief Medical Officer

Lead Committee

Quality and Safety Committee & Finance Planning and Digital Committee

Board Assurance Framework 2022-23

Constrained resources (incorporating system Triple Lock' investment process) NEW **BAF 8**

The local ICS has one of the biggest proportional financial deficits in the Country and is required to take action to return to break-even. In tackling this additional controls on new investments have been introduced through a triple lock process that requires three tiers of authorisation (Organisation, System and Regulator). This has led to multiple organisational approved investments being paused pending identification of system funding with consequential risks to quality, standards of care and patient experience.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: August 2022

Reviewed Date: December 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Investment Decision making policy
- ✓ Triple lock process for new investments
- ✓ System financial improvement plan

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

- ✓ Executive Team scrutiny and approval process for all investment cases proposed
- ✓ Finance Planning and Digital Committee scrutiny and approval for cases over £250k
- ✓ Investment Panel within ICS comprises multi-disciplinary roles from each partner with agreed prioritisation protocol
- ✓ QEIA process in place
- ✓ IPC investment approved following amendments to triple lock process based on regulatory/safety concerns

Gaps In Controls:

C1: Unmitigated financial risks within the ICS currently stand at ~~£23m~~ £59m which is preventing routine investments from occurring

Gaps in Assurance:

A1: Fully mitigated ICS financial plan – ongoing discussions with NHSE

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Ongoing discussions/engagement with NHSE regarding financial performance of ICS – now escalated to the national team	Chief Finance and Planning Officer	ongoing	RJAH improved on plan by £1.1m with a further £0.6m proposed non recurrently relating to Annual Leave accrual release for non clinical roles. Regular check in's on progress with NHSE and updates provided to RJAH FPD Committee
A2	Recurrent rollover financial plan to be agreed for all ICB partners as part of 23/24 planning process	Chief Finance and Planning Officer	March 2023	
A3	Re-assessment of financial gap for 23/24 based on confirmed system allocation and agreement of organisational share of expected shortfall between ICB partners under Intelligent Fixed Payment System	Chief Finance and Planning Officer	March 2023	

Exec Lead

Chief Finance and Planning Officer

Lead Committee

Finance, Planning and Digital Committee

Board Assurance Framework 2022-23

Delivery of year on year efficiencies and productivity gains NEW **BAF 9**

Operational plan requires delivery of efficiency programme and return to pre COVID levels of productivity for patient throughput

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: August 2022

Reviewed Date: October 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Cost improvement schemes identified
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Tracking of theatre productivity
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews
- ✓ Agency controls in place

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

- ✓ SLG Oversight
- ✓ Finance Planning and Digital Committee oversight
- ✓ Scrutiny at organisation, system and regional level of delivery of the financial plan
- ✓ Monitoring of CIP delivery via performance meetings
- ✓ System wide transformation Boards including MSK

Gaps In Controls:

- Agency spend running ahead of control limit driven by workforce pressures

Gaps in Assurance:

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Re-instate agency controls in line with revisions to agency usage policy	Chief Finance and Planning Officer	~~December 2022~~ Complete	Complete – Agency policy refreshed and agreed oversight transfer to people Committee
A2	Productivity improvements to be incorporated 23/24 Operational plan as part of overall delivery plan	Managing Director for Strategy and Planning	March 2023	
A3	Efficiency targets to be assessed and agreed for 2023/24 based on national planning guidance	Chief Finance and Planning Officer	March 2023	

Exec Lead

Chief Finance and Planning Officer

Lead Committee

Finance, Planning and Digital Committee

Board Assurance Framework 2022-23

Compliance with Strategic Oversight Framework — **BAF 10**

Failure to satisfy NHSE criteria, continued breach of licence and SOF3, increased regulatory scrutiny, reputational damage

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: December 2022

Source of Risk:

Corporate Risk Register

Controls:

- ~~✓ External support from NHSE (Improvement Director)~~
- ✓ IPC Governance role established
- ✓ Quality Management System - IPC dashboard
- ✓ IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review
- ✓ Senior IPC/ Deputy DIPC recruited in partnership with Shropshire Community Trust
- ✓ Temperature checks using sustainability tool for IPC improvements
- ✓ Identification of gaps against NHS Oversight Framework
- ✓ CQC action plan and Niche well led review action plan
- ✓ CQC engagement meetings

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

- ✓ IPC Quality Assurance Committee
- ✓ NHSE oversight and support for delivery of IPC improvement plan
- ✓ Self-assessment against undertakings monthly
- ✓ Formal improvement review meeting with NHSE monthly
- ✓ Formal NHSE IPC reviews to assess compliance against IPC standards
- ✓ IPC standing agenda item at Trust Board
- ✓ Self-assessment against strategic oversight framework completed and submitted
- ✓ Regulatory Oversight Group (ROG)

Gaps In Controls:

- ~~C1: IPC improvement action plan to be completed~~
- C2: Implement GGI recommendations
- ~~C3: Executive Team oversight of gaps against NHS Oversight Framework~~
- C4: CQC stakeholder engagement

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Completion of improvement action plan – meeting undertakings and continuation of IPC improvement plan and sustainability	Chief Nurse and Patient Safety Officer	~~Oct 22 and Mar 23~~ Complete	Good progress is being made and regular update meetings with NHSE continue. The Performance meeting with the system and region have been cancelled following high levels of assurance reported. Final IRM held in October 2022. Internal monitoring through IPC Quality Assurance Committee
C2	Implement GGI recommendations - an action plan is to be developed following the GGI recommendations	Chief Nurse and Patient Safety Officer	Dec 2022	Action plan presented to the Board of Directors in December 2022- agreed for Audit and Risk to have oversight (for assurance) individual actions linked to the relevant assurance committee.
C3	Delivery of actions in support of moving to segment 2 of NHS Oversight Framework (ambition of segment 1)	Assistant Chief Executive	~~Oct 22~~ Complete	Gap analysis agreed with Executive Team and leads assigned to metrics. Continue to deliver the Trusts IPC Improvement plan, the Trust completed a formal assessment against the undertakings which saw the Trust was fully compliant. Aligned to ROG.
C4	CQC stakeholder engagement plan	Chief Nurse and Patient Safety Officer	~~Nov 22~~ Feb 2023	Briefings to Trust Management Group and Board and SNAHP. Mock inspections to be re-established. CQC communication toolkit updated.
C4	Self-assessment to evidence against new CQC Quality statements	Chief Nurse and Patient Safety Officer	~~Nov 22~~ Feb 2023	CQC relationship manager has changed – statements to launch in January. PMO has been established.

Board Assurance Framework 2022-23

Exec Lead	Lead Committee
Chief Nurse and Patient Safety Officer	Quality and Safety Committee / IPC Quality Assurance Committee

0. Reference Information

Author:	Kirsty Foskett, Head of Clinical Governance & Quality	Paper date:	11 January 2023
Senior Leader Sponsor:	Sara Ellis Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	5 January 2023
Paper Reviewed by:	Executive Team	Paper Type:	Governance
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	No	Purpose of Paper:	Assurance

1. Purpose of Paper

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

The paper presents the Trusts current live 15+ risks. The information is shared with the Board of Directors to ensure oversight on the risks, mitigations and actions being implemented.

2. Executive Summary

2.1. Context

There are 13 finally approved live risks with a rating of 15+ or more in the Trusts corporate risk register.

The delivery units are to review those risks which are aligned to their remit on a monthly basis before onward presentation at the Trust Performance and Operational Improvement Board for consideration.

Each risk has an Executive Directors assigned as the Executive lead and is aligned to an assurance Committee for greater oversight and awareness.

2.2. Summary

- There has been two new high rated risk since the last the report, these relate to
  - 2992 – Call bell system for tetraplegic patients unavailable
  - 2918 – Overdue outpatient appointments (replaced risk 1551)
- Research risks mitigated scores are under review by the Director of Research, Audit, Outcomes and Innovation
- No risks have increased since the last report

A risk management group has now been established to review corporate risk register and review the flow of risk assurance.

2.3. Conclusion

The Board of Directors is asked to review and consider the contents of the report.

Datix ID	Title	Clin. Group	Risk Owner	Handler	Hazard, work task, activity	Description	Likelihood (initial)	Consequence (initial)	Rating (initial)	Risk Level (initial)	Existing Control Measures	Likelihood (current)	Consequence (current)	Rating (current)	Risk Level (current)	Risk treatment plan/additional control measures	Likelihood (target)	Consequence (target)	Rating (target)	Risk level (target)	Risk Management	RAM - Committee	Date of assessment	Date of review (1)
2918	Overdue Outpatient appointments - replaces risk 1551	Specialist Unit	Forrest, Mrs Dawn	Daelemans, Karin	Increased overdue list size. Increased risk of patient complications or deterioration.	Service specification recommends annual review for spinal injury patients. Covid and the need for social distancing have reduces our OPD capacity and an increase cancellation rate due to patients or staff being covid positive. Increased overdue wait list size during Covid. Current overdue wait list size without a booked appt is 1149 AO 329 JRC 330 NK 223 SCB 267	5 - Almost Certain	3 Serious	15	High	Harms process being followed for all >52 week waiters. OJP being offered to consultants. Additional OPD room awaiting final sign off. Task and Finish group including consultant to look at increasing capacity by OJP, review of job plan, aiming to return to pre-covid template once the additional room is fully operational - expected late May/early June 22.	5 - Almost Certain	3 Serious	15	High	Surveillance nurses to monitor patients with concerns. Helpline. Harms reviews - includes letter to all patients with warning signs to look out for and method for contacting us. ACP role going through job matching process to increase capacity.	2 - Unlikely	3 Serious	6	Low	Treat Risk	Patient Harms Group	24/05/2022	30/12/2022
2996	Organisational capacity impacting on the effectiveness of Clinical Research	Corporate Services	Longfellow, Dr Ruth	Wales, Johanna	Operational and Clinical capacity is impacting the ability for individuals and departments to effectively engage in clinical research, projects as a contributor and collaborator, and as a developer of own research.	This impacts: - The Trusts ability to effectively engage with Clinical Research. - The ability to expand the number of research projects undertaken and the growth of local research. - Lack of research studies, impacts the Trust financially as it creates an inability to achieve the financial plan. - Reputational risk and impacts the Trusts vision of 'Aspiring to achieve world class care'. - Lack of capacity for individual's to oversee research projects as CI/PI can increase the likelihood of breaches and trigger inspection by the MHRA	5 - Almost Certain	3 Serious	15	High	RJAH Nursing Strategy highlights the importance of Research Annual Research Day increases awareness within the Trust. Research Links in all wards / depts. increase awareness.	5 - Almost Certain	3 Serious	15	High	Changes to format of Annual Research day to be more inclusive Strategic approach to encourage staff to be engaged in research Addition of research involvement to the appraisal process Research activity / participation is included in job descriptions.	3 - Occasionally	3 Serious	9	Moderate	Treat Risk	Research Committee	02/11/2022	22/12/2022

3000	MCSI Registered Nurse Vacancies	Specialist Unit	Coulson, Katy	Newton, Lisa	MCSI currently have 14.8 WTE RN vacancies (1.96 WTE maternity leave- currently off sick prior to mat leave). Awaiting start date for 1 WTE RN. MCSI requires staff with specialist spinal cord injury knowledge and skills to nurse patients admitted to MCSI in order to reduce and prevent complications and to provide effective rehabilitation to patients to ensure a safe patient discharge. Ongoing RN recruitment attempts have been unsuccessful due to lack of candidates due to NHS wide shortage of registered nurses. HCA vacancies filled (awaiting recruitment checks for 6.52WTE). Attempting to block book agency RNs. Providing regular bank and agency staff with specialist spinal cord injury competency training to bridge skill gap.	Patient safety affected due to risk of complications i.e. pressure sores, UTI, constipations, bowel impaction if patients not provided with specialist spinal cord injury care. Complications can lead to Autonomic Dysreflexia, a medical emergency, which can lead to death if complications are not treated immediately. This again requires specialist knowledge and skills. Staffing gaps and poor skill mix increases risk of patient safety incidents i.e., medication errors. Staffing gaps and poor skill mix will lead to increase in patient complaints. Staff well-being is affected by staffing gaps and poor skill mix due to increased pressures or substantive staff leading to increased sickness levels and further staff resignations. Staff are unable to complete mandatory training due to staffing gaps and poor skill mix as cannot be relieved from ward to attend training. Increased length of patient stays due to lack of specialist nursing staff to provide effective acute and rehabilitation care to patients. Reduced admissions due to staffing gaps and poor skill mix resulting in inability to admit patients safely.	5 - Almost Certain	4 Major	20	High	Ongoing RN recruitment attempts have been unsuccessful due to lack of candidates due to NHS wide shortage of registered nurses. HCA vacancies filled (awaiting recruitment checks for 6.52WTE). Attempting to block book agency RNs. Providing regular bank and agency staff with specialist spinal cord injury competency training to bridge skill gap. Delaying admissions.	4 - Likely	4 Major	16	High	RN recruitment. Registered Nursing Associate recruitment. Reduced admissions/bed closures.	2 - Unlikely	4 Major	8	Moderate	Treat Risk	Quality and Safety Committee	07/11/2022	18/11/2022
2997	Insufficient capacity to ensure Clinical Research regulatory requirements	Corporate Services	Longfellow, Dr Ruth	Wales, Johanna	As an organisation actively participating in Clinical Research there are National and International regulatory requirements that we are required to adhere to provide assurance regarding patient safety, research quality and financial responsibility. The department's staffing establishment does not allow for Clinical Research governance requirements to managed effectively.	- Failure to meet regulatory requirements, which could have further impact in the Trusts ability to engage clinical research. - Failure to have the policies and processes in place which support good clinical practice. - Failure to provide evidence to support local clinical change - The role of research governance is currently completed by one individual on part-time hours, which is a single point of failure for the Organisation.	5 - Almost Certain	4 Major	20	High	At all times staff ensure patients are safe. Project managers ensure that regulatory duties are adhered to where possible, including reporting to Health Research Authority and MHRA (Medicines & Healthcare products Regulatory Agency). The dept. administrator is assisting the role currently and would be able to manage EDGE, but currently not able to conduct any of the governance tasks / processes. The Deputy dept. Manager and Dept. Manager would step in and conduct some tasks, but not without a significant amount of training.	4 - Likely	4 Major	16	High	To re-evaluate the governance roles and explore opportunities within RJAH, within Research Dept. budget and within ICS to strengthen the mitigations.	1 - Rare	4 Major	4	Low	Treat Risk	Research Committee	03/11/2022	22/12/2022
1742	Lack of autonomy to make organisational investments	Corporate Services	Macbeth, Craig	Salisbury, Mark	Due to ICS financial deficit the finacial framework requires all investments to be proritised and agreed by an ICS investment panel.	Removes RJAH autonomy and will slow down required investments.	5 - Almost Certain	4 Major	20	High	Investment requirements submitted to investment panel and clear ranking against other system priorities. Investments can only be agreed where sufficient efficiency offset is identified at system level. Non recurrent opportunities to mitigate RJAH risks from delayed investment.	4 - Likely	4 Major	16	High	Lobbying ICS to implement a diminimis level for automanous investments. Assurance on delivery of efficiencies required for sustainability plan will unlock funding to be released.	2 - Unlikely	4 Major	8	Moderate	Treat Risk	Finance Planning & Digital Committee	20/07/2017	06/06/2022
											Demand and capacity modelling completed Appointment of additional consultants for Knee and Sports injuries, Paediatric Orthopaedics, Upper Limb. Revised theatre allocation process in place from 1st April 2017, with 3 month forward planning of OJP theatre sessions to secure set activity level per month. Additional theatre operational with further theatres to open in October					Increase bank/agency spend to mitigate vacancies to secure additonal activity until theatre staff recruited in place and appropriately trained. Administrative review for additional resources to strengthen booking processes be confirmed, during theatres efficiencies. Daily scheduling review to ensure theatre session allocation remains on plan.3 month forward view of theatres and clinic								

2934	Patient waiting times outside of national targets	Corporate Services	Carr, Mike	Dalgarno, Beth	Cause: Lack of capacity in sub specialties together with a failure to follow policies and embed RTT management processes. There is a pressure on a number of subspecialties where demand exceeds capacity. Resource constraints prevent commissioners investing in sufficient activity to sustain waiting times. Position at October 2016 shows that Trust is breaching open pathway target and has a number of 52-week waiters. Due to the COVID19 Pandemic, waiting lists have increased and we now have a number of 104 week waiters as of Nov 2022.	Impact: Breach of contracts and key targets Risk of contract penalties Potential for increased costs if OJP or external capacity used. Risk of harm to patients caused by long waits. The Trust will continue to receive close scrutiny from NHS Improvement and local press - we will suffer a reputational loss.	5 - Almost Certain	4 Major	20	High	2017 to facilitate capacity for new consultant posts Fast track recruitment days for Theatre staff reduced number of vacancies for theatres, process ongoing. New Access Policy in place with training programme for key operational staff Close monitoring of shortfall in theatre sessions through daily scheduling reviews Weekly senior team meetings and RTT Exec Comms cell RTT Board established Transformation work streams established for pre-op, outpatients, theatre utilisation, demand and capacity, follow up backlog. Project management structure established with identified Project lead, project manager and exec sponsor. CCG PLCV/ VBC authorisation process placing controls on demand to RJAH. Referrals being monitored as part of monthly planned care working group and monthly contract meeting with CCG (Service & Performance Forum) Complete roll out of Consultant training on patient choice based on patient management plan expectations.	4 - Likely	4 Major	16	High	allocation. Trajectory in place for delivery of Open pathway by Q4 2017/18. 2021 - Recruitment of substantive theatre staff from overseas underway. Recruitment of Consultant and associated staff (ie Specialist Physio and Clinical Nurse Specialists) for areas identified as being under resourced underway. Additional infrastructure required to support full recruitment to manage demand. Efficiencies and utilisation of existing resources under regular monitoring from appropriate forums. Admin review complete and Access staffing more stable. Harms Review Policy embedded and patients being managed safely via it	2 - Unlikely	3 Serious	6	Low	Treat Risk	Finance Planning & Digital Committee	22/06/2022	07/12/2022
2992	Call bell system for tetraplegic patients unavailable	Specialist Unit	Forrest, Mrs Dawn	Coulson, Katy	Current 'ping pong' call bell system used for tetraplegic patients is ineffective. Call bell system used by pressing 'ping pong' which sets off call bell. Acute tetraplegic patients unable to move head due to risk of neurological deterioration therefore unable to press call bells. Difficult to position ping pong bell due to lack of clamps (broken).	Patients unable to call for assistance as required.	4 - Likely	4 Major	16	High	Voice monitors in use however it is difficult to hear patients calling through them during day when ward is busy/noisy. Some patients are unable to communicate verbally so unable to use voice monitors.	4 - Likely	4 Major	16	High	New specialist call bell system in place which can be used using voice control/blowing/eye contact/touch Risk to be reviewed and aligned to the Medical Devices Committee for an overall review of the call bell system	2 - Unlikely	4 Major	8	Moderate	Treat Risk	Patient Safety Committee	28/10/2022	01/12/2022
2993	Registered Nurse unavailability impacting safe staffing levels	Corporate Services	Ellis Anderson, Sara	Foskett, Kirsty	The unavailability of registered nurses through vacancies, sickness and maternity leave is impacting the Trusts ability to meet safe staffing requirements.	The impact of this is: - Closed beds impacting operational capability - Increase use of agency nurse usage - Through increased use of temporary staffing this creates unintended issues surrounding ownership, training, adherence to policies and procedures. - Ward Managers loss of supervisory capacity - Impact to staff health and wellbeing	5 - Almost Certain	4 Major	20	High	- Increased use of temporary staffing to fill RN unavailability - Bed closures to support safe staffing levels - Ward Managers working in the safe staffing numbers - Daily State of Play meeting to discuss staffing levels - Recruitment and Retention Working Group established to achieve longer term objectives	4 - Likely	4 Major	16	High	- Proactive recruitment campaign to support recruitment of registered nurses - Uplift of Registered Nurse establishments to include maternity cover. review of establishment uplift based on the last 3 years of data for sickness, training requirements and maternity leave. - Review current workforce establishment to reflect future workforce initiatives, .i.e. Nurse Associates.	3 - Occasionally	4 Major	12	Moderate	Treat Risk	People Committee	31/10/2022	08/12/2022
2995	Potential for Industrial Action	Corporate Services	Ellis Anderson, Sara	Foskett, Kirsty	NHS trade unions are currently conducting either an indicative or statutory ballot to assess the level of support of their membership for strike action and action short of full strike action. The impact of this unavailability of staff is currently unknown but is a risk to patient safety and experience if activity is stood down as a result.	The impact of this unavailability of staff is currently unknown but is a risk to patient safety and experience if activity is stood down as a result.	5 - Almost Certain	4 Major	20	High	EPRR meetings in place for business continuity plans Safer staffing escalation SOP in place Clinical Prioritisation process in place	4 - Likely	4 Major	16	High	EPRR meetings in place to assess and monitor operational impact Communications to staff and patients to be developed when further detail is known	2 - Unlikely	4 Major	8	Moderate	Treat Risk	People Committee	02/11/2022	08/12/2022
2653	Theatre staffing- Impact of staffing levels to meet activity	MSK Unit	Banks, Jo	Flood, Rachael	Establishment is based on 134 sessions per week. Due to a potential Trust shortage of Theatre staff it has been difficult to recruit to this establishment level. This is further impeded by a well-recognised national shortage of Theatre staff including available of skilled scrub practitioners.	Risk to delivery of Theatre session plan. This staffing shortfall reduces the number of theatres that can be safely utilised.	5 - Almost Certain	4 Major	20	High	Use of Bank staff, plain time, overtime and Theatre specialist Bank staff to cover shortfalls. Rolling job advert for recruitment (for Scrub and Anaesthetic practitioners) Use of agency staff	4 - Likely	4 Major	16	High	International recruitment of experienced Orthopaedic Scrub practitioner staff to cover the difficulties and shortfalls of recruiting within the UK, therefore recruiting to present establishment successfully. Nurse Recruitment campaign digital launch Nov. Open day planned for 28/01/22.	1 - Rare	4 Major	4	Low	Treat Risk	People Committee	26/04/2021	06/12/2022
2911	FPD - Consultant & Anaesthetist Workforce recruitment dependencies and ongoing reliance on flexible workforce	MSK Unit	Carr, Mike	Banks, Jo	FPD -Consultant & Anaesthetist vacancy (workforce gap) and also a recruitment (new consultant) growth gap could impact on delivery of the 2022/23 Operational plan	FPD - Workforce recruitment dependencies and ongoing reliance on flexible workforce -could impact on delivery of the 2022/23 Operational plan	3 - Occasionally	4 Major	12	Moderate	Consultant recruitment Project Group established and meeting fortnightly	4 - Likely	4 Major	16	High	Sustainability plans through consultant recruitment 6.5 WTE consultant recruitment planned in 2022/23.	1 - Rare	4 Major	4	Low	Treat Risk	Finance Planning & Digital Committee	16/05/2022	11/11/2022

2913	FPD - System pressures necessitating future mutual aid support	MSK Unit	Carr, Mike	Banks, Jo	FPD - System pressures necessitating future mutual aid support could impact on delivery of the 2022/23 Operational plan	FPD - System pressures necessitating future mutual aid support could impact on delivery of the 2022/23 Operational plan	4 - Likely	4 Major	16	High	System Sliver and Gold call oversight for decision making around system support requirements	4 - Likely	4 Major	16	High	Impact seen in Month 1 with activity reduction through provision of mutual aid. Protected services and delivery of activity for patients over 90 weeks to be maintained during mutual aid support.	1 - Rare	4 Major	4	Low	Treat Risk	Finance Planning & Digital Committee	16/05/2022	11/11/2022

2793	Provision of Consultant Microbiologist at RJAH	Specialist Unit	Carr, Mike	Evans, Pat	Consultant Microbiology looking to retire 31st March 2022. SaTH provide consultant microbiologist PA's via SLA. SaTH have found recruitment of consultant microbiologist challenging in the past. It is not clear at this time if a consultant microbiologist with an interest in joint infection/orthopaedics will/can be recruited to enable delivery of the SLA by SaTH. It should be noted that the current Microbiologist delivers advice for activities across the Trust as per the SLA in addition to clinical.	No Consultant Microbiologist provision would be in breach of the current SLA with SaTH. Clinical advice. on site visits including ward rounds, attendance at Infection MDT and any further MDT requirements, plus the further professional advice given in line with the SLA provision would not be received. This would put all clinical services within the Trust at risk.	4 - Likely	4 Major	16	High	Discussion with current service provider (SaTH) are taking place to give assurance that they are managing the risk and the SLA will be honored. Discussion ongoing with other service providers to establish if microbiology service can be obtained elsewhere.	5 - Almost Certain	4 Major	20	High	Discussion with SaTH to provide assurance that they can continue to offer the service if and when the current Consultant Microbiologist retires Discussion with other service providers to establish if there is provision to take on RJAH microbiology service if SaTH cannot. 28/11 SLA being reviewed to understand current requirements and assess whether SaTH can provide the level of agreement required. If not, scope to source other providers.	2 - Unlikely	4 Major	8	Moderate	Treat Risk	Infection Control Committee	18/10/2021	29/11/2022

0. Reference Information

Author:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper date:	11th of January 2023
Senior Leader Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	09th of January 2023
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Trust Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Noting

1. Purpose of Paper

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

This paper presents an overview of key updates within the chief nurse portfolio for members of the Trust Board on items not covered within the main agenda.

2. Executive Summary

2.1. Context

This paper presents an overview of key updates within the chief nurse portfolio for members of the Trust Board on items not covered within the main agenda.

2.2. Summary

- Regionally we are seeing a rise in flu and covid related admissions. There was 1 Covid outbreak on Sheldon ward in December
- Covid/Flu vaccination programme progress is slower than anticipated across the organisation with several actions being taken to encourage uptake.
- NHSE/ICS IPC assurance visit saw the Trust maintain its Green rating against the NHSE IPC matrix showing sustained improvements.
- The RCN industrial action is planned for the 18th and 19th of January and plans are underway to ensure patient safety is maintained.
- Registered Nursing digital recruitment campaign launched in December with an open day planned at the end of January

2.3. Conclusion

The Board is asked to note the contents of the report.

3. The Main Report

3.1. Covid/Flu Vaccination programme

We've started our flu and covid booster campaigns on the 19th of September. Weekly reporting for the 5th of January gave 57% uptake for Flu and 66% for Covid Booster overall. Flu uptake is approximately 14% lower than this time last year. Staff are being reminded via several communication channels on the importance of staying well this winter by having the vaccine. The vaccination hub is open to all staff and there is a peer vaccinator system in place.

Regionally we are seeing increased admissions for flu and covid across acute hospitals. At RJAH we have had one outbreak of Covid affecting staff and patients on Sheldon ward.

3.2. NHSE/ICS IPC Assurance Visit

On the 30th of December we invited IPC colleagues from NHS England and the ICS to do a follow up assurance visit on IPC to ensure we had sustained the improvements and progress made since September. Sustained improvements were seen across all areas with the Trust remaining Green rated on the NHSE IPC matrix.

3.3. RCN Industrial Action

The Royal College of Nursing (RCN) members at RJAH have chosen to take strike action with RJAH being included in the second round of industrial action planned for the 18th and 19th of January. The Trust are working with the RCN to ensure safety is maintained at all times for our patients.

3.4. Nurse Recruitment Update

The nurse recruitment digital campaign was launched with #timetocare as our unique selling point. The first advert reached over 31,000 people with 605 clicks through to RJAH recruitment pages. The advert was shared a total of 59 times with overwhelmingly positive comments about the hospital and the care people had received.

There is an open day planned on the 28th of January for nurses to have interviews and offers if successful on the day. This will include stands from the learning and development team and various departments and the option of a tour around the hospital.

3.5. Conclusion

The Board are asked to note and discuss the contents of the report.

Appendix 1: Acronyms

NHSE	NHS England
ICS	Integrated Care System
IPC	Infection Prevention and Control
RCN	Royal College Nursing

Trust Board - Quality & Safety
November 2022 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

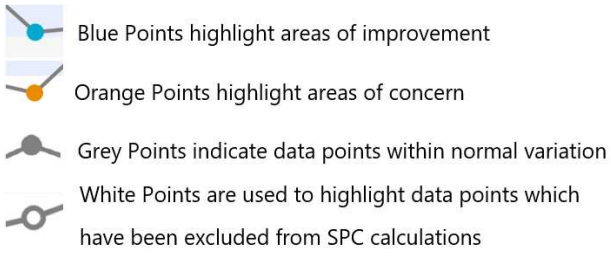
Different colours have been used to separate these trends of special cause variation:

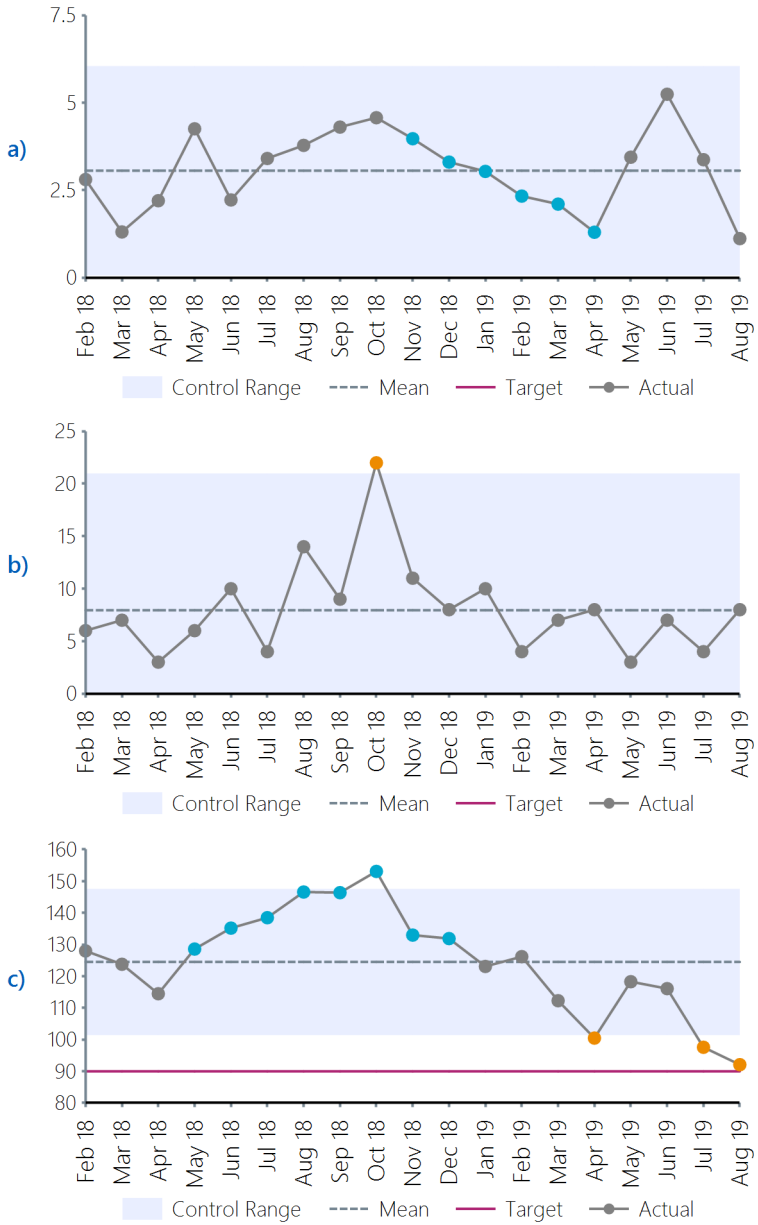
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.





Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?

Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

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

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

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

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	?		
Never Events	0	0		N/A to SPC	?		
Number of Complaints	8	10			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		
RJAH Acquired Klebsiella spp	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?	+	

Summary - Caring for Patients

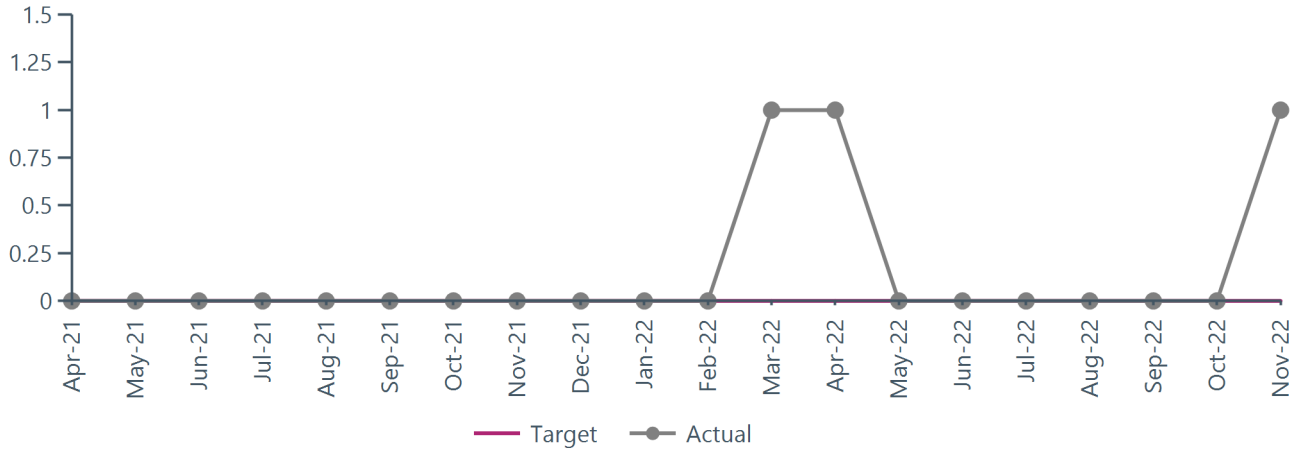
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	0		N/A to SPC	P		
Total Deaths	0	1		N/A to SPC	F	+	16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P		

RJAH Acquired Klebsiella spp

RJAH Acquired Klebsiella spp 217635

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	1	N/A to SPC	?



Trajectory/H2 Forecast

What these graphs are telling us

This measure is not appropriate to display as SPC. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

There was one RJAH acquired Klebsiella spp infection reported in November.

Actions

A post infection review is scheduled for 9th December to confirm the likely source of the infection.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
0	0	0	0	1	1	0	0	0	0	0	0	1

- Staff - Patients - Finances -

Surgical Site Infections

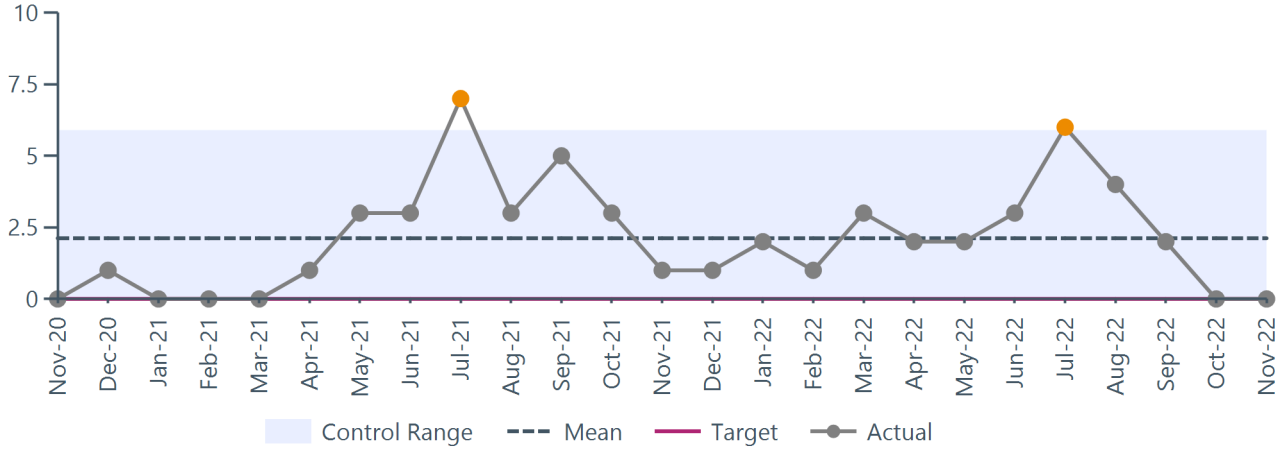
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead:
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	0		

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

Surgical Site infections are monitored for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in the past twelve months. The data represented in the SPC above shows any surgical site infections that have been reported where they're shown on the graph above based on the month that the procedure took place.

In the latest twelve month period, covering December-21 to November-22, there have been 19 surgical site infections. There were three additional infections confirmed in November relating to a procedures that took place in May (1), August (1) and September (1). A data quality check has been carried out with the IPC team to ensure the latest twelve month period is reported correctly.

Latest complete quarters breakdown is as follows:
- January 22 to March 22 - 6 SSIs with all Post Infection Reviews Complete
- April 22 to June 22 - 6 SSIs with all Post Infection Reviews Complete
- July - September 22 - 12 SSIs - as at 1st December 2022 11 Post Infection Reviews complete with remaining 1 due to take place within 30 days of confirmation at MDT

Actions

Actions in this area are:
- A table top discussion was held at the start of November to establish if there are any further contributing factors. A further meeting then took place later in November where a significant action plan was drawn up. This will be monitored through the IPC Working Group.
- MSSA decolonisation of all patients has commenced from 21st November
- A review of theatre cleanliness and equipment cleanliness has been completed
- The frequency of IPC Quality walks moved from 6 to 3 months
- Equipment props now included as specific question on theatre environmental IPC audit

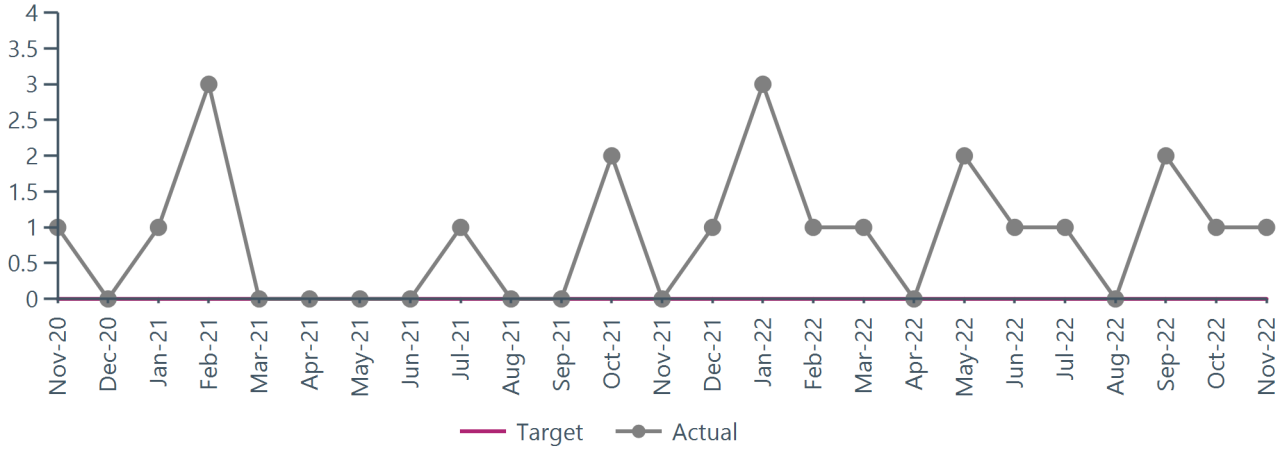
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
1	1	2	1	3	2	2	3	6	4	2	0	0

Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
0	1	N/A to SPC	F



Trajectory/H2 Forecast

What these graphs are telling us

This measure is not appropriate to display as SPC. Based on data for the past three months, the assurance indicates that this is consistently failing the target.

Narrative

There was one death within the Trust in November; this was an expected death.

Actions

All deaths are reviewed by the Hospital Mortality Lead.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
0	1	3	1	1	0	2	1	1	0	2	1	1

- Staff - Patients - Finances -

IPC Improvement Plan

0. Reference Information

Author:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	11th of January 2023
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	3rd of January 2023
Paper Reviewed by:	N/A	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Trust wide IPC improvement plan and progress against actions identified. The Board is asked to **note** the actions taken and seek additional assurance if required.

2. Executive Summary

2.1. Context

RJAH was escalated to red on the NHSE/I IPC Matrix and following a visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance the Trust was moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. The Trust has an IPC improvement plan and there have been formal inspections in June and September where the Trust has moved to amber and green respectively on the NHSE/I IPC matrix. A final improvement review meeting (IRM) was held on 27th of October where it was agreed undertakings had been met.

2.2. Summary

- As of the 3rd of January 2023
  - 0 action behind plan
  - 83 actions complete (an increase of 3 since last report)
  - 12 actions in progress with clear action owners and timescales
- On-going actions will continue to be monitored monthly through IPCC and IPC Quality Assurance Committee
- A formal 6 monthly visit by NHSE took place on the 26th of September with confirmation the Trust has moved to green on NHSE IPC Matrix
- Formal assessment against undertakings at meeting held on 27th of October saw undertakings being fully met.
- NHSE/ICB IPC assurance visit in December – Trust continues to be rated green on NHSE IPC Matrix demonstrating sustained improvements
- Key risks include Microbiology provision and advice and delays in implementation of ICNet to support wider SSI surveillance.

2.3. Conclusion

The Board is asked to **note** the progress being made and actions taken and seek additional assurance if required.

3. The Main Report

3.1. Introduction

The Trust declared an MRSA outbreak on the Midlands Centre for Spinal Cord Injury (MCSI) on the 20th of July 2021. The NHSE IPC team completed an assurance visit on 2nd of August 2021 highlighting areas for improvement. Subsequently RJAH was escalated to Red on the NHSE IPC Matrix and a subsequent improvement plan with external support was developed and progressed. The Trust was moved into SOF 3 of the single oversight framework and issued with enforcement undertakings.

On the 26th September 2022 the 6 monthly formal IPC review from NHSE took place supported by a desktop review of key IPC documentation. The Trust has received the formal letter confirming that it has been moved to green on the NHSE IPC matrix. This was followed by a regional improvement review meeting where it was confirmed exit criteria and undertakings had been met.

On the 30th of December 2022 a follow up IPC assurance visit from NHSE and the ICS confirmed the Trust would remain rated Green following a demonstration of sustained improvement.

3.2. IPC Improvement Plan

In response the IPC improvement plan has been developed to ensure actions are embedded trust wide and improvements are sustained. The plan has been developed to include all actions and recommendations from various sources. The IPC improvement plan has been split in to nine themes and set against the 7 exit criteria that have now been met. The improvement plan is a live document and now has a total of 95 actions with a summary provided below.

Table 1: Overview of progress against actions IPC Improvement Plan on 03/01/2023

No.	Objective (Exit Criteria)	Not Started	Behind Plan	In Progress	Complete	Total
1.	Evidence of board assurance, senior leadership, and delivery of actions	0	0	1	5	**6**
2.	Trust staff have the necessary improvement skills to sustain improvement	0	0	1	15	**16**
3.	Trust IPC audits demonstrate improvement	0	0	9	33	**42**
4.	Trust reporting on HCAIs, outbreaks and SSIs	0	0	1	24	**25**
5/6.	Improvement in external IPC inspections	0	0	0	3	**3**
7.	Agreement between regulators, commissioners and the System that there is evidence of significant progress and confidence in the Trust leadership Team	0	0	0	3	**3**
	Total	**0**	**0**	**12**	**83**	**95**

The evidence for the improvement plan was reviewed as part of a desk top review by NHSE and the ICB on the 20th of October. A report has been received demonstrating a wealth of evidence to support the significant improvements made and progress against the exit criteria and undertakings.

IPC Improvement Plan

Actions in progress due in January:

No	Priority	Area for Improvement	Target completion date	Accountable Exec	Responsible Lead	RAG status	Progress
1.2	High	IPC Strategy to be launched	31/01/23	Chief Nurse	Sam Young	Amber	To be launched at IPC Summit. For Jan 23
6.4	Low	Wipes are required to be in wall mounted brackets ensuring adequate access for effective cleaning	31/01/22	Director of Finance	Sian Langford	Amber	Standardisation of wipes agreed through IPCWG. Awaiting final system IPC sign off.
6.6	Low	Obtain quote for digital solutions to equipment library	31/01/23	Director of Digital	Phil Davies	Amber	EBME will oversee medical equipment library. Space required – preferred option is phase 2 of theatre extension plan
3.14	Medium	Review and update of IPC Risk Assessment templates to reflect infection type and modes of transmission, to aid appropriate mitigation and actions	31/01/23	Chief Nurse	Sam Young	Amber	Date moved to end of Jan to encompass wider review of IPC policies to align to newly published NIPCM

Key achievements in December:

- 15 housekeepers have been appointed, three have started in November with a further three starting in December and four starting in January. 5 are awaiting pre-employment checks.
- Bay doors installed on Gladstone ward
- Funding agreed for increased linen capacity on site
- All shower chairs replaced on MCSI
- Tendable reporting module available for electronic audits
- SSI improvement plan engagement across all disciplines
- IPC assurance visit from NHSE and ICS confirmed sustained improvements

3.2.1. On-going assurance and oversight

- RJAH IPC Quality Assurance Committee to continue to meet monthly until March with a review in January.
- Monthly agenda item on Trust Board agenda to continue
- Joint System/NHSE Quarterly walk around March
- Joint System/NHSE Quarterly desktop review of SSI's – December and March (in addition to usual NHSE touch points with the system for quality oversight)

3.3. Associated Risks

- Microbiology provision and impending retirement of Consultant Microbiologist (March 23) – this risk has now escalated due to sickness of Consultant Microbiologist.

  The microbiology SLA has been extended to March 2023. There are ongoing meetings to revise the SLA and consider other options. This work is being expedited due to the sudden sickness of our Consultant Microbiologist. Anti-microbial ward rounds continue twice weekly by anti-microbial pharmacist with remote advice from SaTH.

- Digital capability to support increased SSI surveillance – this will be reduced when ICNet has been implemented.

  A case of need for ICNet has been agreed by the Executive team. Director of Digital is now progressing the purchase and implementation of the software. This has been delayed due to review of pathology and microbiology SLAs.

3.4. Conclusion

The Trust has now moved to GREEN on the NHSE Midlands Infection Prevention and Control escalation matrix and formal undertakings have been met. A further assurance visit in December confirmed RJAH remains rated green following evidence of sustained improvement.

The improvement plan will continue to be monitored through internal IPCC, IPC Quality Assurance Committee with system oversight at the STW System Quality Group.

The Board is asked to ***note*** the actions taken and progress to date and seek additional assurance if required.

Acronyms

ANTT	Aseptic Non Touch Technique
AMR	Antimicrobial Resistance
BAF	Board Assurance Framework
BBE	Bare Below Elbow
CCG	Clinical Commissioning Group
DIPC	Director of Infection Prevention and Control
E&F	Estates and Facilities
HCAI	Healthcare Acquired Infection
HCSW	Health Care Support Worker
HH	Hand Hygiene
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IRM	Improvement Review Meeting
MCSI	Midlands Centre for Spinal Cord Injury
MRSA	Methicillin-resistant Staphylococcus aureus
NHSE/I	NHS England and Improvement
NIPCM	National IPC Manual
PIR	Post Infection Review
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
SLG	Senior Leadership Group
SOP	Standard Operating Policy
SSI	Surgical Site Infection
STW	Shropshire Telford and Wrekin

NHS England Midlands

To:
- Sara Ellis-Anderson
  Director of IPC &
  Interim Chief Nurse
  Robert Jones and Agnes Hunt

cc.
- Nina Morgan – Regional Chief Nurse
- Fran Steele – Director of S&T – Midlands
- Jacqueline Barnes – Interim Director of Quality and Improvement RJAH
- Alison Bussey – CNO STW ICB

NHS England
NHS England - Midlands
Regional Chief Nurse
Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT

10 January 2023

Dear Sara,

NHS England Visit 30 December 2022

I would like to thank you for organising the formal review visit of the Trust, this took place on 30 December 2022. The visit took place within December as scheduled as part of the follow up to the undertakings and as agreed as part of the improvement and support offer. Tracey Whittaker, Infection Prevention and Control (IPC) Specialist Nurse, Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) joined me for the visit as agreed. This letter has been drafted as a single report representing both the NHSE and the ICB view of the visit.

As this visit was part of the formal review process to assess the Trusts progress, NHSE have taken the opportunity to review the Trust against the NHSE Midlands Infection Prevention and Control internal escalation matrix. Following the sustained improvement that was observed and the demonstration that areas for improvement are part of the action plans, I can confirm that the Trust have sustained the **GREEN** rating on our matrix.

The day started with an updated presentation/discussion from you and your team on the work that has been completed since the previous visit and the next actions that are in progress, demonstrating the Trusts ongoing commitment to IPC and to ensuring the changes that have been made are embedded within processes and the learning continuing to be implemented. Across the day we visited the Baschurch and Theatre, the Veterans Centre and Outpatients as well as Sheldon ward. We also reviewed the new doors that had been completed on Gladstone ward, which completed the outstanding work for fitting doors to the bays on this unit as part of the MRSA outbreak actions.

During the visit we were accompanied by various members of your multidisciplinary team, including the IPC team, Matrons, and ward leaders for each of the areas that were visited. Tracey and I provided detailed feedback to each area immediately where good practice or improvements required were identified.

I would like to pass my thanks to the teams in these areas who were happy to show us around, share the improvement works that have been undertaken and identified the areas that they are now working on, the engagement across the teams was evident throughout the day. Of note, members of the wider team were able to explain how they have used the improvement methodology to support other work that they were undertaking within their departments as well.

At the end of the visit, Trust level feedback was provided to the wider team of Senior Leaders, including yourself and the Trust Chief Executive, this demonstrates the level of ownership and ongoing commitment to the improvement journey within the Trust. The continued engagement was observed across the organisation on this visit as well and this highlights that the new ways of working are becoming embedded within the culture of the organisation.

Below is the high-level summary of the key findings shared on the day. Generally, the improvements we have observed previously were still in place and there was improvement noted across the organisation and within each area that was visited throughout the day.

Key areas of improvement identified:

- Estates work:
    - The remaining doors have been fitted to Gladstone ward, this work has been finished to a high quality and has already proven beneficial to support the isolation of patients in the bay, without having to move the ward around.
    - Small works have been commenced within the theatre department, there is a list of works that can be undertaken without causing too much disruption to the theatre workings and not posing a risk to the patients undergoing procedures.
    - Work has been completed in the pack room in theatre where the racking was damaging the wall, this has now had white roc fitted and there is a visible reduction in the amount of dust within this room.
    - Door protection is being fitted in the theatre area.

- The veterans centre has been finished to a high standard
- The refurbishment to the toilet areas in outpatients has been completed and there is a significant improvement in this area.

- We observed a high level of compliance with the bare below the elbow's initiative, across all staff groups.
- On one of the previous visits we identified a concern with the "leg troughs" which were stained inside the covers despite cleaning. At the last visit we noted the interim solution that was in place was working well. We reviewed these again on this visit and, I am pleased to report that none of the leg troughs that we reviewed had any strike through and the new process appears to be working well, maintaining the integrity of the trough and ensuring they can be effectively decontaminated between patients.
- The storage of stock in the corridor in theatre is much improved from the previous visit, the surgical tables are no longer used for storage, the storage in this area has been reviewed and only "high turnover" items are stored in this area, this has meant far less storage and an easier environment to keep clean.
- All patient observation trolleys and commodes that were observed across the course of the visit were visibly clean.
- Personal protective equipment (PPE) was available throughout the areas of the hospital to ensure appropriate access and staff were observed wearing PPE when indicated.
- We observed the bay doors on Gladstone ward closed as part of IPC actions, signage was appropriate, and staff were observed to be wearing PPE correctly.
- The excessive amounts of tape and sticky residue from the bolster cushions has now been removed, these cushions are on a rolling replacement programme.

Key themes where improvement is identified, and work needs to continue:

- There are ongoing estates works that are required, most of the estates works that were observed during the visit had already been reported through your processes. Examples include areas of flooring where the seals have split, or the coving is separating from the floor or wall.

- At the last visit you had recently introduced a new role to support wards with storage and stock levels. We advised at the previous visit that we had started to see this improvement on Sheldon ward, this was more evident on the ward during this visit with the stock levels more controlled and the storeroom layout starting to show some improvement.

- The sluice room and the storeroom on Sheldon have shown continued improvement and work is ongoing in this area to improve further. We were advised of the next phase of work that was being completed on this area and note that the plans are subject to the ability to decant the ward.

- Compliance with mask use has improved overall since the previous visit, however, there were still couple of staff who needed to be reminded to pull masks up over their nose.

- On the previous visit we identified concerns with sharps bins not being put together properly and inappropriate items being disposed of in the sharps bin. During this visit we identified sharps bins that were not labelled in line with the Trust policy, inappropriate items being disposed of in the sharps bins, such as packaging and swabs and two sharps bins which were filled over the fill line. None of the sharps bins that we observed during the visit had the temporary closure mechanism deployed.

- The physio bars in the rehabilitation area on Sheldon ward had been painted prior to the visit in September, these were already chipped and in need of being repainted, we discussed whether there is a need to replace these or to consider a different coating due to the need for repair in such a short space of time.

- There was chewing gum stuck to the underneath of a chair in Baschurch, this was the only chair this was observed on during the visit on this occasion. When we discussed with colleagues in outpatients, we established that there was a regular checking process in place as part of the weekly checks, it is evident that this is working well for this department.

- The floor in the phlebotomy room in outpatients requires fixing, this appears to be new damage to the flooring in this room.

- Consideration should be given to wipe clean pull cords in the toilet areas, two were observed to be contaminated during the visit, these were both actioned at the time.

- Only one member of staff was observed to be wearing gloves inappropriately. This was discussed with the theatre team at the time and an explanation as to why this was inappropriate and what should have taken place was provided, the team advised that they will address this and share the learning.

Key themes where improvement is still required:

- Estates work is still required in the theatre department, this has been reviewed and the estates team have begun the process of identifying and costing the works that need to be completed. The Trust have confirmed that the risk assessment has been completed and that the work within this has also been assessed, I would recommend ongoing system discussions around additional mitigations or mutual aid to support the planning and completion of this work. In addition to this, the theatre patient entrance from the lift is in need of repainting, there are areas of the wall where the paint has pulled off, increasing the risk of dust and decreasing the effectiveness of cleaning.

- On Baschurch, the macerator handle in the sluice is broken, the macerator was not visibly clean inside and we were unclear on the frequency of cleaning for this item, the “I am clean” label was not reflective of the cleaning frequency.

- The access to the handwash basin in Baschurch was blocked by the wall bracket used for storing vomit bowls, recommend that this is relocated to the other wall. There was a linen bag of empty alcohol hand gel and cleaning product bottles hanging from this bracket, staff were unsure why they were there, and this is not in line with waste management policy.

- Cleaning products were made up in “sani-cloth buckets” although it was unclear what was in each bucket and how long the solutions had been there.

- Attention to detail when cleaning was a continued theme on this visit however the overall cleaning standards continue to improve.

- Within the veterans centre, the team had set up a list of rooms to be ticked off when they had been used so as they could be cleaned, I would advise against this as there is a significant chance that this will not be kept up to date or overlooked when busy, as discussed with the team these rooms should be cleaned in line with the cleaning standards.

- The cleaning room in the veteran’s centre had a janitorial unit in which the drain appears to be placed in upside down and water was unable to drain effectively, there

was a significant collection of water remaining in the unit. In addition, when the tap was turned on there was a significant splashback.

- There is a site wide plan for the replacement of soap dispensers and hand moisturiser dispensers, as most of these are cracked and difficult to clean. As part of this work please can we ensure that all of the hand hygiene posters are updated, these should be placed next to hand wash basins to support with appropriate hand decontamination technique, we observed that these were not visible at all of the hand wash basins, this was noted in all areas that were visited.

- There were some items of theatre equipment, which were observed to be contaminated with blood and/or body fluids. This included the Allen table and one of the props/cushions in the area behind the curtain. The Allen table was observed to be contaminated on the previous visit as well, a review of the cleaning process for this piece of equipment would be recommended. In addition, the haemocue was contaminated, we believe that this is contamination from the solution, however the cleanliness of the machine should be maintained.

We were advised that the Barns theatres had undergone a deep clean, provided by an external company. We reviewed the area as part of the visit on the day and noted that the overall standard of the deep clean was poor. Sticky residue had not been removed from surfaces, there was a build up of dust and debris noted under the scrub sink and a sharps bin bucket behind these sinks which had not been moved/removed during the cleaning process, your team did take a photograph of this. I would recommend discussion with the company that provided the cleaning services about the standards and also a review of your internal sign off process post deep clean to ensure that the cleaning is to the standard that you have requested and would expect.

Within the veterans centre there was a wall of plaques, consideration should be given to whether this would be better behind glass in order to reduce the cleaning required and the levels of dust that will collect in this area, we were informed that the volunteers were supporting the cleaning in this area.

Next Steps

As part of the continued support offer and to ensure that the improvement is embedded within the organisation, we have agreed to complete a:

- Quarterly walk through of the Trust in March 2023, this will be in conjunction with System leads, provisional date of 30 March has been agreed.

- Quarterly desktop review of SSI data, themes and trends and review of the processes, we can do this as part of the visit on the day or as a separate 2 hour focused meeting.

During the review of your SSI plan, I have also recommended working with the ICB to review the cases that presented to the GP so as we get a thorough review of the SSIs that are being identified and to ensure that we are not missing actions. Further actions were discussed and agreed during the discussion of the plan on the day of the visit, these have been added to your SSI action plan.

We have provisionally agreed some time to write up the MRSA outbreak on MCSI for publication and submission for presentation at conferences to showcase the work that has been done and the changes within the organisation as a result of this work, I am looking forward to working with yourself and the team to complete this piece of work

Please use this to continue to develop your IPC action plan around the “Hygiene Code” to address the concerns identified. This should work alongside your action/improvement plan.

Finally, please discuss share this report with your Trust Board and confirm by email that this has been completed.

Yours sincerely,

Kirsty Morgan
Assistant Director of IPC – NHS Midlands

0. Reference Information

Author:	Alison Harper, Interim MSK Governance Lead/Matt Hughes Governance Assistant	Meeting date:	24 November 2022
Senior Leader Sponsor:	Sara Ellis Interim, Chief Nurse, and Patient Safety Officer	Paper written on:	14 November
Paper Reviewed by:	Quality and Safety Committee 24/11/2022	Paper Type:	Governance and Quality
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Noting

Executive Summary

The paper presents the results of the Adult Inpatient Survey 2021. It highlights response rates, areas scoring well, identifies areas for improvement, and comparison against other Trusts.
Overall, we have been named by the CQC as one of the organisations placed in the top band of Trusts across England delivering results that are considered "much better than expected".

- Results from the 2021 survey show that patients continue to give outstanding patient feedback about the quality of care and experience they have received at the RJAH in line with other years.
- The RJAH was ranked top for 20 out of 47 questions including **overall experience, nursing care, doctors, food, and cleanliness** out of the all the NHS Trusts in England.

Progress / Impact on Patient Care

The purpose of the national Inpatient survey is to understand what patients think about their care and treatment they have received, by telling us about their experiences so Trusts can improve the quality of services that the NHS delivers.

Risk and Issues

There have been no associated risks identified.

Next Steps and Actions

The suggested areas for improvement include;

- Support after leaving hospital to help recover or manage their condition
- Length of time on the waiting list before admission
- Patients bothered by lighting at night
- Asked to be given their views on the quality of care provided
- Patients given enough privacy when being examined or treated.

The areas for highlighted will be discussed at the delivery Unit Governance Meetings to help formulate and agree actions for improvement.

Conclusion

The Board is asked to note the report following a discussion at the Quality and Safety Committee in November where the areas for improvement were agreed.

The Adult Inpatient Survey 2021 results

The NHS Adult Inpatient Survey runs every year, and all NHS Trusts in England are required to conduct the survey to provide a measure on what our patient think about their experience.

The Adult Inpatient Survey includes 134 NHS acute trusts in the country and asked 62,000 adults who had stayed in hospital for at least one night during the period Aug 21-Nov 21 about the care they received. The survey mode changed from paper only to mixed mode of paper/online survey and reminders sent by SMS text

The Picker Institute carries out the survey on behalf of the RJAH.

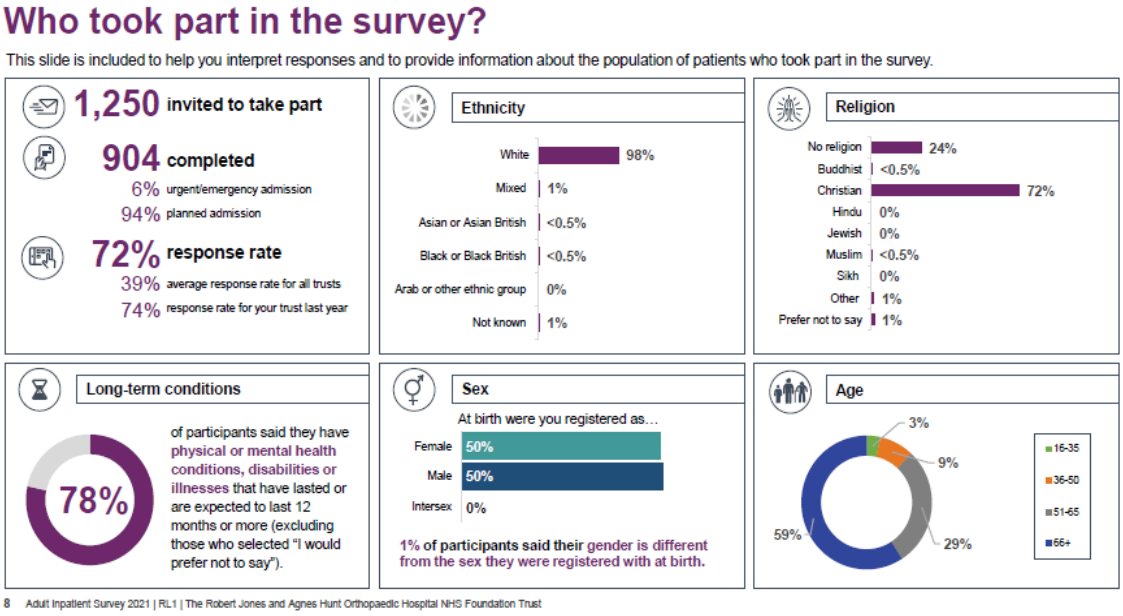
The CQC full benchmark reports are available when published on the CQC website: http://www.cqc.org.uk/inpatientsurvey.

2021 RJAH results - **Another year of very positive results to celebrate!**

Overall, we have been named by the CQC as one of the organisations placed in the top band of Trusts across England delivering results that are considered “much better than expected”.

At the time that this survey was carried out, the hospital was very much in the grip of the coronavirus restrictions – necessary measures that nevertheless impacted our patients. Despite all this, our patients tell us that we continue to deliver excellent care and, we once again score No. 1 in the country for the overall patient experience we offer, and this is just one of several significant highlights.

- For RJAH a total of 1,250 patients were asked to complete the survey.
- 72% of patients (904) returned the survey, which was slightly reduced from the previous year (74%). The national average is 39%



The highlights

The Trust received the highest score for 20 out of 48 questions nationally (134 NHS Trusts) including food, and cleanliness of the wards.

The highlights to note are:

- Overall patient experience: RJAH rated No 1 in the country for the third year in a row
- Hospital food: Our food has been rated No 1 in the country for the 16th time in the last 17 years
- Cleanliness of wards and rooms: We rated No 1, for the second year running, for patients reported that their room or ward was clean

Highest scoring questions, 100% or 99%

- Hospital: Room or ward very or fairly clean – 100%
- Hospital: Got enough to drink – 99%

- Doctors: Doctors answered questions clearly – 99%
- Doctors: Had confidence and trust in the doctors – 100%
- Doctors: Doctors included patient in conversation – 99%

- Nurses: Had confidence and trust in the nurses – 100%
- Nurses: Nurses answered questions clearly – 100%
- Nurses: Nurses included patient in conversation – 99%

- Care & Treatment: Felt able to discuss worries and fears with staff – 99%
- Care & Treatment: Given enough privacy when being examined or treated – 100%
- Care & Treatment: Staff helped control pain – 99%
- Care & Treatment: Staff helped when needed attention – 99%
- Care & Treatment: Questions before procedure were answered well – 100%

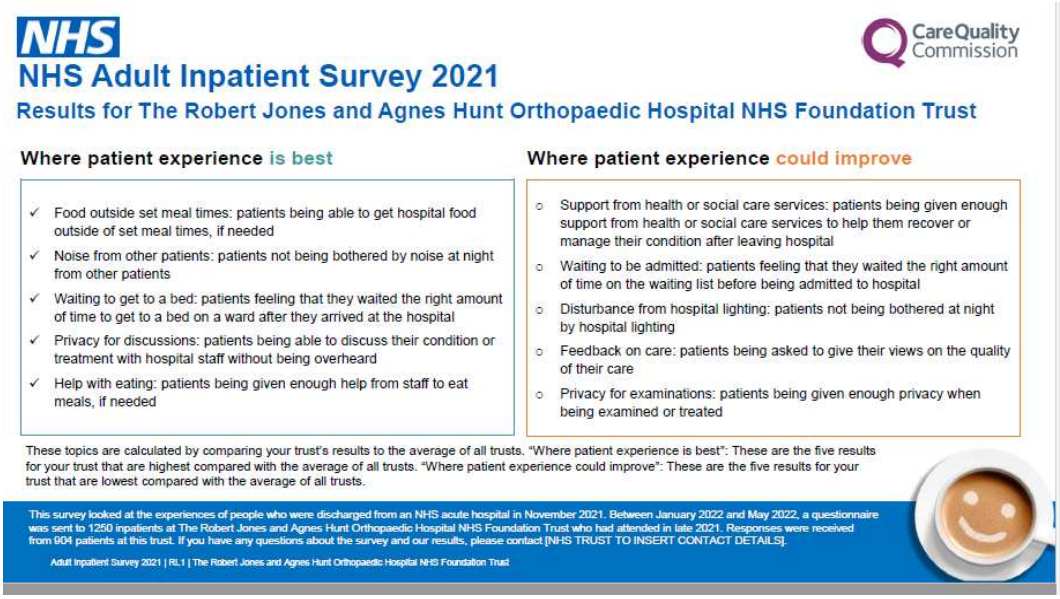
- Leaving Hospital: Understood information about what they should or should not do after leaving hospital – 99%

- Overall: Treated with respect and dignity overall – 100%

Comparison to 2020 results

The questions in this report where your trust showed a statistically significant increase or decrease compared to 2020 results are listed below.

Significant Increase	Point change	Significant Decrease	Point change
Your trust has not shown a statistically significant increase for any questions		Q46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	-1.6
		Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	-0.4
		Q9. Did you get enough help from staff to wash or keep yourself clean?	-0.4



NHS

NHS Adult Inpatient Survey 2021

Care Quality Commission

Results for The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Where patient experience is best

- ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- ✓ Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed

Where patient experience could improve

- Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Disturbance from hospital lighting: patients not being bothered at night by hospital lighting
- Feedback on care: patients being asked to give their views on the quality of their care
- Privacy for examinations: patients being given enough privacy when being examined or treated

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2021. Between January 2022 and May 2022, a questionnaire was sent to 1250 inpatients at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust who had attended in late 2021. Responses were received from 904 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Adult Inpatient Survey 2021 | RL1 | The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Action plan

The below action plan outlines suggested actions for improvement. Agreement of the actions will be taken through the MSK and Specialist Unit Governance meetings.

Area Requiring Improvement	Trust score	Top score in England	Actions Required	By Whom	By When
Q46 After leaving hospital did you get enough support to help recover or manage your conditions	5.7	8.2	Work with Ward Managers to understand advice and support offered to patients on discharge. Promoting attendance at Joint School to prepare patients expectations on discharge.	Specialist and MSK Matron/ Unit Clinical Governance Managers	March 2023
Q2 How did you feel about the length of time you were on the waiting list?	7.0	9.2	Links with one of the Trusts Quality Prioirties – Waiting Well Initiative	Beth Delgarnon and Sammy Davies	March 2023
Q5 Were you prevented from sleeping at night by noise by hospital lighting?	8.2	9.5	Discussion with Ward Managers to discuss what further actions can be taken to promote a positive sleep experience	Specialist and MSK Matron/ Unit Clinical Governance Managers	January 2023
Q49. During your stay were you asked to give your views on the quality of your care?	1.9	3.4	Patients are asked for their feedback after discharge via SMS text so patients would be asked. Further action required through ward communications to promote to patients that they will be asked for their	Unit Governance Managers /Ward Managers	Nov 22

			feedback whilst they are on the ward.		
Q28. Were you given enough privacy when being treated or examined?	9.9	9.9	Discussion to be had with Ward and Departmental Managers about what further actions can be taken. To note although this is highlighted as an area of improvement, the Trust scores the highest rating.	Ward Managers and Unit Governance Managers	January 2023

0. Reference Information

Author:	Ruth Longfellow, Chief Medical Officer	Paper date:	11 January 2023
Senior Leader Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper written on:	5 January 2023
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an update to Board members on key local activities across several business areas not covered within the main agenda.

2. Executive Summary

2.1. Context

This paper provides an update regarding some of the most noteworthy events and updates since the last Board from the Chief Medica Officer.

2.2. Conclusion

The Board is asked to note and discuss the contents of the report.

3. The Main Report

- **Integrated Care System critical incident**

Last week, due to a STW ICS critical incident and sustained UEC pressures, RJAH was asked to take patients from its neighbouring Trusts, onto Kenyon ward. The situation at SaTH was extreme, with long ambulance waits and corridor care exceeding normal levels, a picture that has been seen across the whole of the NHS. Due to the clinical risk to patients in SaTH and also patients waiting at home for ambulances, it was agreed that medically fit patients under the care of Shropshire Community Trust, waiting for their discharge package of care, could be transferred to RJAH. This was to free up beds in community hospitals, to provide space for patients to be discharged from SaTH. In total 14 patients have been transferred.

We would like to thank all the teams involved for providing care for these patients at such short notice.

Will be reviewing processes, to learn what went well and what issues were encountered.

- **Extended Surgical Team HEE funding application**

We were successful in our application to HEE for funding to take part in an Extended Surgical Team (EST) pilot. This has been developed following a RCS report that recognises that to improve patient care and to enhance the training experience for trainee surgeons, a new model of care is required.

The focus of this pilot is the role of the other, non-medical practitioner team members. Appropriately trained practitioners can be advantageous in the outpatient setting, the theatre environment and on the surgical ward. We have secured funding for two Physician Associates to join the arthroplasty team.

- **Zimmer Biomet Update**

The Trust were made aware of a Field Safety Notice implant recall for the NextGen knee implant, manufactured by Zimmer Biomet, in December 2022.

The Trust's implant manager confirmed that this implant has only been used in one patient at RJAH, and the patient has subsequently had a revision procedure, using a different implant.

The communication team issued a notice on the Trust website to reassure patients of the above, and that there was no need to contact to the hospital.

4.0. Conclusion

The Board is asked to note and discuss the contents of the report.

Chair's Assurance Report
Quality and Safety Committee 20 October 2022

0. Reference Information

Author:	Mary Bardsley, Acting Trust Secretary	**Paper date:**	11 January 2023
Executive Sponsor:	Sara Ellis Anderson, Chief Nurse, and Patient Safety Officer	**Paper written on:**	10 January 2023
Paper Reviewed by:	Chris Beacock, Quality and Safety Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Extraordinary Quality and Safety Committee meeting held on 22 December 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of patient safety and quality to the Quality and Safety Committee. This Committee is responsible for seeking assurance on the quality and safety of the services it delivers in order that it may provide appropriate assurance to the Board.

2.2 Summary

Key escalation and discussion points:

ALERT: areas of non-compliance/risk or matter to be addressed urgently
▪ There are no new risks to highlight to the Board
ADVISE: areas of on-going monitoring with new developments
▪ **Shoulder never event (declared in August 2022)** - Assured that processes are being followed and are in place. A validation exercise has been completed to identify the patients who will be contacted imminently. MHRA/CQC and system are aware and supporting the investigation. Partial assurance was given, this related to some patients are yet to be contacted.
ASSURE: areas of assurance
▪ **Performance Report** - The Committee commended the PIFU data along with the improvement within the complaints response rate, which has increased.

2.3. Conclusion

The Trust Board is asked to note the Chair's Report for assurance purposes and consider any additional assurances is required.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Extraordinary Quality and Safety Committee which met on 22 December 2022. The meeting was quorate with 2 Non-Executive Directors/ 1 Associate Non-Executive Director and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:			
Present:	Chris Beacock	Non-Executive Director (Chair)	CB
	Ruth Longfellow	Chief Medical Officer	RL
	Martin Newsholme	Non-Executive Director	MN
	Sara Ellis-Anderson	Chief Nurse and Patient Safety Officer	SEA
	Stacey Keegan	Chief Executive Officer	SK
In Attendance:	John Pepper	Associate Non-Executive Director	JP
	Kirsty Foskett	Head of Clinical Governance & Quality	KF
	Lisa Newton	Assistant Chief Nurse Specialist Unit	LN
	Mary Bardsley	Acting Trust Secretary	MB
	Jacqueline Barnes	Director of Improvement & Quality	JB
	Steph Wilson	Performance Insight & Improvement Manager	SW
	Heather Pickering	Executive Assistant (Minute Secretary)	H
Apologies:			
Penny Venables			

3.2 Actions from the Previous Meeting

Due the meeting being an extraordinary session, there were no actions for consideration.

3.3 Key Agenda

The Committee received all items required on the work plan (except IPC agenda items) with an outline provided below for each:

Agenda Item / Discussion	Assured	Assurance Sought
CNO and CMO Update		
Chief Nurse Update: • Shoulder never event declared in August 2022.	Partial	Assured that processes are being followed and are in place. A validation exercise has been completed to identify the patients who will be contacted imminently. MHRA/CQC and system are aware and supporting the investigation.
• longest waiting patient on the spinal ward.	Yes	The Trust met with the commissioners and a care package has been confirmed but being recruited to. Repatriation to local hospital has been suggested as an interim solution.

Chief Medical Officer Update: • the Zimmer Biomet NextGen knee implant and confirmed the recall does not affect RJAH.	Yes	1 RJAH patient alone received one of the implants in question and it was revised shortly afterwards, no other patients have received the implant. Information is available on the website for patients
• the Exactech recall.	Yes	Gaining support from Hill Dickinson to prepare communications for patients with FAQ and plan for reviewing patients which is due to take place early in the New Year.
Board Assurance Framework and Corporate Risk Register		
• 5 BAF Risks aligned to the Committee • 3 Corporate Risks of 15+ Following a query in relation to the complexity action, it was confirmed that a list of metrics for complex patients has been compiled and has presented interesting data. The Trust continue to investigate.	Yes	
Performance Report		
Area to highlight included: • Commended the Trust on the PIFU data • Queried how effective the pathways are for patients to get back in touch and re-enter the system to initiate follow-up. It was confirmed that patients re-contacting the Trust are monitored but will also look at the Patient Experience and Health Inequalities aspect to ensure a safety net is there for patients and they have all the information required. • 31 MCSI patients waiting for admission and requested further context and if a trajectory is being modelled. There is a suspected national increase in the spinal injuries network not just an increase at RJAH.	Yes	The Committee commended the PIFU data along with the improvement within the complaints response rate, which has increased.
Serious Incidents and Never Events		
Key points included: • 0 serious incidents or never events for November and to date in December • 1 Never event open with an RCA in the sign-off process • 2 Actions closed since last report The Trust confirmed that the shoulder introducer fragment never event will continue to be recorded as one incident with patients being followed up as part of the ongoing action plan being monitored through Q&S Committee.	Yes	
Health Inequalities		
The report gives examples of intelligence being populated within the health inequalities	Yes	Work is being completed to streamline reporting and links between Ethnicity

improvement dashboard and the recommendations are • Align internal reports with the national dashboard to increase regular oversight • Align ourselves with the reporting being developed nationally by the experts and ensure this is shared and connected with the System focus following observations of the outputs • The vision is to ensure high quality healthcare for all through equitable access and excellent experience and outcomes. Examples can be seen within the report.		and Disability issues. The Trust is to establish a Health Inequalities Group which report to EDI.
Items To Note		
• Chair Report Research Committee – noted • Chair Report Trust Performance and Operational Improvement Group – noted • Chair Report Childrens Board – noted • Work plan – noted	Y	

4. Conclusion

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

Trust Board - People & Workforce
November 2022 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

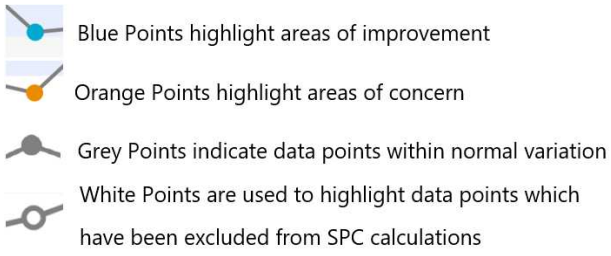
Different colours have been used to separate these trends of special cause variation:

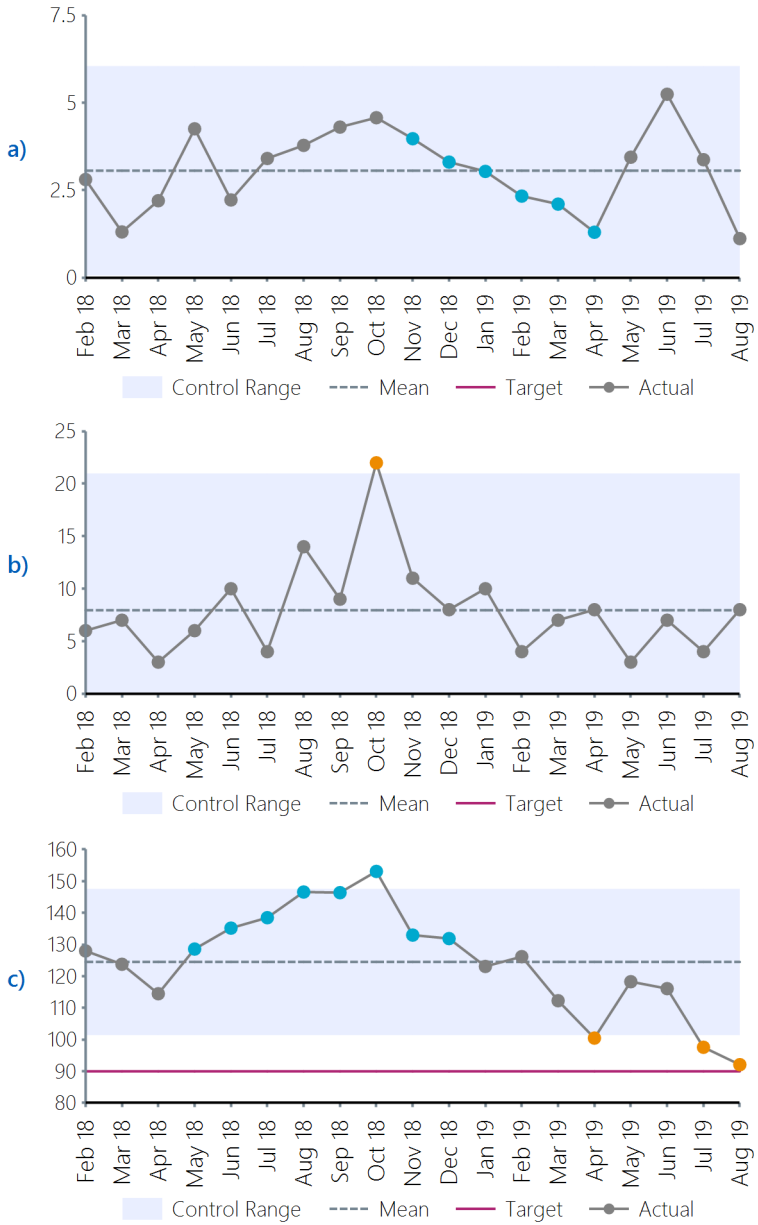
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.





Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?

Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

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

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

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

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	5.67%			?	+	27/02/20
Staff Turnover - Headcount	8.00%	12.45%		H	F	+	24/06/21
In Month Leavers		14			No Target	+	
Vacancy Rate	8.00%	9.91%		H	?	+	14/03/19

Summary - Caring for Finances

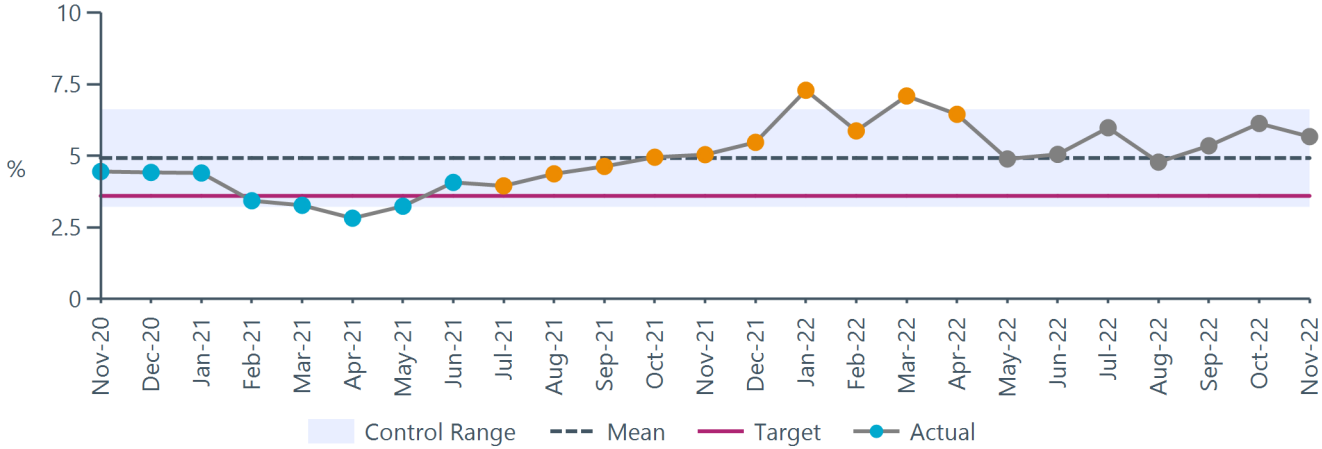
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Agency Core	132	273		H	?	+	

Sickness Absence

FTE days lost as a percentage of FTE days available in month 211161

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
3.60%	5.67%		



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others) as the target line sits within the control range.

Narrative

The sickness absence reported for November is 5.67% where 'infectious diseases' accounted for 0.42%, leaving remaining sickness at 5.25%. The rate remains within our control range. Further detail by area below:
* Specialist Unit - 6.79% (6.47% excluding 'infectious diseases') - hot spot areas; Outpatients Dept 19.57%, Gladstone Ward 14.50%
* MSK Unit - 5.53% (5.06% excluding 'infectious diseases') - hot spot areas; Therapies T&O 23.96%, Pre-Op Assessment Unit 14.70%
* Corporate areas - 4.87% (4.41% excluding 'infectious diseases') - hot spot areas; Research 14.77%, Housekeeping 11.62%

'Anxiety/stress/depression/other psychiatric illnesses' was the highest reason for absence in all areas.

Actions

The Chief People Officer has commissioned a review of the Trust's Sickness Policy with an external third party. This review is due for completion with feedback to the People Committee in January. Bite-size training sessions have been scheduled through to March. Invites have been sent to managers to book onto sessions.

In recognition of winter-related illnesses, we would anticipate short term sickness to increase during this winter period, as can be seen in this period last year. To support the health of the workforce, the Trust continues to encourage staff to take up the offer of both covid and flu vaccinations. The current update, as at 7th December is 54.79% for flu and 48.63% for covid.

For long-term sickness, a review of current cases has been undertaken with relevant managers to ensure management plans are in place for each individual. Once approved, the new policy will have some changes to monitoring long term sickness with a key milestone approach.

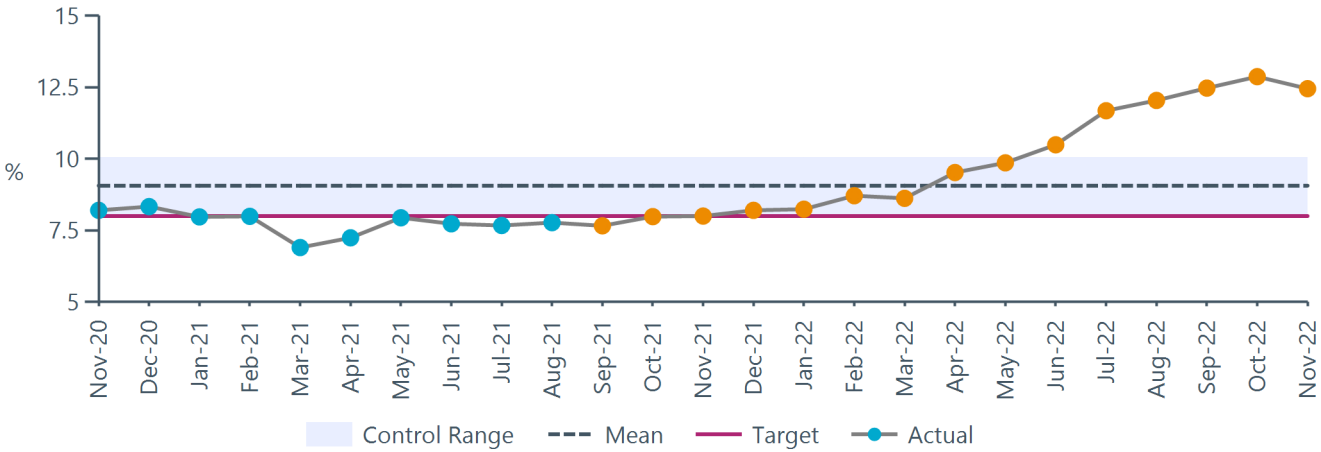
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
5.04%	5.47%	7.29%	5.87%	7.09%	6.45%	4.89%	5.05%	5.98%	4.78%	5.35%	6.13%	5.67%

Staff Turnover - Headcount

Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 217394

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	12.45%	H	F



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

Staff Turnover, at Trust level, has now been reported above the 8% target since November-21. The November rate of 12.45% remains above the control range. Five out of eight staff groups are reported above 8% as follows:
- Allied Health Professionals - 14.51%
- Nursing and Midwifery - 14.37%
- Additional Clinic - 14.01%
- Estates and Ancillary - 13.64%
- Administrative and Clinical - 10.53%

In the latest twelve month period, December-21 to November-22, there have been 203 leavers throughout the Trust. This is in relation to a headcount in post of 1631, as at 30th November 2022. The top three reasons for leaving that accounts for 113 leavers/56% at Trust level were:
* Voluntary Resignation - Other/Not Known - 44 / 21.67%
* Retirement age - 35 / 17.24%
* Voluntary Resignation - Work Life Balance - 34 / 16.75%

Actions

Actions in relation to voluntary staff turnover include:
* Therapies has been highlighted as a 'hot spot' area. This area has undergone a full service review to assesses workforce and clinical pathways. Report currently being reviewed before wider dissemination.
* Revised policies for Staff Exits and Keeping In Touch Conversations to be prepared by Head of Resourcing will a new process role out in quarter 4.

STW ICB have developed a Recruitment and Retention Strategy/Workplan to drive improvements in retention, with RJAH a partner organisation in the group. Themes included are:
* Effective use of turnover data
* Meeting the needs of a modern workforce - flexible working
* Recruit and retain existing and experienced workforce (professional development and careers)
* Looking after our People Health and Wellbeing

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
8%	8%	8%	8%	8%	9%	9%	10%	11%	12%	12%	12%	12%

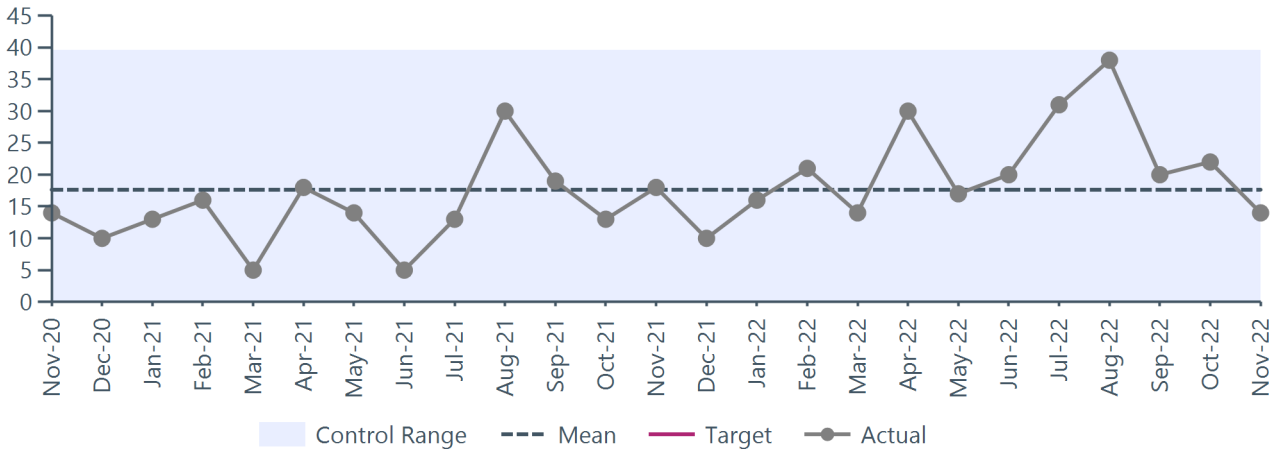
- Staff - Patients - Finances -

In Month Leavers

Number of leavers in month 217809

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
-	14		No Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing common cause variation. Target to be agreed for this new KPI.

Narrative

This is a new KPI that has been added this month to provide details on the number of leavers in month, as opposed to a rolling twelve month position that has historically been reported through the Staff Turnover metric.

In November, 14 staff left the Trust. These were from the following areas of the Trust; MSK Unit (7), Corporate areas (5) and Specialist Unit (2). Those staff that left in November by staff group were Administrative & Clerical (4), Nursing & Midwifery Registered (3), Medical & Dental (2), Additional Clinical Services (2), Allied Health Professionals (2) and Estates & Ancillary (1).

Reasons for leaving were categorised as end of fixed term contract (2), lack of opportunities (2), relocation (2), work life balance (2), employee transfer (1), retirement age (1), health (1), other/Not known (1), promotion (1) and to undertake further education (1).

Actions

As this is a new measure the themes and findings will be analysed to arrive at appropriate actions. People Committee are asked to consider the appropriate target for this measure. Based on data for the past 25 months, there have been, on average, 18 leavers per month.
Actions that were already in place in relation to turnover are:
* Therapies has been highlighted as a 'hot spot' area. This area has undergone a full service review to assesses workforce and clinical pathways. Report currently being reviewed before wider dissemination.
* Revised policies for Staff Exits and Keeping In Touch Conversations to be prepared by Head of Resourcing will a new process role out in quarter 4.

STW ICB have developed a Recruitment and Retention Strategy/Workplan to drive improvements in retention, with RJAH a partner organisation in the group. Themes included are:
* Effective use of turnover data
* Meeting the needs of a modern workforce - flexible working
* Recruit and retain existing and experienced workforce (professional development and careers)
* Looking after our People Health and Wellbeing

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
18	10	16	21	14	30	17	20	31	38	20	22	14

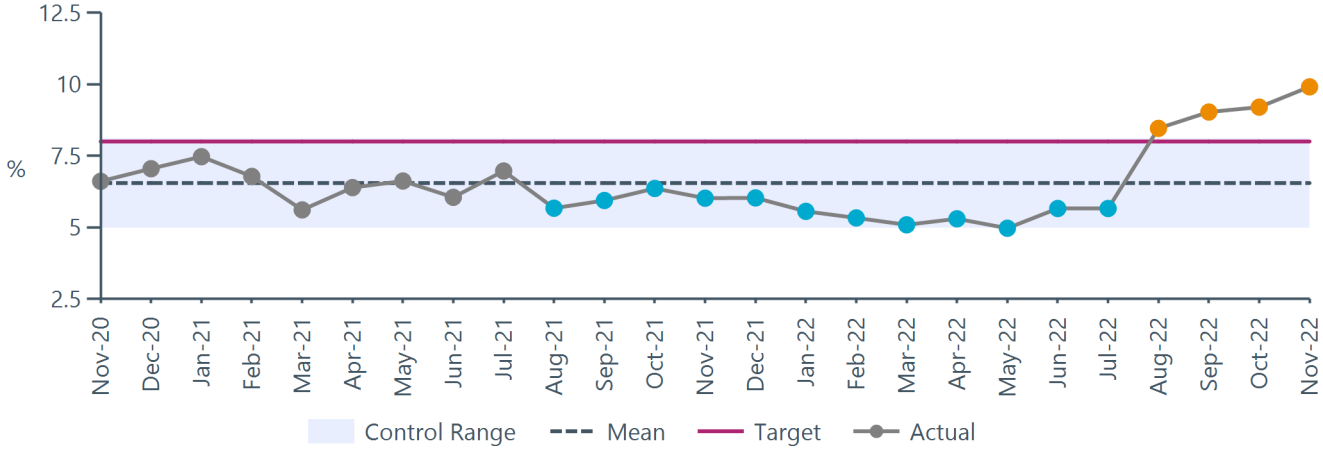
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	9.91%	H	?

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently meeting the target as the control range sits below the target line.

Narrative

The vacancy rate is reported at 9.91% this month and exceeds the 8% target for a fourth month. This equates to vacancies across the Trust at 155.68 WTE. The data remains special cause variation of concern above our expected control range.

A breakdown by area is:
- Specialist Unit - 11.53% / 49.87 WTE vacant
- MSK Unit - 10.21% / 70.25 WTE vacant
- Corporate areas - 7.89% / 35.56 WTE vacant

Further details on the staff groups is provided against other KPIs (Nursing, Radiographers and Healthcare Support Workers). The vacancy rate for Allied Health Professionals is another hot spot area so this will be added as an additional KPI next month. At the end of November the vacancy rate for this staff group was 6.43% that equates to 11.04 WTE.

Actions

Actions in this area include:
* Revised policies for Staff Exits and Keeping In Touch Conversations to be prepared by Head of Resourcing with a new process role out in quarter 4.
* Rolling adverts are now in place for Nursing and Healthcare Support Worker vacancies.
* Following initial focus upon Registered Nursing and Healthcare Support Worker fill rates, the bi-weekly Recruitment Working Group will expand reporting to consider vacancy rates in other staff groups above target and without recruitment pipeline. This will support need identification for registered staff international recruitment.
* Weekly review of recruitment pipeline to ensure minimal delays in recruitment checks process.

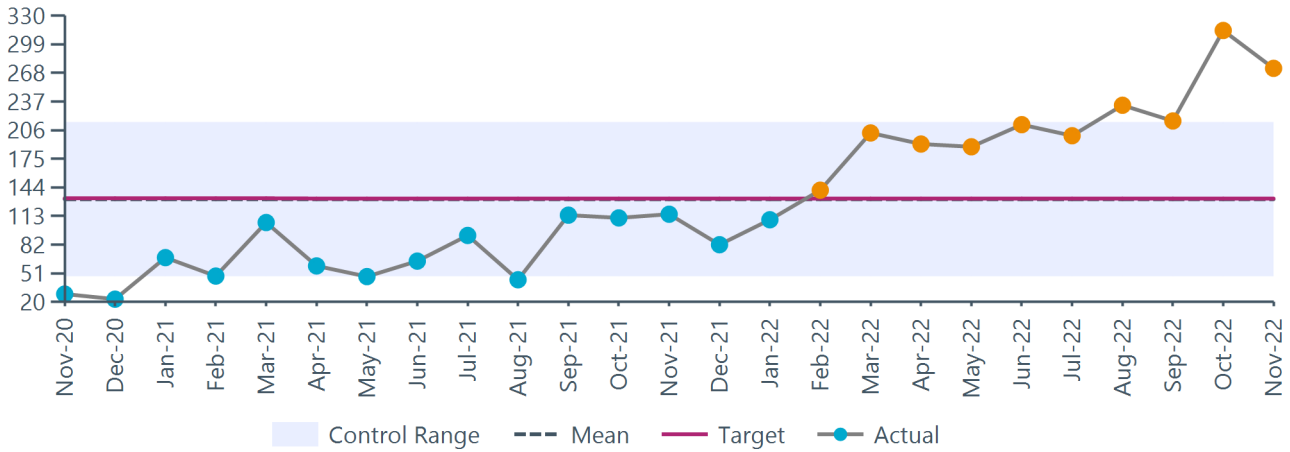
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
6.02%	6.03%	5.56%	5.33%	5.09%	5.30%	4.97%	5.66%	5.66%	8.46%	9.03%	9.20%	9.91%

Agency Core

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency only 216336

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
132	273	H	?



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of concern. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

Core agency adverse to cap driven by vacancy rates and absence levels. Decrease in monthly agency spend of £41k from last month.

Actions

Agency overseen by People Committee for oversight and context against recruitment objectives.
Recruitment plans focus, particularly registered nursing, HCA and consultants (anaesthetics, rheumatology, MCSI).
Trainee nurse associate initiatives supported to increase workforce numbers.
International recruitment second cohort H2.
Launch of bank incentives and bonus scheme.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
115	82	109	141	203	191	188	212	200	233	216	314	273

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Liz Hammond, FTSU Guardian	Paper date:	24th November 2022
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	NA	Paper Ref:	N/A
Forum submitted to:	People and Culture Committee	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to People and Culture Committee and what input is required?

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q2. The paper was presented the People and Culture Committee where it was asked to note the content and agree any subsequent recommendations/actions.

1.2. Context

The Trust Board should seek assurance from the FTSUG and Executive Lead that staff are confident in the process of Speaking Up and that appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues and that learning is being identified and shared across the Trust.

2.2. Summary

The number of cases raised has remain static. Due to a change in the National Guardian Data (NGD) collection this will impact on the numbers collated on certain categories.

Eight Champions have been trained in the Trust to promote, support and signpost staff when they raise a concern. FTSU month was celebrated by promoting and the FTSU Champions to the Trust via communicate.

2.3. Conclusion

The Board is asked to note the content of the report and agree the recommendations as described above.

2. The Main Report

2.1. Introduction

The Trust board should seek assurance from the FTSUG and Executive Lead that staff are confident in the process of Speaking Up and that appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues and that learning is being identified and shared across the Trust.

2.2. Assessment of cases

The assessment for the NGO Data has been changed for the way that the Guardians record the professional groups. The original data require was:-

Numbers of cases brought by professional group
Administrative/clerical staff
Allied Healthcare Professionals (other than pharmacists)
Board members
Cleaning/Catering/Maintenance/Ancillary staff
Corporate services
Dentists
Doctors
Healthcare assistants
Midwives
Nurses
Not Known
Pharmacists

This has now been changed to:-

Allied Health Professionals
Medical and Dental
Ambulance (operational)
Registered Nurses and Midwives
Administrative and clerical
Additional professional scientific and technical
Additional clinical services
Estates and ancillary
Healthcare scientist
Not Known
Other

This Quarter we have received five concerns. Four out of the five concerns were from the Administrative and clerical profession. As the administrative and clerical profession now includes, non-clinical managers, administration officers, executive board members, who do

Freedom to Speak Up – Guardian R

not have significant patient contact as part of their role, this will increase the number of staff falling into this category.

Below is the latest Quarterly Data:-

Data For Quarter		April 2022- March 2023							
Organisation		Robert Jones & Agnes Hunt Orthopedic NHS Foundation Trust							
Size of organisation		Small Under 5,000							
Region		Midlands							
								April-June	**July-Sept**
Number of cases brought to FTSUGs per quarter								7	5
Numbers of cases brought by professional level									
Worker								1	5
Manager								2	0
Senior leader								0	0
Not disclosed								4	0
Numbers of cases brought by professional group									
Allied Health Professionals								0	0
Medical and Dental								2	0
Ambulance (operational)								0	0
Registered Nurses and Midwives								0	0
Administrative and clerical								1	3
Additional professional scientific and technical								0	1
Additional clinical services								0	0
Estates and ancillary								0	0
Healthcare scientists								0	0
Students								0	0
Not Known								0	0
Other								4	1
Of which there is an element of									
Number of cases raised anonymously								4	0
Number of cases with an element of patient safety/quality								3	1
Number of cases with an element of worker safety or wellbeing								0	1
Number of cases with an element of bullying or harassment								0	0
Number of cases with an element of other inappropriate attitudes or behaviours								1	1
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'de									
Response to the feedback question,									
'Given your experience, would you speak up again?									
Total number of responses									
The number of these that responded 'Yes'								1	1
The number of these that responded 'No'								1	0
The number of these that responded 'Maybe'								0	
The number of these that responded 'I don't know'								0	
The number of these that responded 'I don't know'								0	

Until the end of Quarter 2, 22/23 three contacts remain open.

Reasons for cases remaining open are: -

Complex employee relation issues,

Cases are being actively addressed.

The number of concerns raised remain consistent to previous quarters. There is one department which remains a concern. This area has been highlighted to the Executives and Managing director of MSK. The case remains active.

Learning and Improvement

Learning and improvement is a challenge as may concerns raised are often individual difficulties and queries.

Training packages for Managers on how to deal with staff speaking up have been developed and require implementation.

FTSU is triangulating the RJAH NGO date with Datix.

Speak up, and Listen up, HEE training package have been completed by the Board.

The FTSUG attends events and meetings organised by the NGO. This, as well as the NGO bulleting enables the Guardian to keep up to date with developments in the FTSU area, which in turn supports the handling of concerns effectively.

FTSUG attends monthly regional meetings where updates and good practice is shared.

Feedback

Feedback to staff has been difficult, as once the concern has been escalated to the appropriate manager, the Guardian is sometimes taken out of the feedback loop. It is not clear if the person who has raised the concern has received feedback from the manager dealing with the escalated concern.

To counter this FTSU have contacted the person who raised the concern to check on how they are and to ascertain if they have received feedback. Correspondence is also sent to the person dealing with the concern and asked to update and feedback actions and learning achieved.

Staff, who have responded to the feedback about their experience of the FTSU have said they would use the facility again and would recommend it to other staff.

Patient Safety or worker experience issues

Themes

FTSU has been contacted, this quarter, with one patient safety issue, one bullying concern, one worker safety and two process/ system concerns.

Patient Safety

Action taken in response to this concern involved escalating to the Chief Medical Officer. The outcome and learning concluded that better communication and real time data entry on Blue Spier would give a clear picture of the chain of events.

Worker Safety

This has been escalated. Concern remains active. Preventative and safeguarding measures in place.

The Trust Datix system has captured 32 worker safety incidents. The Trust datix concerns do not capture the concern raised to FTSU and there are no themes that linked to FTSU concerns.

Bullying and Harassment

Sign posted for advice to Trade Union as this is an isolated issue reported to FTSU. Area noted in case there is an increase of concerns raised in this department.

The Trust Datix system has captured two cases of bullying within this quarter. The concerns came from different departments.

No exit interviews have been facilitated by the FTSUG this quarter.

Increased triangulation of data is required with the quality and inclusion. At the present time this post is vacant

2.3. Actions to improve FTSU culture

FTSU Is impartial and confidential service.

All concerns raised have been responded to within 48hrs and escalated if required or signposted to the appropriate department.

Eight Champions have been trained to promote FTSU, support and signpost anyone, raising a concern, to the appropriate person. Confidentiality and a person's right to anonymity has been a key theme in the training.

The Champions have been encouraged to take advantage of Audit Day to give a short presentation in their departments about the FTSU service and to give staff the opportunity to contribute by speaking up about improvements for patients and staff working environment.

The Trust has engaged a diverse group of Champions so that staff, who find it difficult to speak up, have a varied group of staff who they can confide in. With the addition of the Champions this has raised awareness of FTSU and given staff a wider choice of staff they feel comfortable speaking to.

There have been no cases of anyone, who has raised a concern, reporting that they have suffered detriment due to speaking up.

An intranet page, on Percy, specifically for FTSU is available for information and contact details of the Guardian and Champions.

To improve the skills, knowledge, and capability of workers to speak up Speak up and Listen Up sessions are required in all departments. Staff need to be given the tools to enable them to Speak up.

Mandatory HEE FTSU training to be introduced.

A visible presence of the FTSUG around the Trust. This is restricted at this time due to ringfenced time available, to fulfil the basic requirements of the role

2.4. Recommendation

The Trust has a FTSU Action Plan pertaining to the recent self-assessment. However, with a renewed focus on improving the speaking up culture of the Organisation, there are further recommendations to consider.

- Ensure there are visible FTSU posters accessible for all staff.
- All managers to feedback and liaise with the FTSUG about actions and learning to provide a feedback loop and share learning experiences.
- A visible presence of the FTSUG around the Trust. This is restricted at this time due to ringfenced time available, to fulfil the basic requirements of the role
- Review the ring-fenced time for the FTSUG.
- Consider whether FTSU HEE training packages should be mandated.
- Consider enhanced, bespoke FTSU training for managers.

2.5. Conclusion

The Board is asked to note the content of the report and agree the recommendations as described above.

Chair's Assurance Report
People and Culture Committee – 22nd December 2022

0. Reference Information

Author:	Mary Bardsley, Acting Trust Secretary	**Paper date:**	11 January 2023
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	06 January 2023
Paper Reviewed by:	Martin Evans, Chair of People & Culture Committee	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Extraordinary People Committee meeting held on 22nd December 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the People Committee. This Committee is responsible for seeking assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

Key escalation and discussion points:

ALERT: areas of non-compliance/risk or matter to be addressed urgently
▪ No new risks to highlight to the Board
ADVISE: areas of on-going monitoring with new developments
Recruitment and Retention Deep Dive - The Committee were partially assured that plans are in place to support and improve the recruitment however ongoing concerns of gaps in staffing levels were noted as a concern. The committee felt that there was a need for a stap change in the Trust's approach to recruitment. This will remain a focus area for the Committee and note the recruitment challenges impacts the overall operational and financial delivery for the Trust.
ASSURE: areas of assurance
▪ **Nursing Staff Workforce -** The Committee agreed that the report is of value to offer assurances and focus. To improve further, the Committee asked triangulation to activity and the impact of this on the Trust.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

The Board of Directors is asked to consider and approve the Equality Workforce Annual Report following a recommendation from the People and Culture Committee.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the People Committee which met on 22nd December 2022. The meeting was quorate with 1 Non-Executive Director, 2 Associate Non-Executive Directors and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Martin Evans	Associate Non-Executive Director (Chair)
Chris Beacock	Non-Executive Director
Denise Harnin	Chief People Officer
Sara Ellis-Anderson	Chief Nurse and Patient Safety Officer
Stacey-Lea Keegan	Chief Executive Officer
In Attendance:	
Jacqueline Barnes	Director of Quality and Improvement
Andrea Martin	Interim Deputy Chief People Officer
Mary Bardsley	Acting Trust Secretary
Amber Scott	Executive Assistant (minute secretary)
David Gilburt	Associate Non-Executive Director
Apologies:	
Mike Carr, Ruth Longfellow, Sarfraz Nawaz, Penny Venables and Craig Macbeth.	

3.2 Actions from the Previous Meeting

As there meeting was an extraordinary meeting, there were no actions tabled for discussion.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured	Assurance Sought
Performance Report		
The Committee noted the performance report and agreed the focus of the meeting was recruitment and retention. The vacancies rates were highlighted as a concern to which the Trust confirmed detail would be presented within the deep dive presentation.	N/A	
Recruitment and Retention Deep Dive		
The Committee welcomed the deep dive into recruitment and retention which led to an in-depth discussion on actions being implemented, monitored and further areas of focus- these include: ▪ The information team are working on developing data and a dashboard ▪ The learning and development team are creating opportunities for staff professional development ▪ Clinical teams are focussing on recruiting staff and creating new roles. ▪ the Consultant vacancies have significantly reduced, anaesthetics remaining the main key area of focus. ▪ Focusing on maximising our advertising ▪ Encouraging staff to stay and understanding what we can do to support	Partial	The Committee were partially assured that plans are in place to support and improve the recruitment however ongoing concerns of gaps in staffing levels were noted as a concern. The committee felt that there was a need for a stap change in the Trust's approach to recruitment.

▪ Ensuring new starters have a valuable experience ▪ Complying with any national/regional must do's ▪ Getting the core basics right and building on successes. Examples were highlighted in the meeting of some current adverts that are showing incorrect detail which could put potential applicants off. ▪ Consideration being given to offering staff the national living wage rather than the national minimum wage. ▪ Ensure adverts for recruitment are attractive and information is correct – a link to the Trust website to be embedded.		This will remain a focus area for the Committee and note the recruitment challenges impacts the overall operational and financial delivery for the Trust.
Chair Report: Recruitment Working Group		
The Chair report was noted by the Committee with all detail discussed under the previous agenda item.	Yes	
Nursing Staff Workforce		
The key messages were highlighted: ▪ fill rates do remain above target, although this is only being achieved using bank, agency, and closure of beds ▪ bed closures have been on Kenyon ward to move staff into MCSI and Powys for safety reasons. ▪ 15 red flags have been reported for October have been reviewed against patient safety incidents and no patient harm has occurred because of staffing levels. ▪ an increased risk, particularly for registered nurse vacancies on MCSI. Assurance was provided that work is ongoing to address the Pastoral support role that is required to support international recruitment.	Yes	The Committee agreed that the report is of value to offer assurances and focus. To improve further, the Committee asked for triangulation to activity and the impact of this on the Trust.
Agency Usage		
The Committee noted the report as an update. It was highlighted that most Trusts are in a similar position across the region. The usage will continue to be presented at the meeting for oversight.	Yes	
Industrial Action Update		
It was confirmed that the Trust will be included in the industrial action scheduled for January. The Committee were assured that robust processes have been implemented to consider and monitor the plans, operational impact, and staffing levels.	Yes	
Workforce Equality Report		
The Workforce Equality Report was presented for consideration before onward presentation at the Board. Assurance was obtained in the following areas: ▪ EDI group has been re-established ▪ Annual Report include the WRES and WDES data which is a statutory requirement Areas for further consideration/improvement included: ▪ Health inequalities information in respect of patients – a working group is to be established ▪ No medical staff are shown as registered as disabled – deep dive to be completed ▪ Increased inclusion agenda throughout the Trust ▪ Continue with the implementation of the actions	N/A	
Chair Report: EDI Meeting		
The chair report was noted by the Committee.	Yes	

4.0 Conclusion

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

Trust Board - Performance
November 2022 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

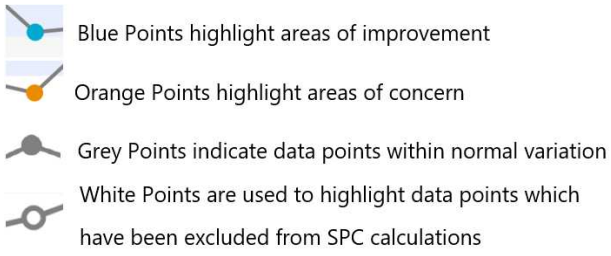
Different colours have been used to separate these trends of special cause variation:

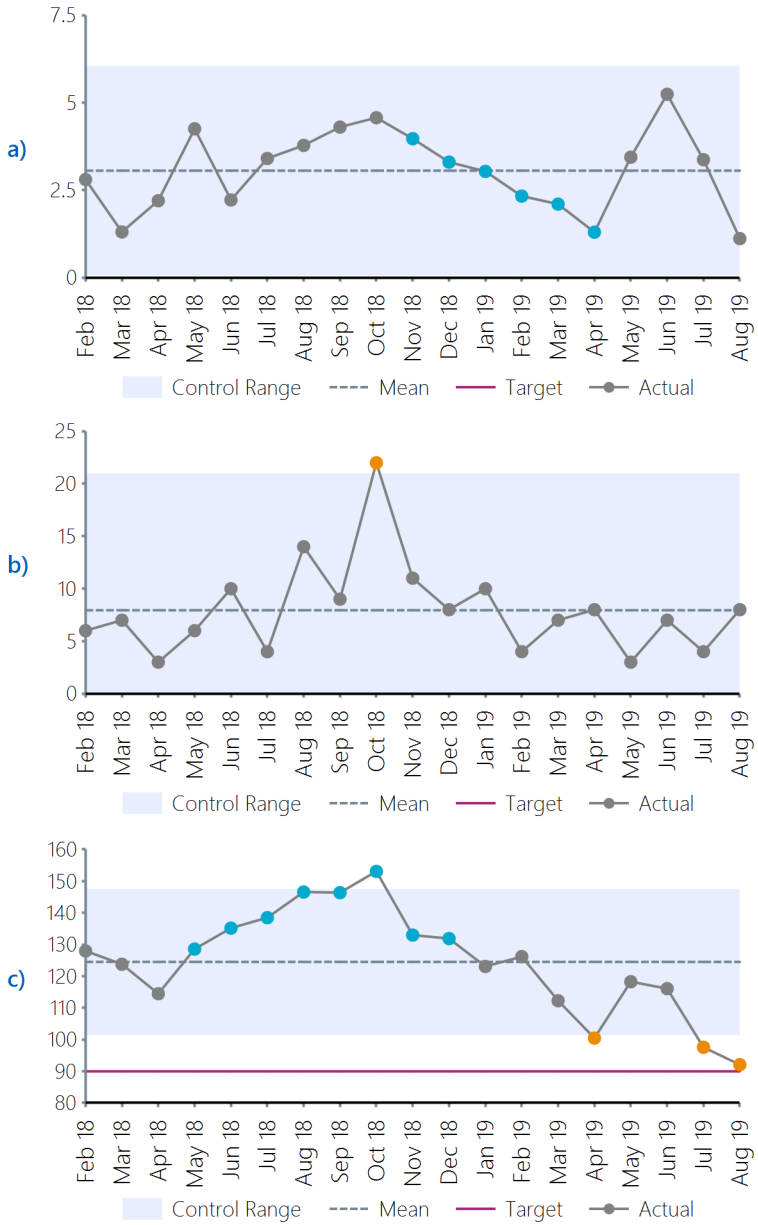
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.





Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?

Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

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

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

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

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
31 Day Subsequent Treatment (Tumour)					?		
Cancer Plan 62 Days Standard (Tumour)*	85%	100%			?	+	
18 Weeks RTT Open Pathways	92.00%	55.53%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,616	1,843	H	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,148		H	No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	371	345	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		304	345	H	No Target	+	
Patients Waiting Over 104 Weeks - English	0	33	33	L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		56	93	L	No Target	+	
Overdue Follow Up Backlog	5,000	13,151		L	F	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
6 Week Wait for Diagnostics - English Patients	99.00%	66.73%		L	F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	69.52%		L	F	+	

Summary - Caring for Finances

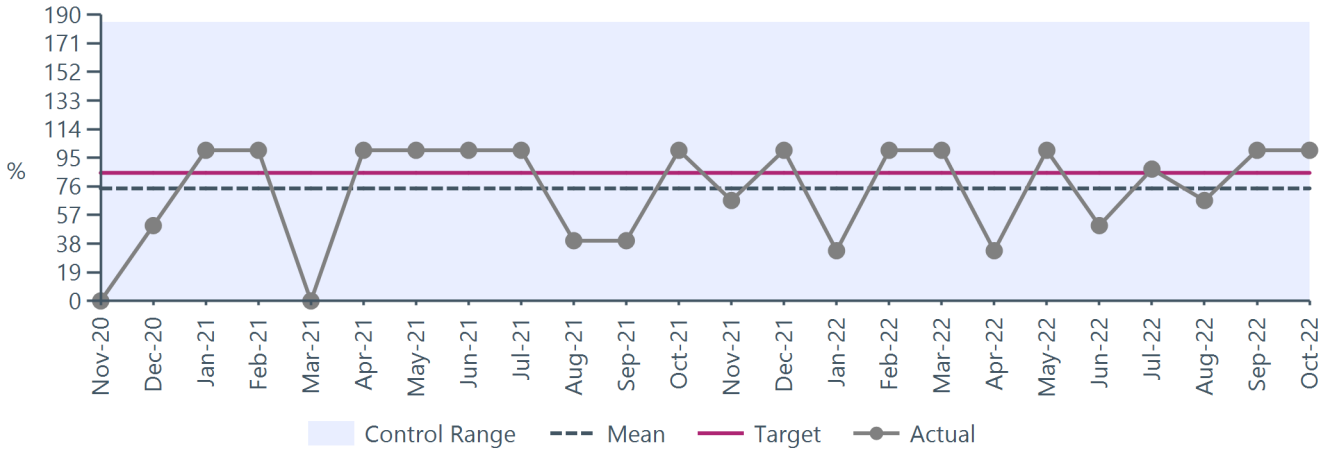
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,171	1,006	921	H	Moving Target	+	
Bed Occupancy – All Wards – 2pm	87.00%	86.62%		H	F	+	09/03/22
Total Outpatient Activity against Plan (volumes)	16,537	14,137			Moving Target	+	
Total Outpatient Activity - % Moved to PIFU Pathway	4.00%	6.83%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,509	2,871		H	Moving Target	+	

Cancer Plan 62 Days Standard (Tumour)*

% of cancer patients treated within 62 days of referral (*Reported one month in arrears) 211045

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85%	100%		



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

This KPI has been included as an exception this month to draw attention to an update to the September figures. Last month we reported performance as 66.67% against the 85% target and this was a result of a breach pathway that had been attributed to RJAH in error. This has now been rectified on the national database by the relevant Trust and the standard is reported at 100%.

Actions

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
66%	100%	33%	100%	100%	33%	100%	50%	87%	66%	100%	100%	

- Staff - Patients - Finances -

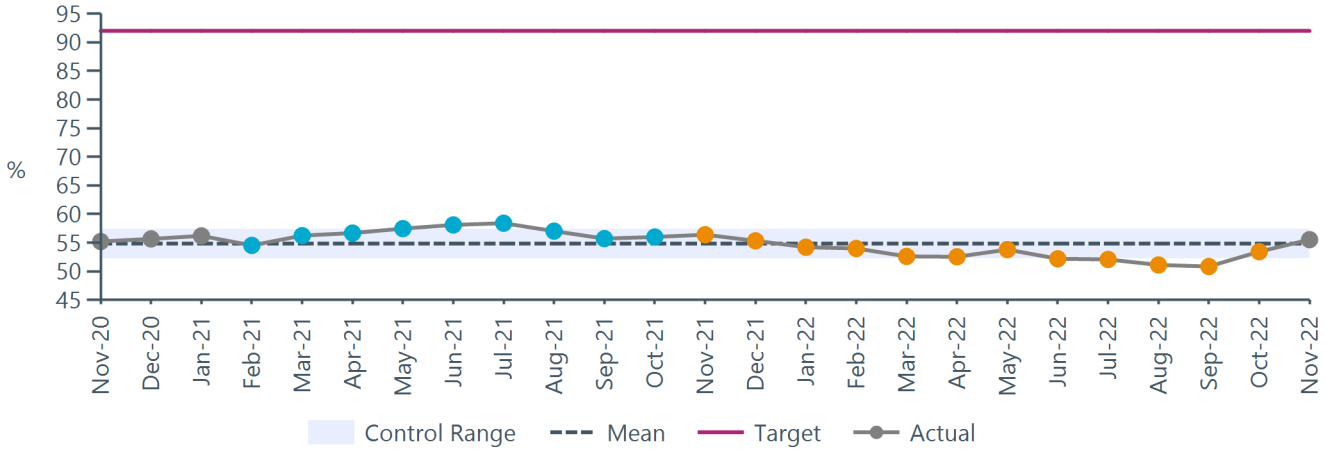
18 Weeks RTT Open Pathways

% of English patients on waiting list waiting 18 weeks or less 211021

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	55.53%		F

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing common cause variation. Metric is consistently failing the target.

Narrative

Our November performance was 55.53% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows:
* MS1 - 8134 patients waiting of which 1952 are breaches
* MS2 - 1632 patients waiting of which 1088 are breaches
* MS3 - 4796 patients waiting of which 3435 are breaches

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 - exceptions are patients choice/specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patient choice / specific specialties
* Develop plans to reduce 52 week waits with ambition to eliminate them by March 2025

Actions

The Operational Team is leading on revised demand and capacity assumptions to inform future planning and future waiting list management. Further detail provided against the list size and weeks waits KPIs.

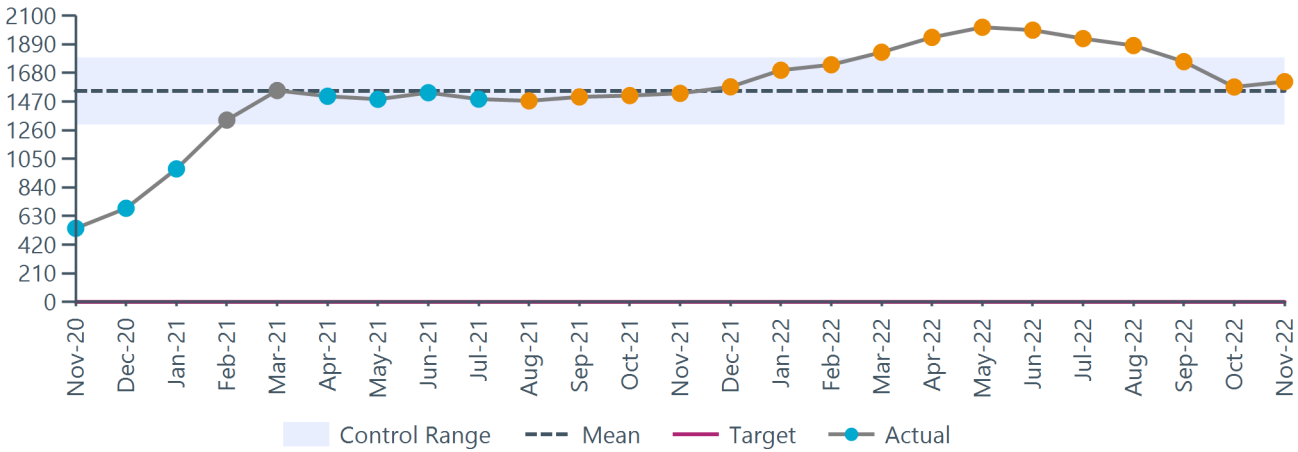
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
56.39%	55.33%	54.21%	53.99%	52.60%	52.54%	53.79%	52.19%	52.07%	51.11%	50.84%	53.43%	55.53%

Patients Waiting Over 52 Weeks – English

Number of English RTT patients waiting 52 weeks or more at month end 211139

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,616	H	F



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

At the end of November there were 1616 English patients waiting over 52 weeks; below our trajectory figure of 1843 by 227. The patients are under the care of the following sub-specialities; Spinal Disorders (625), Arthroplasty (348), Knee & Sports Injuries (310), Upper Limb (138), Foot & Ankle (115), Spinal Injuries (35), Paediatric Orthopaedics (20), Neurology (9), Tumour (5), Metabolic Medicine (4), Rheumatology (3), Paediatric Medicine (2), Orthotics (1) and Occupational Therapy (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1245 patients
- >78 to <=95 weeks - 266 patients
- >95 to <=104 weeks - 72 patients
- >104 weeks - 33 patients

2022/23 operational planning guidance stipulates that Trusts should:
* Develop plans that support an overall reduction in 52-week waits where possible, in line with ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties
The submitted plans have been reflected in the trajectory line above.

Actions

The Trust is currently focusing on greater than 52 weeks that will be 78 weeks by the end of March. Increased bookings for non-admitted pathways is where concentrated efforts are being made. Please see 78+ weeks indicator for further actions.

The Trust continues to utilise, and have in place, a mutual aid co-ordinator and validation resource to support actions being taken.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
1530	1578	1700	1740	1832	1941	2015	1994	1932	1881	1763	1577	1616

Patients Waiting Over 52 Weeks - Welsh (Total)

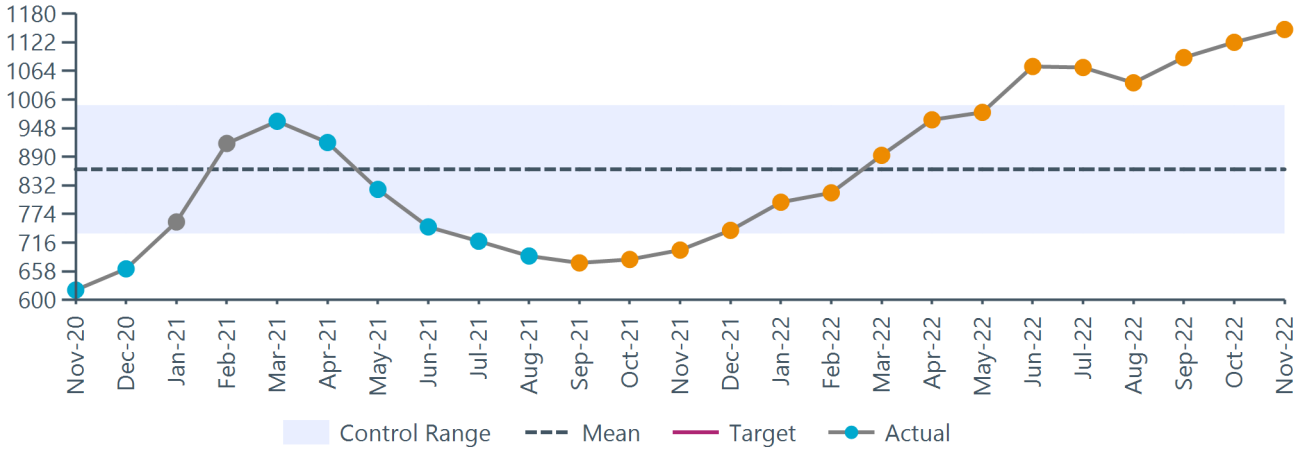
Patients Waiting Over 52 Weeks - Welsh (Total) - Welsh and Welsh (BCU Transfers) combined 217788

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	1,148	H	No Target

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of November there were 1148 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (754), Arthroplasty (133), Knee & Sports Injuries (107), Upper Limb (53), Foot & Ankle (47), Veterans (22), Paediatric Orthopaedics (19), Spinal Injuries (8), Metabolic Medicine (2), Tumour (2) and Paediatric Medicine (1).
The patients are under the care of the following commissioners; BCU (643), Powys (483), Hywel Dda (10), Cardiff & Vale (1) and Abertawe Bro (1). The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 844 patients
- >78 to <=95 weeks - 203 patients
- >95 to <=104 weeks - 45 patients
- >104 weeks - 56 patients

The Welsh Government issued their elective recovery guidance on the 26 April-22 where it stipulates the following:
* Eliminate the number of people waiting longer than one year in most specialties by Spring 2025
* Eliminate the number of people waiting longer than two years in most specialties by March 2023

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients in milestone 1 and there has been a focus in December to date patients currently waiting in this milestone, utilising capacity across the consultant workforce.

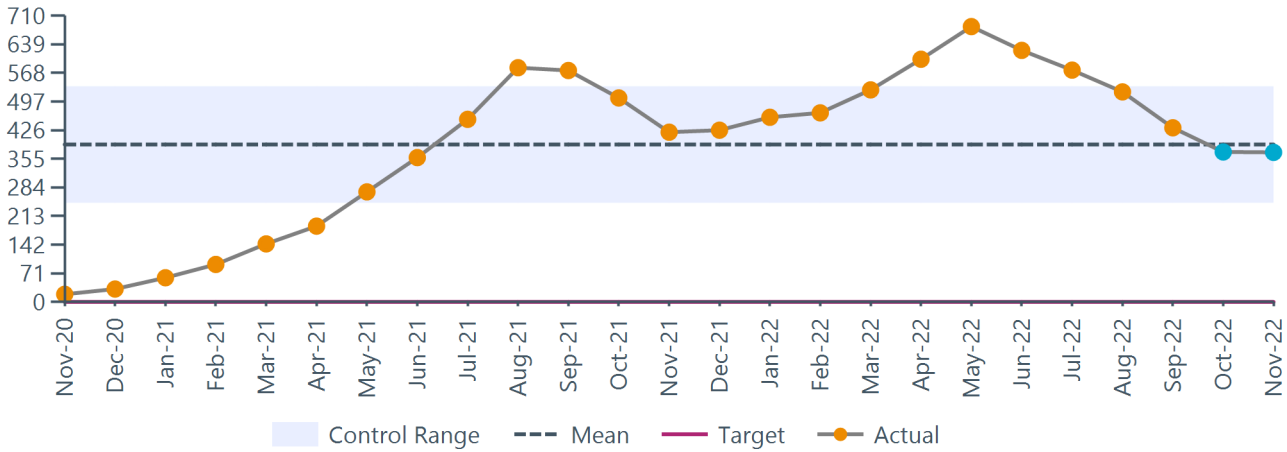
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
701	741	798	817	893	965	980	1073	1071	1040	1091	1122	1148

Patients Waiting Over 78 Weeks - English

Number of English RTT patients waiting 78 weeks or more at month end 217774

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	371	L	F



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric is consistently failing the target.

Narrative

At the end of November there were 371 English patients waiting over 78 weeks; this was 26 patients above our trajectory of 345. There have now been six months of consistent reduction and the data point is flagged as improvement. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Spinal Disorders (223), Knee & Sports Injuries (76), Arthroplasty (26), Upper Limb (24), Foot & Ankle (10), Spinal Injuries (5), Neurology (3), Tumour (2) and Paediatric Orthopaedics (2).

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 by July 2022 - exceptions are patients choice / specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patients choice / specific specialties
The submitted plans have been reflected in the trajectory line above.

Actions

The Trust continues to contact patients, and seek mutual aid, to support its most pressured service. Conversations with a regional provider continue to support both non-admitted and admitted pathways. Discussions are now progressing with a North-West provider to offer further mutual aid. NHS EI regional team are supporting progress for further support with recent returns stipulating our spinal disorders need. Progress has been made internally in reducing and dating patients within non-admitted pathways.

Utilisation of capacity across the consultant workforce continues.

The Trust has agreed participation in the Digital Mutual Aid system that is being led by NHS England.

A mutual aid co-ordinator and validation resource are in place to support actions being taken.

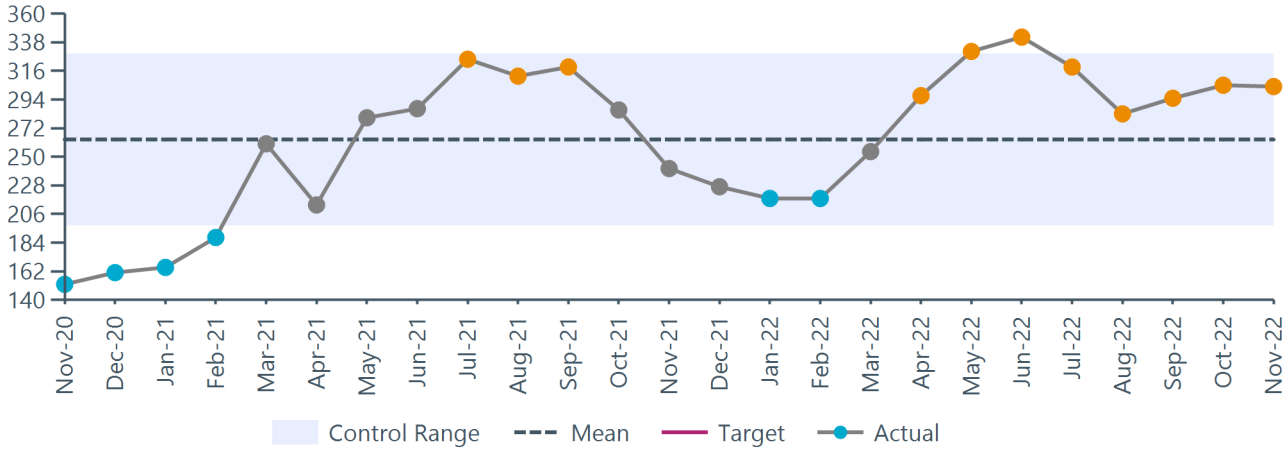
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
421	426	458	469	526	602	683	624	575	521	432	372	371

Patients Waiting Over 78 Weeks - Welsh (Total)

Patients waiting over 78 Weeks - Welsh (Total) 217802

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	304	H	No Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of November there were 304 Welsh patients waiting over 78 weeks; this was 41 patients below our trajectory of 345. The Trust plans are visible in the trajectory line above.

The patients are under the following sub-specialties; Spinal Disorders (272), Knee & Sports Injuries (16), Upper Limb (6), Arthroplasty (4), Foot & Ankle (2), Veterans (1), Spinal Injuries (1), Tumour (1) and Paediatric Orthopaedics (1).

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients in milestone 1 and there has been a focus in December to date patients currently waiting in this milestone, utilising capacity across the consultant workforce.

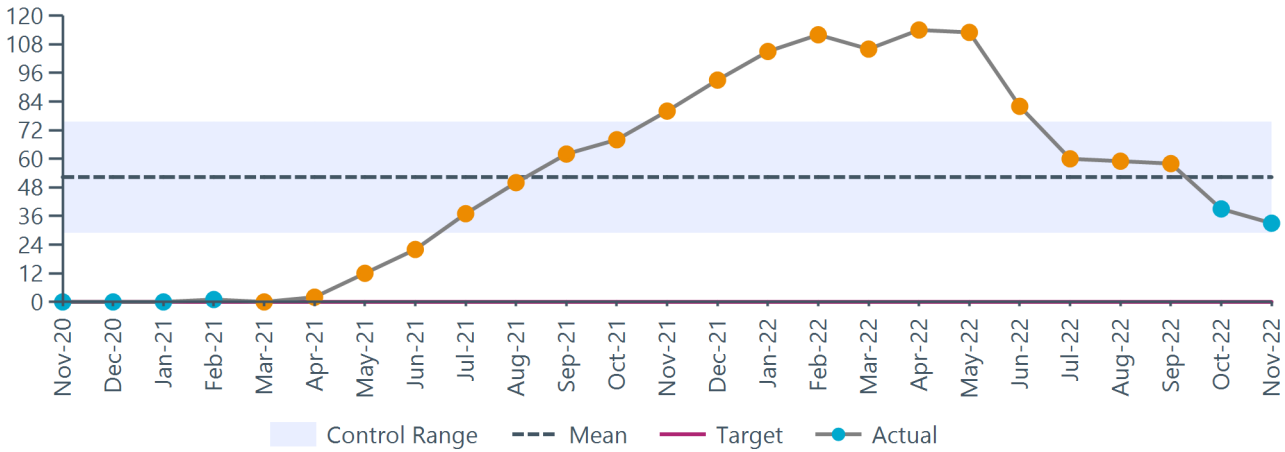
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
241	227	218	218	254	297	331	342	319	283	295	305	304

Patients Waiting Over 104 Weeks - English

Number of English RTT patients waiting 104 weeks or more at month end 217588

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	33	L	F



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric is consistently failing the target.

Narrative

At the end of November there were 33 English patients waiting over 104 weeks, in line with our trajectory.
- Spinal Disorders (30)
- Arthroplasty (1)
- Knee & Sports Injuries (1)
- Upper Limb (1)

By Milestone, there were:
- Milestone 1 (Outpatients) - 1 patient
- Milestone 2 (Diagnostics) - 6 patients
- Milestone 3 (Electives) - 26 patients

Actions

The Trust has been taking actions that helps reduce trip-ins in subsequent months; this has included a focus on non-admitted pathways.
Non-Spinal Disorders: - we continue to support a system partner with their longest waits and clinically urgent patients.

Spinal Disorders: - actions include:
- Seeking mutual aid from ROH and active discussions with a North-West Provider for further support.
- Continued operational and executive discussions with the Trust's surgeons on the longest waiting patients.
- Daily 104+ meetings being held within the Trust and chaired by Chief Operating Officer or Managing Director of Specialist Unit
- Escalation and monitoring through NHSE to support pathways requiring external providers support.
- The Trust is reviewing NHS England revised guidance in relation to patient choice.

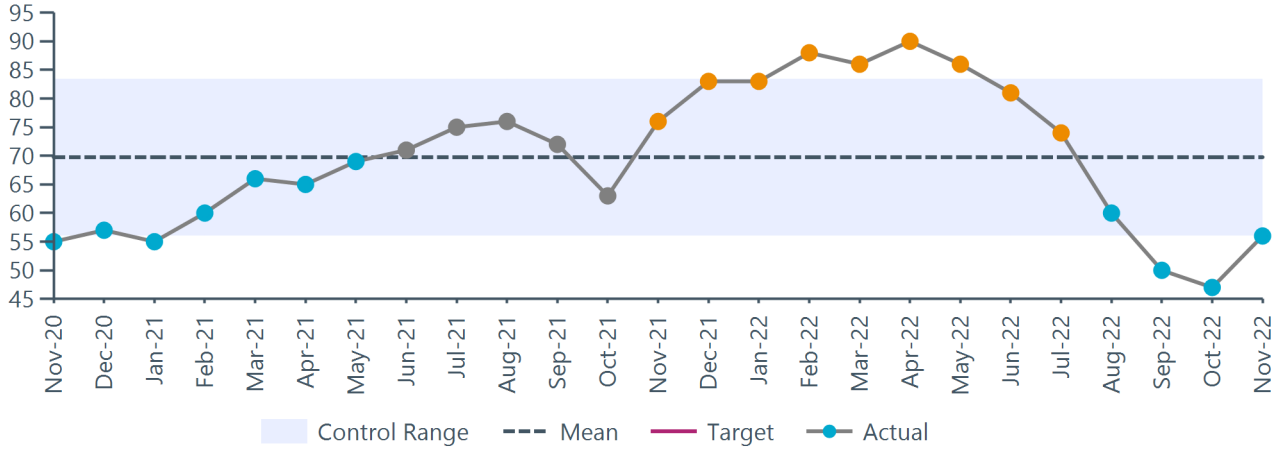
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
80	93	105	112	106	114	113	82	60	59	58	39	33

Patients Waiting Over 104 Weeks - Welsh (Total)

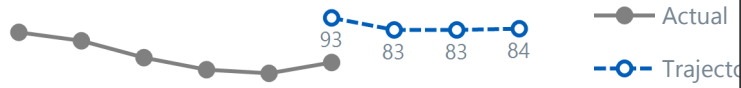
Patients Waiting Over 104 Weeks - Welsh (Total) 217803

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	56	L	No Target



Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of November there were 56 Welsh patients waiting over 104 weeks; below our trajectory figure of 93 by 37.

The patients are under the care of the following sub-specialties;
- Spinal Disorders (55)
- Veterans (1)

By Milestone, there were:
- Milestone 1 (Outpatients) - 7 patients
- Milestone 2 (Diagnostics) - 10 patients
- Milestone 3 (Electives) - 39 patients

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients in milestone 1 and there has been a focus in December to date patients currently waiting in this milestone, utilising capacity across the consultant workforce.

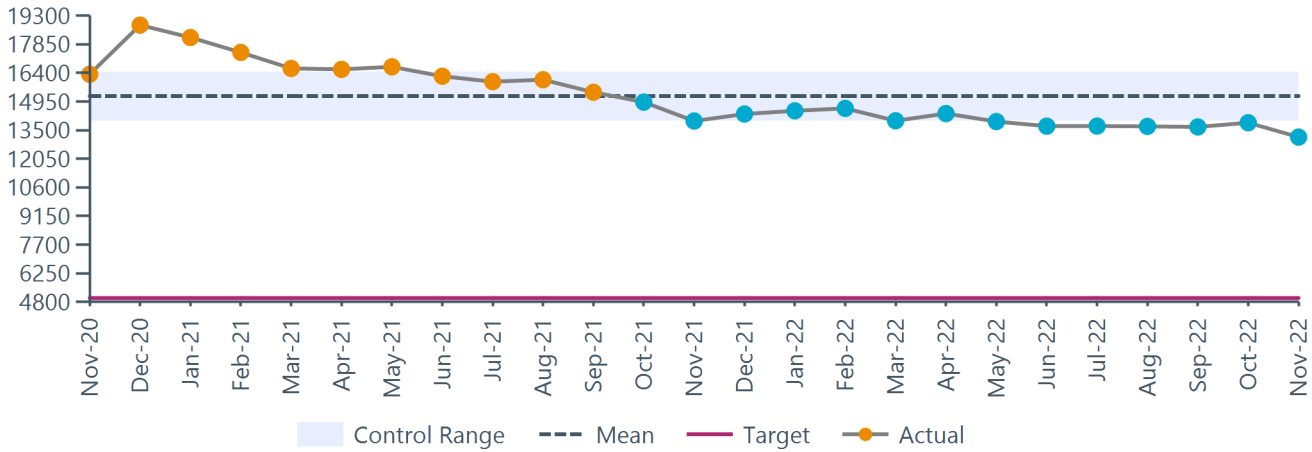
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
76	83	83	88	86	90	86	81	74	60	50	47	56

Overdue Follow Up Backlog

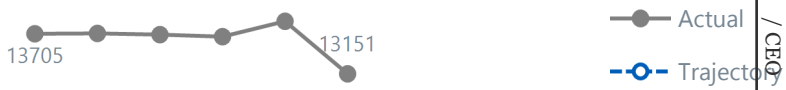
All dated and undated patients that are overdue their follow up appointment 217364

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	13,151	L	F



Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric is consistently failing the target.

Narrative

At the end of November, there were 13151 patients overdue their follow up appointment. This is broken down by:
- Priority 1 is our more urgent follow-up cohort - 8444 with 1339 dated (16%)
- Priority 2 is the lower priority - 4707 with 1220 dated (27%)

MSK backlog at the end of October is 4829. In April 20 it was 4928, it later increased to as high as 10545 and has steadily been reducing. Focus on improvement within Arthroplasty, SOOS, Upper Limb and Therapies as well as revalidation focus on MSK, particularly Arthroplasty.
Specialist backlog at the end of October is 8322. In April 20 it was 5016, it later increased to 8938 and has remained in the 8-9 thousand range. Main focus within the Trust has been on 104 week waiters.
Sub-specialities with the highest percentage of overdue follow ups:
- Rheumatology - 20.14%; Arthroplasty - 18.59%; Spinal Disorders - 12.62%; Spinal Injuries - 8.82%

Planning expectations for 2022/23 is to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023, however, our plans for 2022/23 do not meet this aspiration as the Trust continues to address its overdue follow-up backlog.

Actions

- The information team have developed a tool for use by the operational teams for all specialties that will calculate a trajectory for each sub-specialty based on their input of known bookings / capacity - trajectory to be completed for all specialties by 13th January 2023
- In Rheumatology, additional capacity is now in place for follow ups where it is anticipated an additional 100 patients per month will be seen.
- The Trust has a number of Transformational projects in progress, such as PIFU, that will support in further reductions in this area
- Revalidation to commence within Spinal Disorders
- Outpatient task and finish groups in place
- Expressions of interest out for an outpatient consultant lead

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
13965	14319	14482	14605	13976	14342	13937	13705	13710	13693	13665	13878	13151

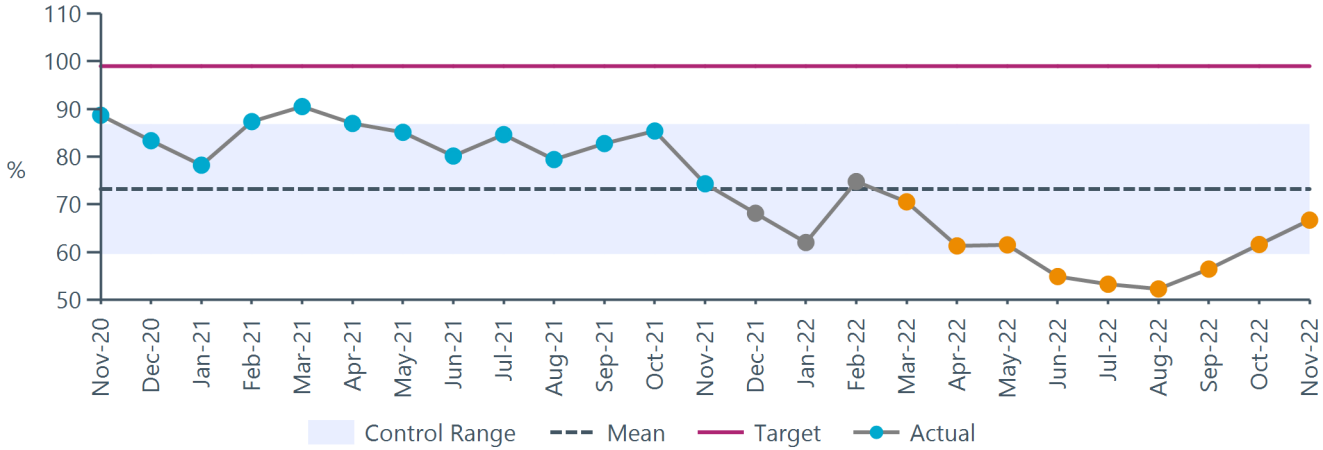
6 Week Wait for Diagnostics - English Patients

% of English patients currently waiting less than 6 weeks for diagnostics 211026

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
99.00%	66.73%	L	F

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 66.73%. This equates to 559 patients who waited beyond 6 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 59% - D2 (Urgent - 0-2 weeks) 6 dated, D3 (Routine - 4-6 weeks) - 9 dated, D4 (Routine - 6-12 weeks) - 478 with 358 dated
- CT - 93.20% - D4 (Routine - 6-12 weeks) - 7 with 6 dated
- Ultrasound - 83.24% - D2 (Urgent - 0-2 weeks) 2 with 1 dated, D4 (Routine - 6-12 weeks) - 58 with 57 dated
- DEXA Scans - 100%

The trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were initially referred to as D4 (Routine - 6-12 weeks) but were updated to urgent at a later date; the 1 undated breach a concurrent appointment has been requested. MRI was reported at 59% against a trajectory specifically for MRI at 59%. It must be noted that all diagnostic activity plans were met in November.

Actions

- Capacity has increased from September for MRI where they are now operating 8am to 8pm, 7 days per week to support backlog clearance.
- Staffed Mobile MRI scanner installed beginning of November for six months in order to help reduce the current waiting list to circa 800.

The national expectation is for delivery of 95% in 6 weeks by March 2025.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
74.35%	68.16%	62.04%	74.81%	70.56%	61.33%	61.54%	54.90%	53.30%	52.31%	56.47%	61.62%	66.73%

8 Week Wait for Diagnostics - Welsh Patients

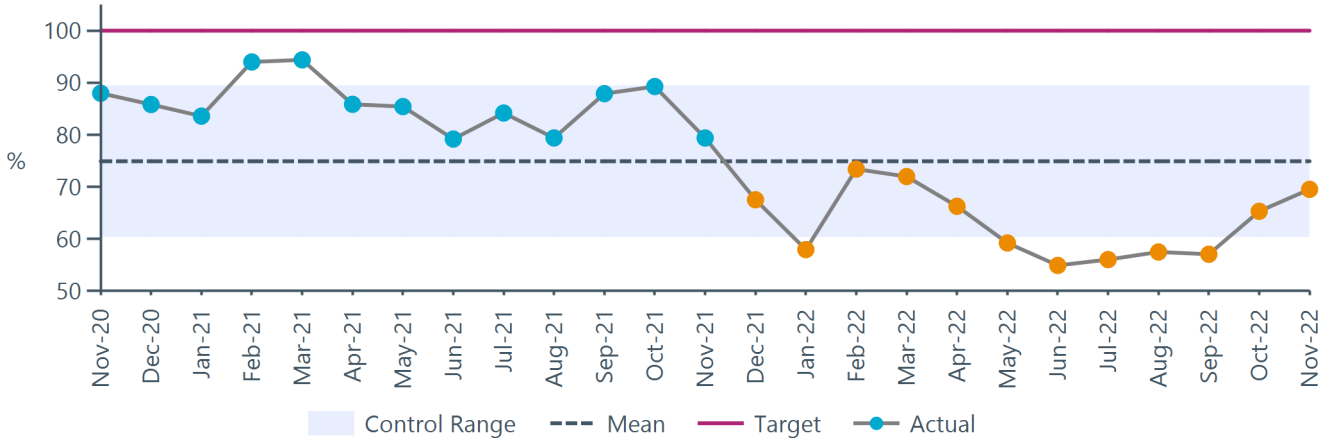
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	69.52%	L	F

Trajectory/H2 Forecast

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 69.52%. This equates to 228 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 65.88% - D4 (Routine - 6-12 weeks) - 217 with 181 dated
- CT - 96% - D4 (Routine - 6-12 weeks) - 1 dated
- Ultrasound - 88.10% - D4 (Routine - 6-12 weeks) - 10 with 8 dated
- DEXA Scans - 100%

It must be noted that all diagnostic activity plans were met in November.

Actions

- Capacity has increased from September for MRI where they are now operating 8am to 8pm, 7 days per week to support backlog clearance.
- Staffed Mobile MRI scanner installed beginning of November for six months in order to help reduce the current waiting list to circa 800.

The national expectations are not for this target to be achieved throughout 22/23.

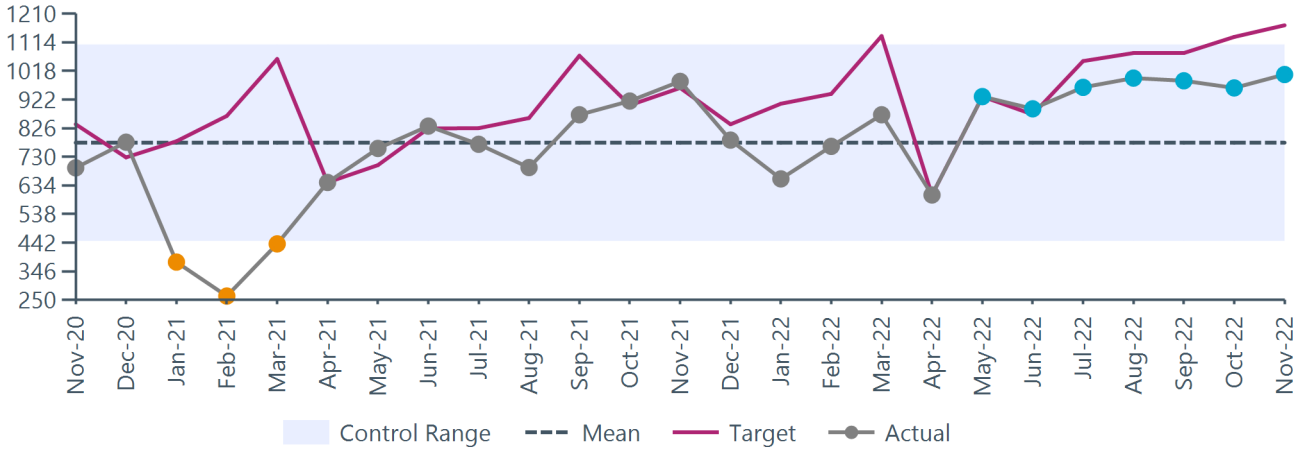
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
79.38%	67.51%	57.94%	73.41%	71.98%	66.27%	59.22%	54.90%	56.03%	57.48%	57.05%	65.30%	69.52%

Elective Activity Against Plan (volumes)

Total elective activity rated against 2022/23 plans. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,171	1,006	H	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

Total elective activity reported externally against plan 2022/23 in November was 1006, 165 below 1171 (85.91%). The internal H2 trajectory for Elective Activity Against Plan (Volumes) was 921 with 1006 delivered (85 above trajectory).
Factors affecting delivery:
- Lack of Independent Sector uptake - 1 undertaken in November against a plan of 18
- 52 on the day theatre cancellations and 38 ahead of TCI
- NHS sessions behind plan
- Cases per session behind plan in Specialist unit

Actions

A full review of Theatre staffing and Theatre processes in progress. Key themes identified for improvement:
- Workforce model – planning and retention.
- Booking and Scheduling
- Working day effectiveness
- OJP alignment to booking processes

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
983	786	656	765	871	602	932	891	963	994	985	961	1006

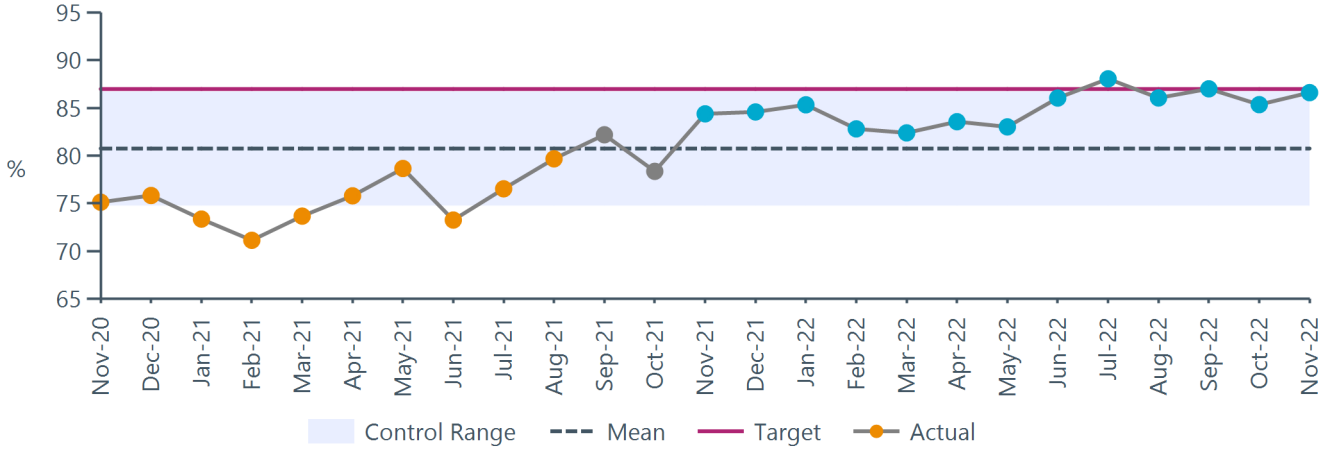
Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm (NHS & Private Beds) 211039

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
87.00%	86.62%	H	F

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric is consistently failing the target.

Narrative

The occupancy rate for all wards is reported at 86.62% for November and remains shown as special cause variation with sustained improvement. Breakdown provided below:
MSK Unit:
- Clwyd - 80.03% - compliment of 22 beds open throughout month
- Powys - 84.23% - compliment of 22 beds open majority of month
- Kenyon - 85.51% - compliment of 22 beds - 6 beds closed for part of month
- Ludlow - 79.96% - compliment of 16 beds open throughout month

Specialist Unit:
- Alice - 66.67% - compliment of 16 beds; open to 4-16 beds dependant on weekday/weekend and demand
- Oswald - 84.59% - compliment of 10 beds open all month
- Gladstone - 92.81% - compliment of 29 beds open majority of month
- Wrekin - 96.63% - compliment of 15 beds open majority of month
- Sheldon - 97.77% - compliment of 19 beds; open 15-19 throughout month

Actions

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
84.40%	84.60%	85.35%	82.82%	82.40%	83.58%	83.03%	86.06%	88.07%	86.07%	87.02%	85.36%	86.62%

Total Outpatient Activity against Plan (volumes)

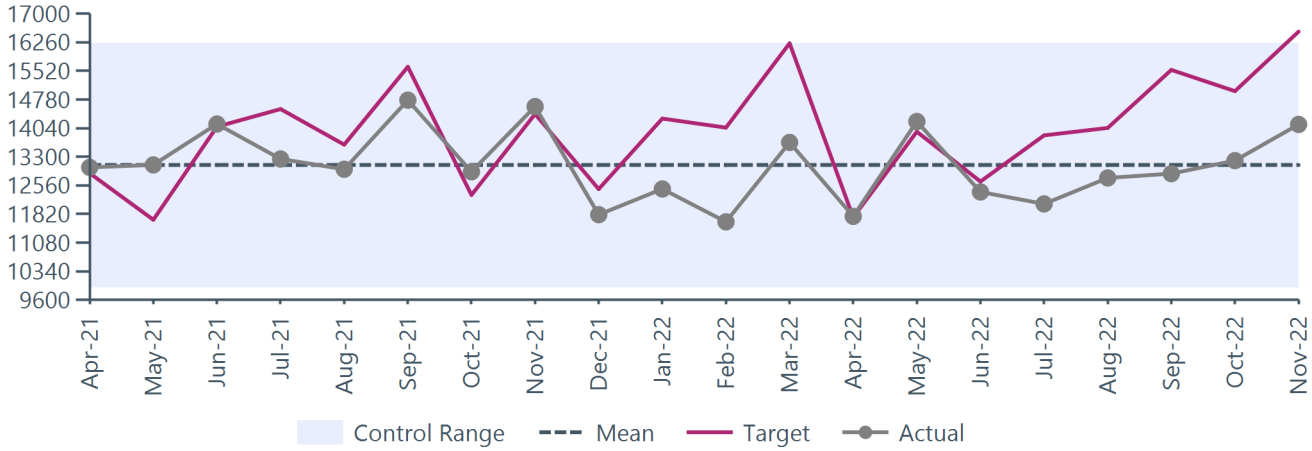
Total outpatient activity (H1 - consultant led, non-consultant led and un-bundled and H2 and 22/23 plan - consultant led and non-consultant led) against submitted plans.

217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
16,537	14,137		Moving Target

Trajectory/H2 Forecast



What these graphs are telling us

Metric is experiencing common cause variation. This measure has a moving target.

Narrative

The plan for November was 101.61% of 19/20 against a national target of 104%. Total outpatient activity undertaken in November was 14137 against the 2022/23 plan of 16537; 2400 cases below - equating to 85.49%.
This is broken down as:
- New Appointments - 4307 against 4994 - equating to 86.24%
- Follow Up Appointments - 9830 against 11543 - equating to 85.16%

The sub-specialities with the lowest activity against plan in November are:
- Physiotherapy - 1716 against 2829 - 1113 cases below - associated with cancellations, unfilled slots, class capacity reduction and high levels of sickness
- Arthroplasty - 1247 against 1685 - 438 cases below - shortfall can be attributed mostly to OJP plan underperformance
- Upper Limb - 1031 against 1302 - 271 cases below - shortfall can mainly be seen against the plan flex

Actions

- Outpatient Improvement Plan which includes all aspects of Outpatient activity including Overdue Follow Ups, DNAs, PIFU, Virtual, IPC, clinic utilisations etc. Task and Finish groups are now in place which encompass all of these workstreams.
- Review clinic templates within sub-specialities to maximise number of appointments
- Therapies is currently under a service review with report currently being reviewed before wider dissemination
- Backlog management Plan for SOOS patients has been developed and an application to the ERF has been made
- Review of staffing within outpatients to meet current demand
- Recruitment (particularly consultants and therapists)
- Review process and systems for radiology plain film
- Expressions of interest out for an outpatient consultant lead

A H2 forecast has been presented to FPD Committee in October and November, however, before final approval there are further actions required. Further refinement to be carried out before presenting to FPD committee again

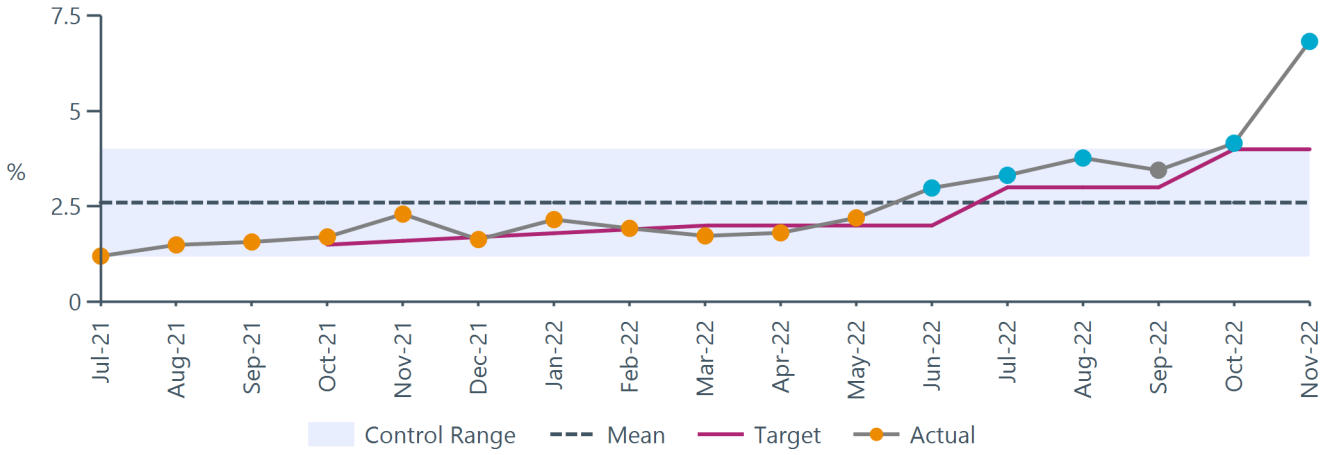
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
14599	11804	12469	11619	13672	11761	14213	12391	12082	12754	12865	13202	14137

Total Outpatient Activity - % Moved to PIFU Pathway

Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway, (Against External Plan (22/23), Catchment Based) 217715

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
4.00%	6.83%	H	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The target for the number of episodes moved to a PIFU Pathway is 5% of all outpatients attendances by March 2023. In November this was exceeded with 6.83% of total outpatient activity moved to a PIFU pathway against the 2022/23 plan of 4%.

PIFU has now been successfully implemented within SOOS, in November 432 SOOS episodes were moved to a PIFU pathway; this equates to 44.77% of the total number of episodes moved to a PIFU pathway in November. Furthermore, Rheumatology will be implementing PIFU in January 2023.

Actions

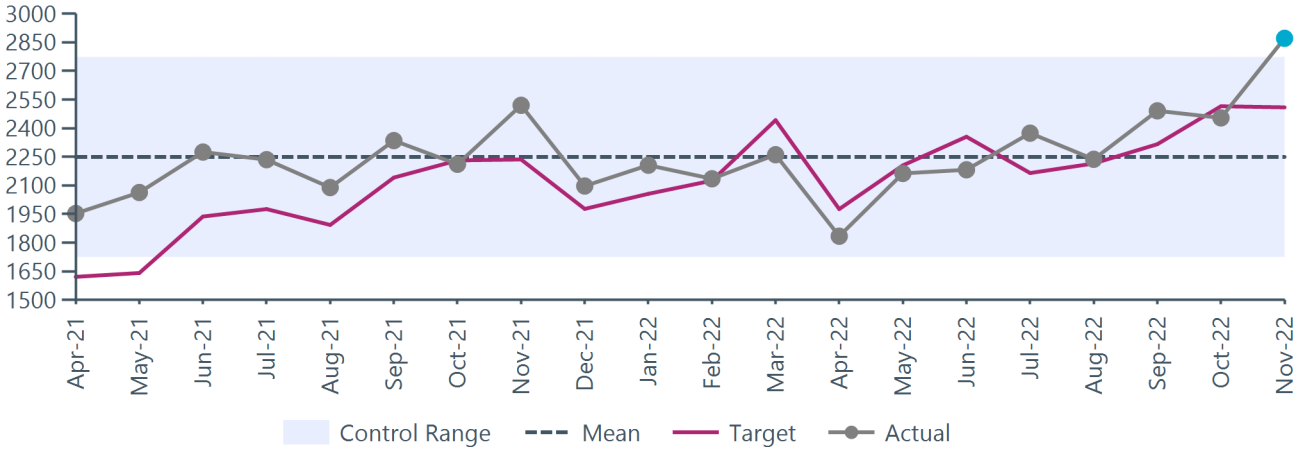
Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
2.30%	1.64%	2.16%	1.93%	1.73%	1.81%	2.20%	2.99%	3.32%	3.77%	3.45%	4.16%	6.83%

Total Diagnostics Activity against Plan - Catchment Based

Total Diagnostic Activity against Plan - (MRI, U/S and CT activity against 2022/23 plan) 217794

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,509	2,871	H	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The plan for November was 107.61% of 19/20 against a national target of 120%. In November this was exceeded as total diagnostic activity undertaken in November was 2871 against the 2022/23 plan of 2509; 362 cases above - equating to 114.43%.
This is broken down as:
- CT - 435 against plan of 428; equating to 101.64%
- MRI - 1549 against plan of 1263; equating to 122.64%
- U/S - 887 against 818; equating to 108.44%

Actions

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
2520	2097	2206	2135	2261	1834	2163	2182	2374	2237	2491	2454	2871

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RJAH Long Waiters - 2022/23

Trust Board

11th January 2023

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2022/23 November and December* Performance

		Plan	Actual	Difference
November	English 104+ Weeks	33	33	0
	Welsh 104+ Weeks	93	56	-37
	English 78+ Weeks	345	371	26
	Welsh 78+ Weeks	345	304	-41

		Plan	Forecast*	Difference
December*	English 104+ Weeks	27	20*	-7
	Welsh 104+ Weeks	83	54	-29
	English 78+ Weeks	361	394	33
	Welsh 78+ Weeks	413	315	-98

**Forecasts based on unvalidated positions*

NHS England Support:

Mutual Aid NHSE to support the 78+ week wait cohort.
- **Providers asked to be 0 by end of March 2023**
- **RJAH submitted NHSE plan of 247 (English)**

Patient choice (English): - NHSE Interim guidance - NHSE Active Monitoring RTT rule changes being made to patients declining mutual aid.
- **Reporting to follow within IPR**

*December forecast subject to clock stop predictions / numbers not converting and application of new patient choice guidance
*December 78+ Weeks subject to further improvements due to outstanding outcomes <31st December. % that do not convert.

The longest waits: - Spinal Disorders remains our challenged specialty:
English December plan = 20 patients. Current forecast:
- 14 Complex (12 Spinal Disorders, 2 non-spines: - 1 x SaTH transfer, 1 spines transfer.)
- 0 Capacity
- 6 Patient Choice (Spinal Disorders) - treatment dates planned

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Milestone Visibility - Combined Waiting Lists > 78 weeks

	31.07.22		31.08.22		30.09.22		31.10.22		30.11.22		19.12.22* *Unvalidated	
Combined	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L	Patients	% of W/L
Milestone 1	419	47%	287	35%	197	27%	203	30%	204	30%	143	22%
Milestone 2	84	9%	156	19%	211	29%	191	28%	186	28%	206	32%
Milestone 3	391	44%	366	45%	319	44%	283	42%	285	42%	300	46%
Total	894		809		727		677		675		649	

- Actions:
  - Non-admitted actions continue.
  - Additional outpatient and inpatient capacity being explored. Including mutual aid.
  - Additional diagnostic capacity for MRI supporting.

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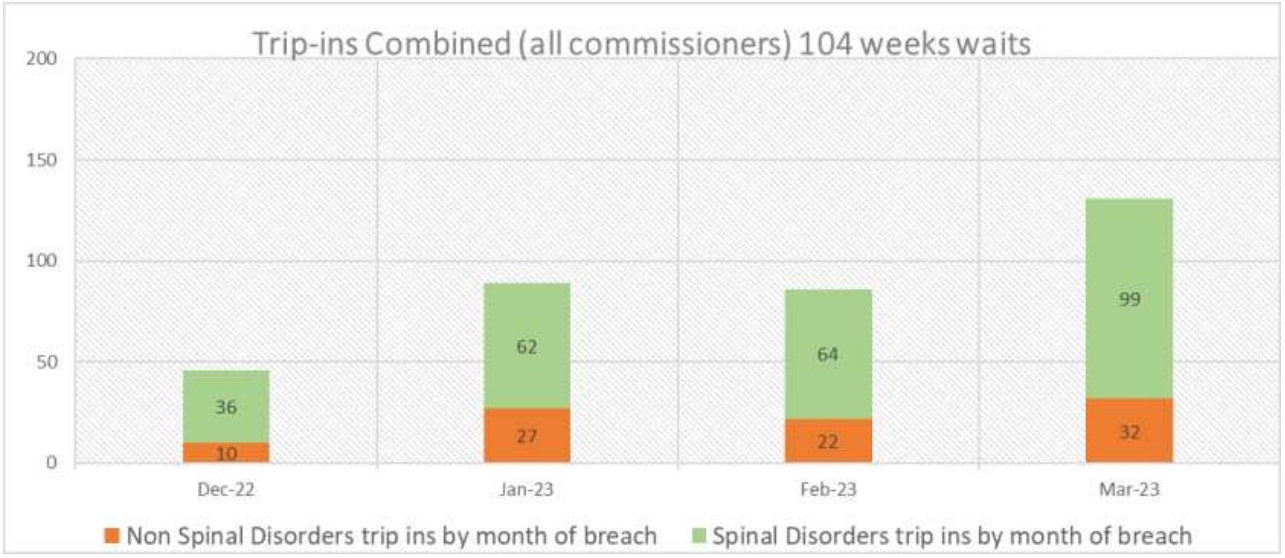
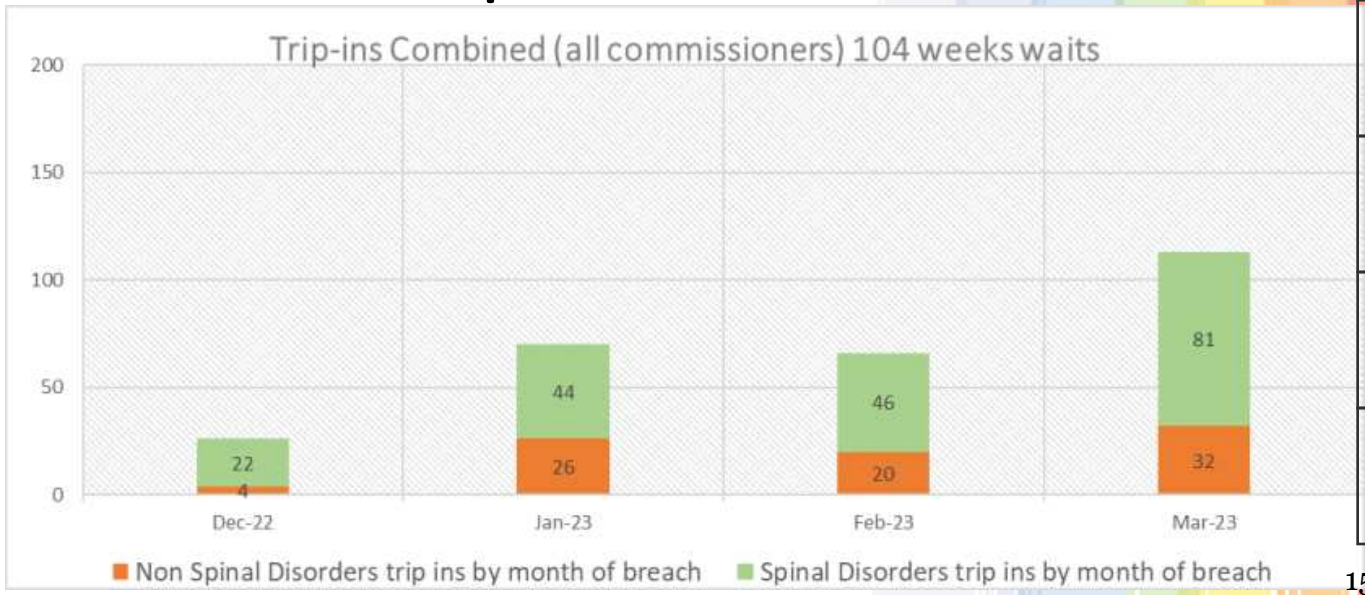
Managing The Trip-ins – 104 weeks - Combined

Snapshot: - 23rd November 2022



Between 23rd November and 19th December. Trip-ins between December and March have reduced from 352 to 275.
Reduction of 22%

Snapshot: - 19th December 2022



Welsh and English commissioning expectations

Metric	English	Welsh
Number of patients waiting more than 104 weeks for treatment	Zero by 1st July 2022	Zero by 2024
Number of patients waiting more than 78 weeks for treatment	Zero by 1st April 2023	
Number of patients waiting more than 65 weeks for treatment	Zero by 1st March 2024	
Number of patients waiting more than 52 weeks for treatment	Zero by 1st March 2025	
Number of patients waiting more than 36 weeks for treatment		Zero by 2026
Percentage of patients waiting less than 26 weeks for treatment		95% by 2026
New Outpatient Appts - Number of patients >52 weeks		Zero by 31st December 2022
Overdue follow-ups: - Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%		A reduction of 30% by March 2023 against a baseline of March 2021

Trust Board - Finance
November 2022 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

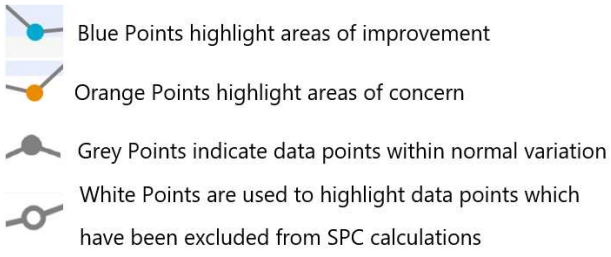
Different colours have been used to separate these trends of special cause variation:

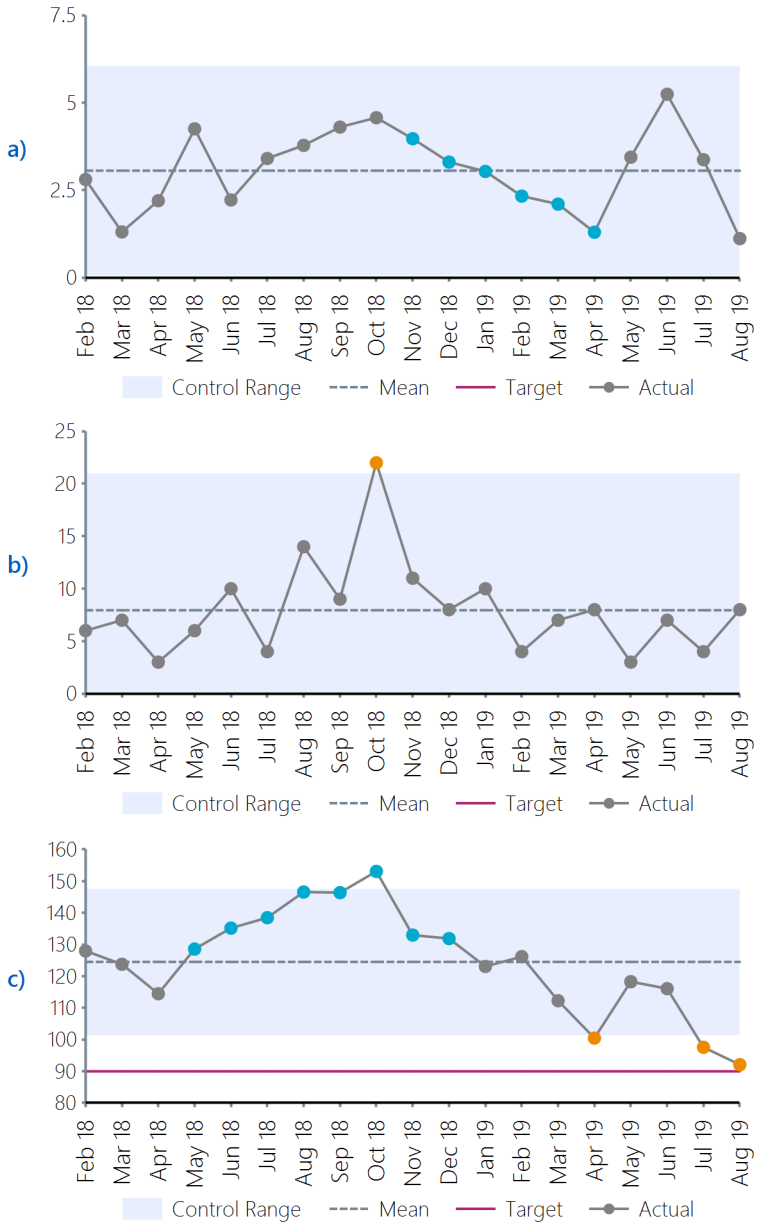
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.





Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?

Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Data Quality Rating Reading Guide

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

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

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

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Finances

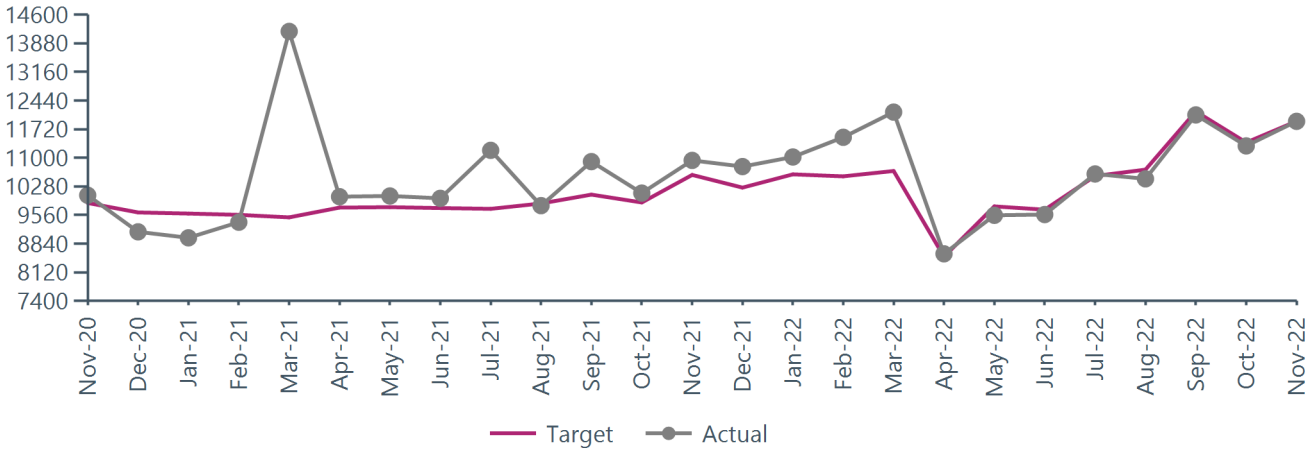
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory/H2 Forecast	Variation	Assurance	Exception	DQ Rating
Financial Control Total	741	888		N/A to SPC	Moving Target		
Income	11,921	11,918		N/A to SPC	Moving Target	+	
Expenditure	11,232	11,080		N/A to SPC	Moving Target		
Efficiency Delivered	165.67	200.00		N/A to SPC	Moving Target		
Big Ticket Item (BTI) Efficiency Delivered	114.33	24.00		N/A to SPC	Moving Target		
Cash Balance	24,170	27,752		H	Moving Target		
Capital Expenditure	448	869		N/A to SPC	Moving Target		

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
11,921	11,918	N/A to SPC	Moving Target



Trajectory/H2 Forecast

What these graphs are telling us

This measure is not appropriate to display as SPC. This measure has a moving target.

Narrative

Income £202k adverse excluding pass through income:
- NHS Clinical Income adverse driven by activity (Welsh variable contracts)
- Private Patients adverse driven by activity/casemix (partially offset by expenditure)
- Other Income adverse (Research)

We continue to benefit from contracting arrangements in place for 2022/23 which have secured £10.2m of income ytd above what would traditionally have been earned from actual activity levels

Actions

Expenditure reductions offset income shortfalls.
Adverse private patient performance to be recovered by year end.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
10935	10780	11021	11516	12150	8585	9554	9573	10594	10471	12079	11299	11918

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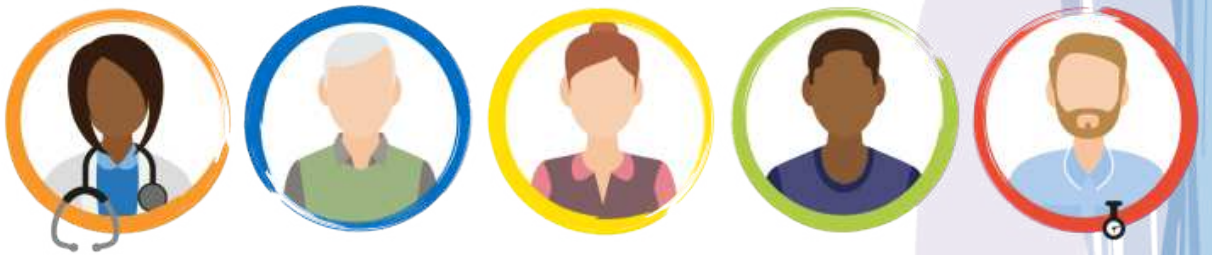
Operational and Financial Planning Guidance 2023/24



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Summary

- The focus of the operational planning guidance for 23/24 is to:
  - Recover core services and productivity;
  - As we recover, make progress in delivering the key ambitions in the Long Term Plan (LTP)
  - Continue transforming the NHS for the future.
- ICBs are expected to work together to plan and deliver a reduction in waiting times whilst delivering a balanced net system financial position. Improving productivity and efficiency will be key
- Legacy deficit from 22/23 will need to be recovered - non compliant systems will not be able to access new capital streams
- Looking to return to performance related payment system (PbR) for majority of activity
- Further investment in Elective Recovery Fund but access only when exceeded system bespoke activity thresholds (further details awaited)
- First draft plans due to be submitted around February 23rd with Final submission date tbc

Performance

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties).
- Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- Increase productivity and meet the 85%-day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings
- Use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS).
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Financial

- Return to Payment by Results for contracts in excess of £0.5m - income will be fully aligned to performance (based on 22/23 our full risk exposure on this is £15m)
  - Contracts under £0.5m will be blocked based on latest 3 year rolling average
  - STW expected to also remain as block under IFP but NHSE approval will be required
- ERF to be transacted only when additional elective activity target requirements met with baselines to be confirmed
- COVID funding further cut by 75% and embedded into tariff prices
- Base efficiency requirement of 2.2% - more will be required for systems in deficit
- Inflation assumes 2% pay award (any excess will be centrally funded) and 5.5% for Non Pay (Will be challenging)
- Agency cap to be set at 3.7% of total pay bill - currently at 6.3% (4.2% excluding LLP)

0. Reference Information

Author:	Mary Bardsley, Acting Trust Secretary	**Paper date:**	11 January 2023
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	06 January 2023
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Extraordinary Finance, Planning & Digital Committee meeting held on 20th December 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

Key escalation and discussion points:

ALERT: areas of non-compliance/risk or matter to be addressed urgently
▪ No new risks to highlight to the Board
ADVISE: areas of on-going monitoring with new developments
▪ **Financial Performance** - Although no concerns were raised regarding the Trust performance, the Committee raised concerns regarding the operational challenges if the Trust is to return to a performance related income model next year. ▪ **Outpatient Activity** - The Committee noted the progress and improvements made to date however, further consideration is to be given on key areas and forward plan to be presented at the next meeting. ▪ **Therapies Report** - the final report does not offer quantifiable feedback and therefore further investigation is required to allow a substantial discussion and plan to be implemented. ▪ **MSK Efficiency Delivery Report** - Mitigations for final 3 months of MSK Efficiency Delivery Report to be presented to Committee along with the plan for the next financial year.
ASSURE: areas of assurance
▪ **Long Waiters** – the Committee commended the Trust on their continued hard work, for raising queries of the forward visibility and actions implemented/monitoring to minimise risks.

2.3. Conclusion

The Board of Directors is asked to note the Chair's Report for assurance purposes and consider any additional assurances required.

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Finance, Planning and Digital Committee which met on 20th December 2022. The meeting was quorate with 2 Non-Executives Directors and 3 Executive Director in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Mike Carr	Chief Operating Officer
Stacey-Lea Keegan	Chief Executive Officer
Craig Macbeth	Chief Finance and Planning Officer
In Attendance:	
John Pepper	Associate Non-Executive Director
David Gilburt	Associate Non-Executive Director
Steph Wilson	Performance Insight & Improvement Manager
Nia Jones	Managing Director for Planning and Strategy
Victoria Brownrigg	Head of Finance
Amber Scott	Executive Assistant (minute secretary)
Dawn Forrest	Managing Director of Specialist Unit (agenda item only)
Apologies:	
There were no formal apologies to be noted.	

3.2 Actions from the Previous Meeting

As the meeting was an extraordinary meeting, there were no actions for discussion.

3.3 Key Agenda

The Committee received all items required on the work plan with an outline provided below for each:

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Performance Report		
The following key highlights were presented to the Committee: ▪ Sickness levels, down to 5.6% ▪ Staff Leaving with a decreasing trend each month ▪ 14.4 % Nursing Vacancy rate ▪ Reduction in delayed discharges ▪ Reduction in cancellations to 4% ▪ RTT performance improved by 2% to 55% ▪ Overdue follow ups reduced by 700 pts in month ▪ Theatre Activity increased ▪ OPD activity increased The Committee were assured that the position was improving for the Trust although the aim is to be performing at higher levels and further focus is being given to increase activity.	Yes	
Long Waiters		
The Committee congratulated the team on their continued efforts, raising query of the forward visibility and actions needing focus on monitoring to minimise risks.	Yes	

Finance Performance Report		
There were no concerns raised in relation to the Trusts financial performance for the financial year. The Committee discussed in detail the focus on the system financial performance and escalation process to improve the consolidated financial position (previous £53m combined forecast deficit for the end of the year). It was explained that the Trust' recurrent position is £3.5m deficit being the roll forward position, and as things stand under the Intelligent Fixed Payment System, we would be taking a further 5% pro rata share of the system deficit for 23/24. This underpins the to work collaboratively with the System in support of reducing the deficit Concern was raised over the operational challenges to the Trust in terms of restoring activity and the financial implications should we return to a performance related income model next year.	Partial	Although no concerns were raised regarding the Trust performance, the Committee raised concerns regarding the operational challenges if the Trust is to return to a performance related income model next year. The Chair has agreed to meet with the Chief Operating Officer to gain further assurance and oversight of the potential implications.
Outpatient Activity		
The focus areas for the plan and the task and finish groups in place were noted. The following was highlighted: ▪ DNA Rates at 5.24% - Plan to be at 5% by March ▪ Deep dive into Paediatrics DNA rates completed as currently at 12.43% ▪ Reminder telephone calls being completed 3 days before appointments along with text reminders ▪ Appointment letters have been simplified ▪ Validation of patients is ongoing ▪ OJP under review to improve allocation ▪ PIFU increased to 6.83% Following a discussion, consideration is given to: ▪ current cost of living crisis, with an offer of virtual clinics to Paediatrics patients to support in concerns of travelling to the appointment. ▪ volume of 'was not brought' for Paediatrics and questioned the process for raising reoccurring non-attenders. ▪ OJP allocations, requesting further review of the OJP being offered by consultants and the sessions being declined by the Trust. ▪ SN thanked all for their input and discussions, requesting that a forward plan is included for the next presentation to offer further assurance.	Partial	The Committee noted the progress and improvements made to date however, further consideration is to be given on key areas and forward plan to be presented at the next meeting.
Therapies Report		
Although the review has been completed, the final report does not offer quantifiable feedback and therefore further investigation is required to allow a substantial discussion and plan to be implemented. It was noted that actions are in place which will offer improvement to the area, although additional detailed actions are required.	Partial	The report will be revised ahead of the next meeting for discussion.
MSK Efficiency Delivery Report		
The Committee requested that the plan for next financial year is also presented along with the scope for mitigations in the final 3 months to gain assurance of deliverability.	Partial	Mitigations for final 3 months of MSK Efficiency Delivery Report to be

		presented to Committee along with the plan for the next financial year.
Any Other Business		
Workplan A review of the workplan is to be completed to support the Committee focusing on key topics towards the end of the financial year.	N/A	
TF2 Bid Confirmation has been received that the TF2 bid to allow building of a new theatre has been approved subject to conditions with increasing day cases and extended working days in Theatres – further information to follow.	N/A	

4.0 Conclusion

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

Reference Information

Author:	Ashling Donohoe – Harrison - Governance Manager	Meeting date:	11 January 2023
Senior Leader Sponsor:	Sara Ellis Anderson – Chief Nurse and Patient Safety Officer	Paper written on:	11 November 2022
Paper Reviewed by:	Quality and Safety Committee 24/11/2022	Paper Type:	Governance and Quality
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	Yes	Purpose of Paper:	Assurance

Executive Summary

This paper provides an overview of performance in relation to Duty of Candour for the reporting period between 01 October 2021 to 31 October 2022. The committee is asked to note the contents of the report.

In summary, the findings are as follows:

- Duty of Candour is discussed monthly at each unit governance meeting
- The percentage of harms classed as moderate remains static
- 2% of closed incidents do not give evidence of duty of Candour being undertaken
- 3% of incidents do not document if duty of Candour should apply which is a total of 5 incidents.

Progress / Impact on Patient Care

The intention of the duty of Candour legislation is to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Risk and Issues

There have been no associated risks identified.

Next Steps and Actions

Recommendations

- Promote education of when Duty of Candour applies
- Review sign-off process for Moderate (+) harm incidents to ensure evidence of duty of Candour has been included in the Datix investigation.
- To ensure Duty of Candour features as an Agenda item on Unit Governance Meetings

Conclusion

The Board is asked to note the report which was presented and discussed at the Quality and Safety Committee in November.

The Main Report

Policy

The Trust's Duty of Candour Policy sets out that when a 'notifiable 'safety incident has happened, a representative of the Trust must notify the patient, or - if appropriate - their family or carer, that an incident has occurred. They must tell them in person. They must speak to the patient, family, or carer, as soon as practicably possible after the incident. The discussion must include:

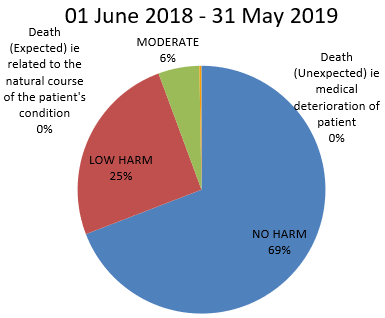
- a truthful account of all facts known at the time
- what further enquiries the Trust will make
- an apology
- what support is available for the patient, family, or carer

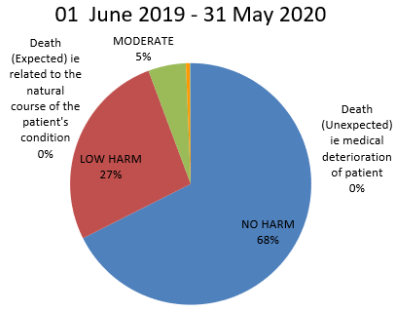
A written record of this conversation must be kept securely and logged on the Trusts Incident reporting system – Datix.

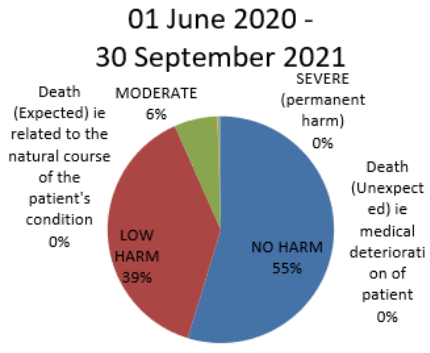
Levels of Harm

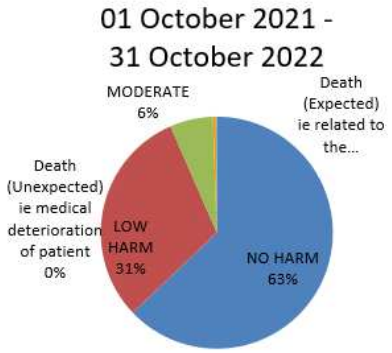
In the period from 1 October 2021 to 31 October 2022, 3012 clinical incidents were reported and finally approved (1894 no harm; 921 low harm; 181 moderate harm; and 17 deaths).

Charts below compare the levels of harm reported in the four previous Duty of Candour annual reports to this Committee.









The proportion of incidents causing moderate harm or above remains constant over the period.

Moderate Harm Incidents

Incidents causing moderate harm or above require evidenced application of the duty of Candour. Moderate Harm incidents are discussed at a bi-weekly Governance and Matrons meeting. As well as these meetings
Duty of Candour and associated performance is now reported monthly at the Unit governance meetings, however there is variability across the Units in the weight given to the discussion.

The policy means that all Datix incidents where the duty applies require evidence to show that the duty has been applied and recorded. This is done by completion of custom fields which appear when an incident is judged to have caused moderate or severe harm. Incidents reporting a patient death trigger a more rigorous process, again involving custom fields, related to the Learning from Deaths policy, and are reviewed by the Learning from Deaths Lead Clinician to the Patient Safety Committee and Quality and Safety Committee.

The table below demonstrates improvement in the documenting of duty of Candour via Datix over the past 3 years. In the last 12 months, there has been a slight decrease, but performance remains high.

- 3% of incidents do not document if duty of Candour should apply which is a total of 5 incidents.
- 97% of cases where the duty applies record how the duty was followed

	Number of Moderate/Severe Harm Incidents	*Does the Duty of Candour Apply?*			Duty applies and evidence given
		YES	NO	no data	
Jan-May 2019	86	52%	17%	31%	*no data*
June 2019-May 2020	132	61%	22%	17%	96%
June 2020-Sep 2021	190	77%	23%	0%	99.9%
Oct 2021 – Oct 2022	197	76%	21%	3%	97%

Quality of information

Where the communication about a duty of Candour event is verbal, the custom Datix fields act as the written record required under the Act.

It is good practice to attach to the Datix documents (e.g., letter from consultant, EPR clinic note of a discussion) which relate to duty of Candour as this gives easily accessible and demonstrable evidence that the policy is being followed. A random sample of 18 moderate harms incidents was therefore taken which looked in detail at any attachments. In 41% of cases in this sample the evidence attached did not show communication with the patient. Subsequent checks on EPR and in PALS and complaints records found that this could have been reduced to 15% had existing documents been attached to the Datix.

Findings for the period 01 October 2021 to 31 October 2022.

- Duty of Candour is discussed monthly at each unit governance meeting
- The percentage of harms classed as moderate remains static
- Duty of Candour information is not complete in 8% of the incidents where the duty applies
- 2% of closed incidents do not give evidence of duty of Candour being undertaken
- 3% of incidents do not document if duty of Candour should apply which is a total of 5 incidents

Recommendations

- Promote education of when Duty of Candour applies
- Review sign-off process for Moderate (+) harm incidents to ensure evidence of duty of Candour has been included in the Datix investigation.
- To ensure Duty of Candour features as an Agenda item on Unit Governance Meetings

Conclusion

The Committee is asked to note the report and agree suggested recommendations.

Health and Safety Annual Report 2021/2022

0. Reference Information

Author:	Ian Gingell, Health and Safety Manager	Paper date:	11 January 2023
Executive Sponsor:	Chief Finance and Planning Officer	Paper Category:	Strategy / Governance
Paper Reviewed by:	Quality and Safety Committee (Nov. 22)	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. This paper presents the Trust's position on health and safety and is for information purposes. In November, the Quality and Safety Committee was asked to note the Trust's position and consider any additional actions it requires before onward presentation at the Board of Directors meeting.

2. Executive Summary

2.1. Context

- This paper highlights the health and safety aspects of risk management undertaken within the Trust during the period April 1st 2021 to 31st March 2022.
- The paper includes Premises Assurance Model data covering the 2021/22 financial year.
- The report covers DATIX incident data on health and safety related incidents during 2021/22.
- The report is not an audit of all the Trust's health and safety systems, and it does not seek to provide assurance on all health and safety duties that relate to the work activities of the Trust.
- The Trust aims to comply with its statutory duties in relation to health and safety at work and to minimise its losses due to risks encountered during operational activities

2.2. Summary

- COVID-19 response impacted significantly on health and safety workload.
- Downward trend in reported safety incidents.
- Significant improvement in adverse weather response arrangements.
- Substantial compliance achieved with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.

2.3. Conclusion

The Board is asked to note the Trust's Annual Health and Safety Report

3. Health and Safety Annual Report

3.1 Introduction

The Health & Safety Executive (HSE) has memoranda of understanding with other regulatory bodies including the Care Quality Commission, General Medical Council and the Nursing and Midwifery Council, which set out roles and responsibilities and clarifies which regulator is likely to act in the event of a patient or member of staff suffering serious harm/death.

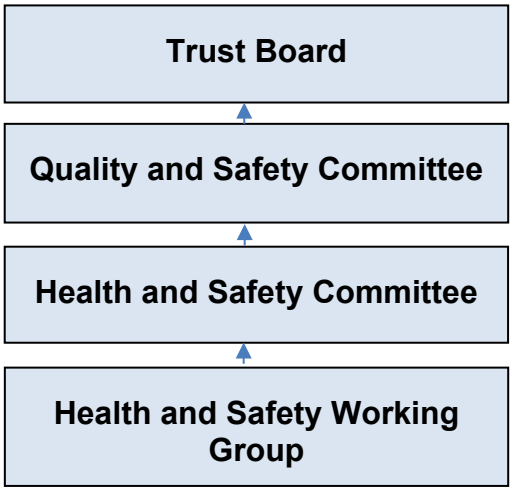
The HSE focus their investigations on systemic failure of management systems, which may include:

- Systemic failures to comply with statutory health and safety duties.
- The absence of or wholly inadequate arrangements for assessing risks to health and safety.
- Lack of suitable controls and inadequate monitoring and maintenance of the procedures or equipment needed to control the risks, resulting in serious harm or death.

The HSE may, dependant on the circumstances, investigate RIDDOR reportable incidents which include some needlestick injuries, work related injuries and serious injuries or ill-health caused by hazardous substances.

3.2 Health and Safety Arrangements

The Trust has a clearly defined structure for health and safety reporting:



The Chief Nurse retained Board-level responsibility for health and safety until December 2021 when responsibility transferred to the Chief Finance Officer. The Trust employed a 0.4 WTE Health and Safety Manager to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

3.3 Fee for Intervention (FFI)

A fee for intervention is charged if the HSE identify a material breach of health and safety law. A material breach is something which an inspector considers serious enough that they need to formally write to the Trust requiring action to be taken to rectify the breach. The fee is currently £160 an hour (increasing to £163 in 2022/23) and the total charge will include the costs covering the HSE inspector's time during inspections, preparing reports, obtaining specialist advice and any costs associated with formal enforcement or prosecutions.

The Trust did not incur any fee for intervention costs in 2021/22

3.4 Health and Safety Management Systems

Organisations have a legal duty to put in place suitable arrangements to manage for health and safety.

The Health and Safety Executive provide a framework in the form of the document 'Managing for Health and Safety' (HSG65). This framework outlines the management arrangements and systems that organisations should have in place to manage their health and safety risks in a proactive manner. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

The ongoing response to the COVID-19 pandemic placed significant pressure on the Trust's health and safety resource and led to a mostly reactive approach leading to challenges in adhering to the HSG65 'Plan, Do, Check, Act' model, however a summary of the activities related to the model are detailed below.

PLAN

The Health and Safety Committee met bi-monthly throughout the year, via Microsoft Teams, and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations,1977.

The Health and Safety Working Group, chaired by the Health and Safety Advisor, also met bi-monthly and provided a valuable forum for the management of operational level safety issues.

The Trust employed a 0.4 WTE Health and Safety Advisor to undertake the role of Competent Person as required by the Management of Health and Safety Regulations 1999. The provision was temporarily increased to 0.8 WTE for 6 months to assist with the pandemic response. The Health and Safety Advisor provision also incorporated the roles of Central Alerting System Liaison Officer and Medical Devices Safety Officer.

DO

COVID-19 specific risk assessments were carried out for all members of staff and all working areas.

The Health and Safety Committee met bi-monthly during 2021/22 and monitored health and safety incidents, RIDDOR reported incidents, safety alerts and legislation changes.

The overarching Health and Safety policy set out the organisational duties of Trust employees and detailed the arrangements required to comply with the Health and Safety at Work, etc Act and the Management of Health and Safety at Work Regulations.

Health and safety risk assessments were recorded in DATIX risk module and monitored in accordance with the Trust's Risk Management Strategy.

The Health and Safety Working Group led on resolving operational level health and safety issues.

CHECK

A programme of health and safety spot checks was introduced, with unannounced safety checks being carried out by the Trust's Health and Safety Advisor and the Premises Assurance Model Manager.

Regular site walkarounds were also carried out to ensure that social distancing was being maintained and national guidance adhered to.

The Trust has a comprehensive incident reporting system in operation. The DATIX database is utilised to record all staff, patient and visitor health and safety related incidents. Fire, security, and violence and aggression incidents are reported to the health and safety committee via a Chair report from the Fire, Security and Electrical Services Group.

The charts below show the number of DATIX health and safety incidents reported by sub-category during 2021/22.

ACT

Concerns with the safety standards in the Occupational Therapy Heavy Workshop resulted in the temporary closure of the facility to allow options to be explored regarding future provision of the service.

Any safety issues noted during unannounced safety spot checks were communicated to the relevant service manager. Immediate remedial actions were taken where appropriate, and a number of capital bids were developed to address concerns with aging equipment that did not comply with current safety standards.

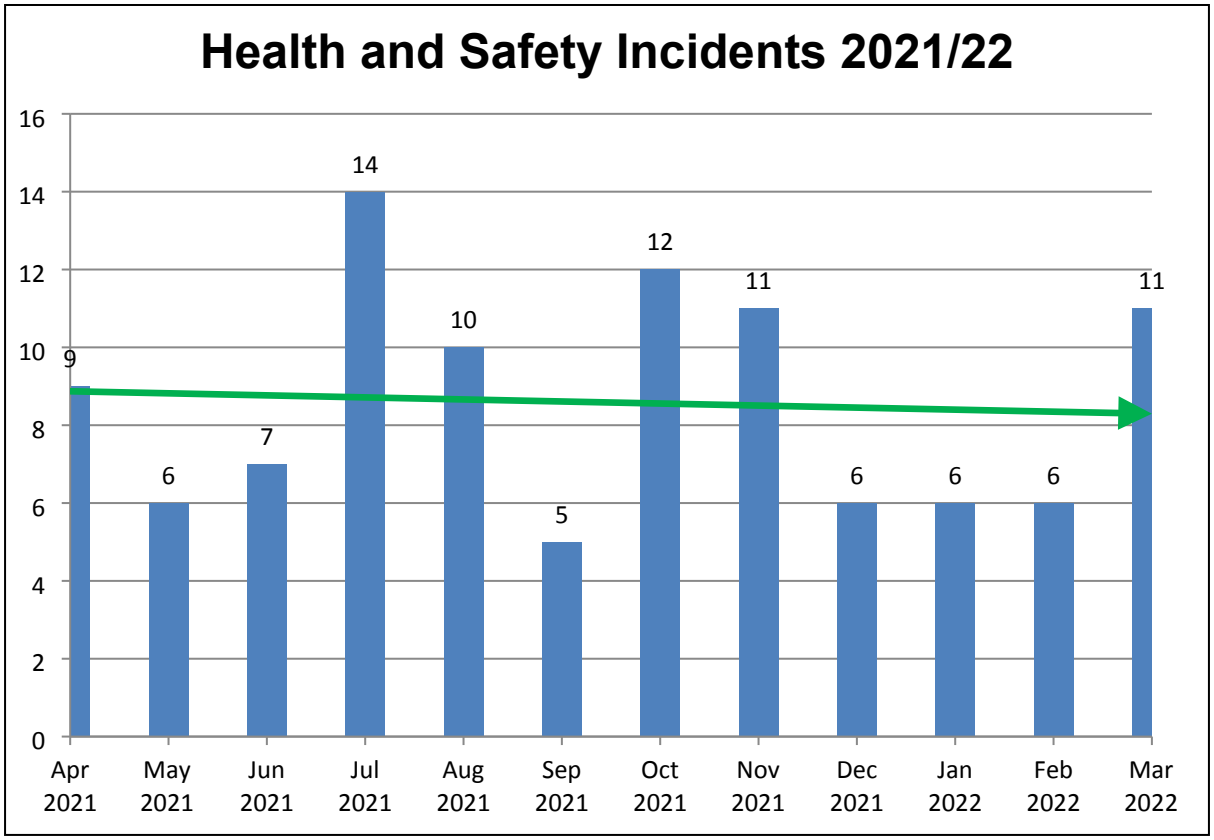
Non-compliance with COVID-19 requirements relating to social distancing were addressed when identified during audits and walkarounds.

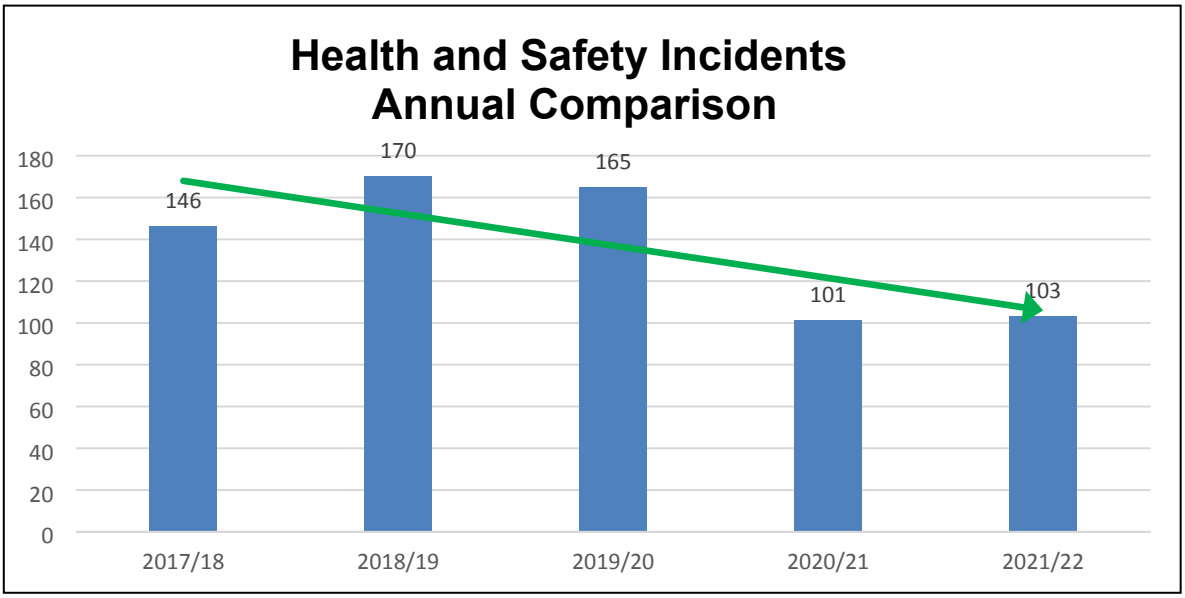
Incidents reported to the Health and Safety Executive as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) were jointly investigated by the Health and Safety Advisor and Staffside Union Safety Representatives.

Non-compliances relating to safer sharps were actively addressed by the Health and Safety Working Group.

3.5 DATIX Incident Reporting (Trends and Analysis)

A total of 103 health and safety incidents were reported during the 2021/22 financial year, a slight increase over the previous year's total of 101. This slight increase must be viewed in the context of increasing activity as the Trust started to return to a 'business as usual' position.

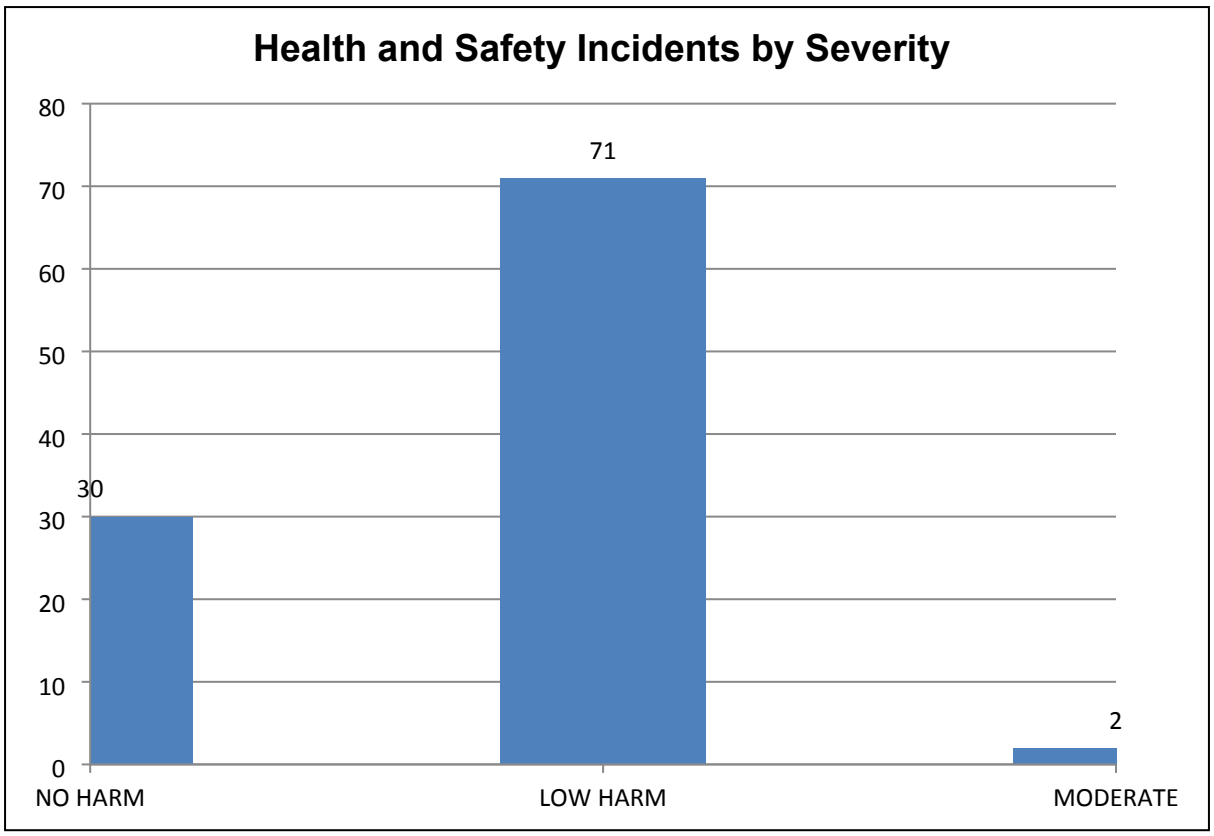

Health and Safety Incidents 2021/22
16
14
12
10
8
6
4
2
0
9
6
7
14
10
5
12
11
6
6
6
11
Apr 2021
May 2021
Jun 2021
Jul 2021
Aug 2021
Sep 2021
Oct 2021
Nov 2021
Dec 2021
Jan 2022
Feb 2022
Mar 2022


Health and Safety Incidents Annual Comparison
180
160
140
120
100
80
60
40
20
0
146
170
165
101
103
2017/18
2018/19
2019/20
2020/21
2021/22

The top 5 sub-categories related to health and safety are shown in the table below:

Category	Number of Incidents
Injury due to trapping of body part	9
Contact with a sharp surface/material	8
Staff fall on level ground	8
Staff slips or trips	8
Near miss - safety	7

Severity of incidents



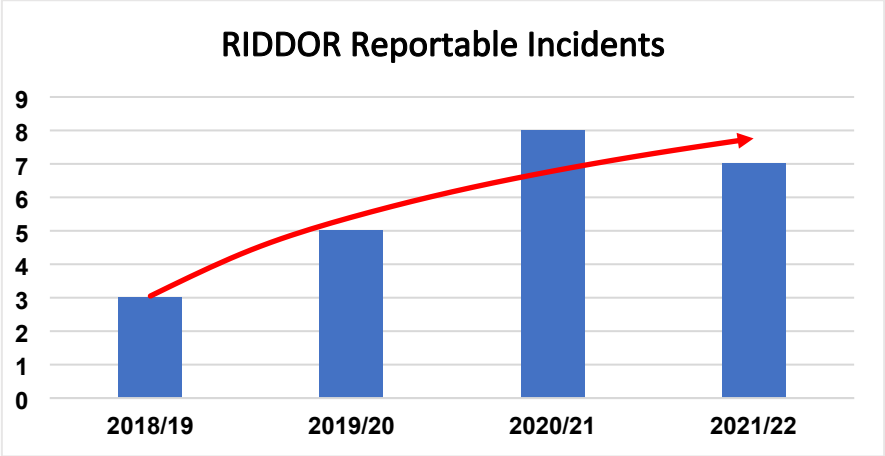
3.6 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

The Health and Safety Advisor ensured that any incident meeting the criteria of the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2015 (RIDDOR) was appropriately reported to the Health and Safety Executive (HSE).

During 2021-22 there were seven incidents reported to the HSE under the requirements of the RIDDOR regulations, compared with eight in 2020-21 and five in 2019-20. No regulatory action or sanction was received in respect of the reported incidents.

3.6.1 RIDDOR Trend Analysis

There remained a relatively low number of RIDDOR reportable incidents in the Trust, and there is an indication that the upward trend previously reported is flattening out.



Slips, trips and falls accounted for three of the RIDDOR incidents this financial year. Three incidents related to staff sustaining injuries when hoisting or manoeuvring patients, and one incident related to a member of staff sustain an injury when wearing a lead apron during a long theatre case.

All incidents have involved members of staff, no patients, visitors or other site users have been injured.

All of the incidents were recorded on DATIX and investigated by the Health and Safety Advisor in conjunction with Staffside Safety Representatives in accordance with the Safety Representatives and Safety Committees Regulations 1977.

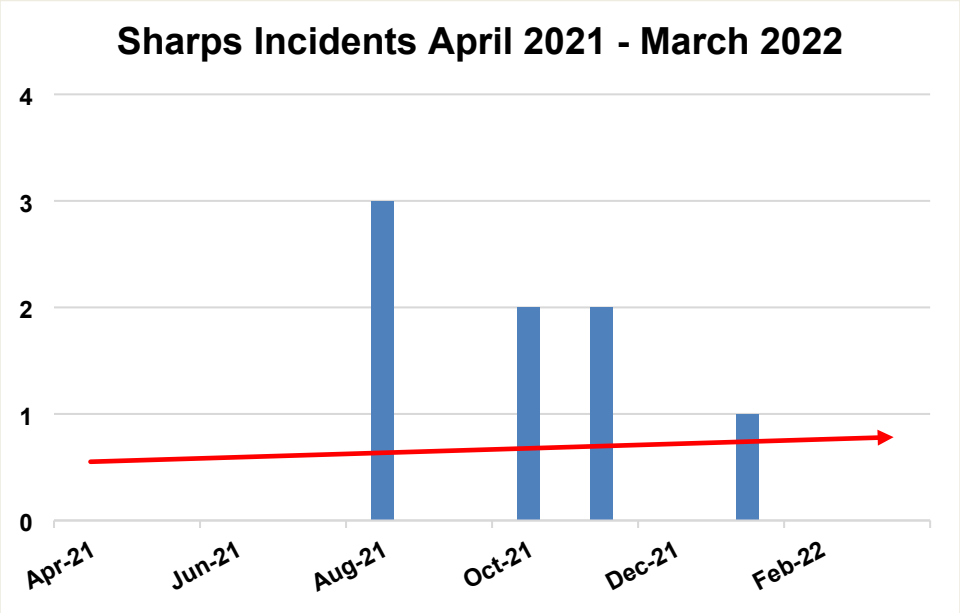
It must be noted that, following an adverse weather response review by the Estates department and a change of gritting contractor, no incident of slips, trips or falls occurred over the winter period.

3.7 Safer sharps

Following a review by the Health and Safety Advisor, it was recognised that the Trust was non-compliant with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013. There were a range of sharp instruments in use around the Trust where safer alternative devices may have been more appropriate.

The Health and Safety working group took responsibility for safer sharps compliance. The pandemic response workload pressures delayed efforts to return the Trust to full compliance in a timely manner, but by year-end substantial compliance had been achieved.

Sharps (including needlestick) injuries remain at a low level and work is ongoing to ensure that safer sharps become the default devices of choice wherever reasonably practicable.



3.8 Health and Safety Committee

The terms of reference were reviewed to better reflect the assurance and escalation purpose of the Committee. A Health and Safety Working Group was established to manage operational level issues. The membership of the Committee was refreshed with the Chair being transferred from the Chief Nurse to the Director of Estates and Facilities.

The Health and Safety Committee met bi-monthly and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations,1977.

Health and Safety Committee Attendance 2021/22						
	April 2021	June 2021	Aug 2021	Oct 2021	Dec 2021	Feb 2022
Chair	✓	✓	X	X	✓	X
Health and Safety Advisor (Deputy Chair)	✓	✓	✓	✓	✓	✓
Governance Representation	✓	✓	✓	X	✓	✓
Estates/Facilities Representation	✓	✓	✓	✓	✓	✓
Clinical Representation	✓	✓	X	✓	✓	✓
People Services /Training Business Partner	✓	✓	✓	X	✓	✓
Staffside Representation	✓	✓	✓	✓	✓	✓
Manual Handling Coordinator	✓	✓	X	X	✓	✓
Quorate	✓	✓	✓	✓	✓	✓

3.9 Central Alerting System Safety Alerts

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Alerts that are distributed include Estates Safety Alerts, Chief Medical Officer Messages, MHRA Drug Alerts, and Medical Device Alerts.

The Health and Safety Advisor undertook the role of CAS Liaison Officer and Medical Devices Safety Officer within the 0.4 WTE provision and was responsible for overall management of the CAS process. Invaluable assistance in administering the alerts was received from the Premises Assurance Model Manager.

Progress towards completion of alert actions was monitored by relevant Committees and overall progress was monitored by the Health and Safety Committee. Executive approval was sought before the Health and Safety Advisor formally signed alerts off via the web portal.

The Trust received a total of 46 safety alerts through CAS in 2021/22, all of which were actioned within their respective deadlines.

A significant number of Field Safety Notices (FSN) and supply disruption alerts were also received. These were sent either directly to the Trust by manufacturers or suppliers or by NHS Supply Chain and are not captured through the CAS portal.

The Medical Devices Safety Officer managed the distribution of FSNs and monitored action completion. All required actions were taken, and confirmation returned to manufacturers where requested.

3.10 Estates Premises Assurance Model (PAM)

The NHS Constitution contains two pledges that relate to the premises in which healthcare is delivered:

- Services are provided in clean and safe environments that are fit for purpose, based on national best practice.
- Continuous improvement in the quality of services users receive, identifying and sharing best practice in quality of care and treatments.

The NHS Premises Assurance Model (PAM) identifies those areas of premises where the NHS Constitution needs to be considered, and where assurance is required.

The annual PAM audit assessed the Trust against PAM model criteria introduced in 2019/20, a half yearly interim PAM Audit was required in June 2021 to assess the Trust against this new criterion. However due to Covid restrictions at the time and change to the model's baseline requirements a true reflection of Trust performance could not be established until this year's audit was completed.

The 2021/22 PAM assessment results allowed for evaluation against the 2019/20 baseline, enabling a more accurate analysis of scores to be assessed. The relaxation of Covid restrictions also enabled a wider audit to be conducted against the PAM requirements. The relaxation of Covid working practices and processes at the Trust automatically downgraded some of the scores within the model, due to the extraordinary additional requirements in specific areas of the Trust because of the pandemic response. It must be noted that this is not a reflection of standards decreasing or that processes are not being followed. The relaxing of Covid measures has brought the Trust back to a more recognisable standard of daily operating processes in line with business-as-usual activity of more pre-pandemic proportions.

The re-introduction of business-as-usual activity brought back into focus the patient experience criteria within the model which was an important aspect of the PAM audit process. Due to the continued suspension of the PLACE assessments which are not expected to be resurrected until September 2022, the patient experience criteria was limited in its review with areas temporarily shown as "Requires Minimal Improvement" against specific PLACE assessment requirements. Overall, it is considered within this limited review of the Patient experience criteria it is still delivered to a "Good" standard.

It is considered that the PAM process has led to significant improvements in health and safety in the Estates and Facilities department and all services that they provide to the Trust.

The 2021/22 annual assessment has led to the development of a PAM action plan. This is being undertaken by relevant parties and audited through the Health and Safety Working Group and Committee.

3.11 COVID-19

The Health and Safety Advisor worked closely with colleagues in Infection Prevention & Control and Estates and Facilities departments to advise and support on the ongoing response to the pandemic and the efforts to return to a 'business as usual' position.

An ongoing process of FFP3 mask face-fit testing, supported by a Department of Health team, remained in place to ensure that all relevant staff had the opportunity to be fitted to at least one model of FFP3 mask.

4.0 Conclusion

The Board is asked to note the content of the annual report.

Appendix 1: Acronyms

CAS	Central Alerting System
HSE	Health and Safety Executive
PAM	Premises Assurance Model
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

0. Reference Information

Author:	Amanda Roberts, Clinical Audit Quality Lead	Meeting date:	11th January 2023
Senior Leader Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper written on:	14th November 2022
Paper Reviewed by:	Quality and Safety Committee (Nov. 22)	Paper Type:	Governance and Quality
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full
Paper to support CQC Evidence:	No	Purpose of Paper:	Noting

Executive Summary

NICE produce in the region of 350 pieces of guidance a year. RJAH has a process in place to review and action NICE Guidance all relevant guidance. NICE Guidance Admin Lead and Consultant NICE Guidance Lead read, disseminate, action and review effects of these actions.

All published NICE guidance for 2021/22 has been reviewed and assessed for relevance and importance to RJAH within a few months of publication.

This paper outlines the NICE Guidance process and activity within the last financial year.

Progress / Impact on Patient Care

NICE Guidelines are published to improve patient care by applying recommendations set out for best practice. This improves patient safety and by auditing and ensuring we have available evidence off assurance, we can determine our compliance with NICE Guidelines.

Risk and Issues

2581 – Lack of assessment of NICE Guidance – Low Harm 6 – Treat Risk

Risk Description - The Trust must be able to demonstrate implementation of NICE Guidance or have a clearly documented rationale for non-implementation.

NICE Guidance published each month is reviewed by the Clinician NICE Guidance Lead and Clinical Audit Quality Lead however as this is a manual data input via an excel document and requires manual chasing it means that it can take some time to ascertain if some guidances are relevant to RJAH or not. A system could easily flag this up in good time to enable effective chasing.

There is no system in place for the assessment of CQC Essential Standards of Quality and Safety, all relevant published NICE guidance, and GIRFT recommendations.

Current Control Measures - This risk is being managed by tracking on a spreadsheet which NICE Guidance have been assessed and who has been asked to complete a baseline assessment.

Monthly monitoring of the spreadsheet and following up outstanding guidances is in place

Where the baseline assessment is not completed in a timely way, these pieces of NICE Guidance will be escalated to the Unit Governance Meetings for the Units to chase.

Next Steps and Actions

NICE Guidance Policy is being reviewed to be more robust. This will ensure staff members understand their roles and responsibilities including NICE Guidelines being actioned within their specialities. The Trust have recently appointed a new NICE Guidance Clinical Lead and working closely together to ensure the NICE Guidance Policy is being carried out accordingly.

Conclusion

The Quality and Safety Committee is asked to note the activity of NICE Guidelines for 2021-22

1. Main Report

1.1 The Current Process for NICE implementing Guidance

All NICE guidance is initially screened by the NICE Guidance Admin Lead and NICE Guidance Consultant Lead for relevance to the Trust. If the Guidance is deemed as relevant or requires further assessment it is sent to the appropriate individual to complete a Statement of Local Practice form and is sent back to the NICE Guidance Admin Lead for dissemination, or logging onto central spreadsheet with the outcome recorded.

NICE Guidance issued by NICE

Guidance received and compiled on spreadsheet by NICE coordinator

NICE Guidance Tracker spreadsheet is emailed to NICE Guidance Clinical Lead at the end of each month to assess new guidance's for relevance to RJAH. All new published guidance is also included in Unit Governance Reports monthly for cross checking.

Low importance or not applicable to RJAH - No further action required

Relevant to trust but due to small numbers of patients affected dissemination of Guidelines all that is appropriate

Guidance emailed to relevant lead for further circulation as they deem appropriate

High Importance:

Needs named consultant + Time scale + Statement of Local Practice to be conducted inconjunction with audit department

Outcome of NICE Guidance Clinical Lead's assessment compiled onto NICE Guidance Tracker spreadsheet for monitoring. Any Guidance applicable to RJAH and require evidence of assurance will be monitored via Clinical Effectiveness Committee and any concerns/non-compliance will be raised at the Committee

If a clinical audit is required to measure against NICE Recommendations a proposal form to be completed and logged via Clinical Audit Registration and Management System and will be monitored via the Clinical Audit Policy

If we have evidence that we are complying with NICE Recommendations either via a policy or existing data, no further action is required

On completion of Clinical Audit

Fully compliant to NICE Guidance – fed back to Clinical Effectiveness Committee and no further action required

Partial or non-compliance – Action plan put in place to change practice. Reaudit 6-12 months after actions have been implemented to ensure full compliance to NICE Guidance

1.2 Associated Risks

There is currently one Risk Associated to NICE Guidance on the Datix Risk Register (see below). The mitigations in place to control this risk are:

- Tracking on the central spreadsheet which pieces of NICE Guidance have been assessed and who has been asked to complete a Statement of Local Practice.
- Monthly monitoring of the spreadsheet and following up outstanding guidance's is in place.
- If a Statement of Local practice is not completed within 3 months of dissemination this will be escalated to Unit Governance Managers and Clinical Effectiveness Committee

The implementation of a clinical audit system that automatically tracks NICE Guidance would enable us to close this risk.

2581	Corporate and Strategic Risk	Lack of assessment of NICE Guidance	Corporate Services	Corporate Services - GOVERNANCE	Amanda Roberts	Kirsty Foskett	The trust must be able to evidence that all pieces of clinical guidance relevant to the trust have been assessed to ensure it is compliant with regulatory bodies such as the CQC and the CCG. If guidance is not assessed, there is no evidence that actions have been put in place to measure compliance if required. Failure to implement NICE guidance without a documented reason would impact on compliance with CQC standards and contracts with commissioners	Low	6	Treat Risk	14/11/2022

1.3 NICE Guidance Activity in 2021/22

A total of 246 NICE Guidance's was published between April 2021-March 2022.

Assessment Conclusion	Frequency
Audit being carried out	2
Evidence of assurance required	4
Fully comply with evidence	12
Guidance Applicable	2
Guidance not applicable to RJAH	199
Need to audit	3
Needs reviewing	4
Partially compliant	1
Terminated Appraisal - no action required	5
Updated Guidance - no action required	14
Total	246

A Statement of Local Practice was carried out for guidance's relevant to the Trust and where appropriate audits were undertaken to measure compliance are put in place. Audits that are being carried out or have been carried out in 2021/22 in relation to NICE guidance include:

- National Rheumatology Audit CG 79 and QS 33
- Audit of Acute Upper GI bleed among in-patients NICE CG 141
- Evaluation into incidents of pressure ulcers during acute stage in SCI patients NICE CG 179
- Audit of clinical management of patients with DMD according to standard of care NICE HST 3

- Reaudit of botox administration in children with cerebral palsy NICE CG 145
- An audit to determine whether the Sepsis 6 pathway is being implemented and adhered to NICE NG 51
- The effectiveness of track and trigger systems in identifying deteriorating patients NICE CG 50
- Ward staff perception of nerve block education provided by the Acute Pain Service NICE NG 124
- Perioperative Management of children with cerebral palsy undergoing major surgery NICE NG 62
- Audit of compliance with the faster diagnosis standard – a retrospective review NICE NG 12

NICE Guidance that requires further evidence of assurance is listed on the Clinical Audit Forward Plan. This is reviewed monthly by the Clinical Audit Quality Lead for assurance purposes.

1.4 Actions following NICE Guidance Audits

Below are the actions taken forward following clinical audit of NICE Guidance Compliance

2122_028 Reaudit of Botox Administration in Children with Cerbral Palsy:

- Consider role of standardised botox risks sticker for consent forms – Completed, stickers have been ordered and rolled out
- Ensure patient information leaflet is provided as part of the pre-op consultation – Completed, Botox leaflet available in clinic via QR / Paper / Online
- Use of the botox proforma / explore potential to integrate this electronically into the new EPR System – In progress, Proforma developed following original audit, but not well utilised due to integration with EPR. This action is best put on hold pending the new EPR system which may allow us to create a more integrated proforma that can be used. Completion date 05/12/2022

2122_003 Ward staff perception of nerve block education provided by the Acute Pain Service:

- Review of technology and its use in education - in progress, need evidence of meeting with People Services completion date 31/01/2022
- Review of information dissemination and methods – Completed, this was presented at Quality Forum for Shared Learning across the Trust and at NOA
- Review of link nurse role – in progress, the link nurse role is being reviewed as part of a hospital wide review completion date 30/09/2022

2122_017 Perioperative Management of Children with Cerebral Palsy undergoing Major Surgery:

- Education of ward staff who complete STAMP tool – in progress completion date 31/07/2022
- Increase input of dietitian review of high-risk patients – in progress completion date 31/07/2022
- Amended STAMP guidance to permit professional judgement in medium risk category patients – Completed, the STAMP guidance was amended in December 2021

2122_024 Audit of Compliance with the Faster Diagnosis Standard – a retrospective review:

- Understanding of the referral process for imaging referrals from Montgomery Unit – Completed, flowchart in place
- Clear and agreed standards for the scheduling and performance of US guided biopsies – Completed, pathway completed and in folder
- Streamline the communication between radiology and Montgomery Unit – in progress, completion date 10/10/2022
- Improve triage process to include patient in earlier stage in pathway – Completed, pathway completed and in folder
- Improve imaging booking process – in progress, completion date 10/10/2022
- Improve how US biopsies are monitored – Completed pathway completed and in folder

2. Conclusion

We have an effective process in place to assess and monitor NICE Guidance within the Trust. Recently appointing a new NICE Guidance Clinical Lead has assisted with reviewing NICE Guidance in a timely manner. We have incorporated NICE Guidance that needs reviewing into Unit Governance Reports. This ensures quality cross checks in the event of any guidance's being reviewed incorrectly.

The Board is asked to note the NICE Guidance Activity for 2021/22.

Appendix 1: Acronyms

NICE	National Institute for Health and Care Excellence
CG	Clinical Guidelines
HST	Highly Specialised Technology
QR	Quick Response code
EPR	Electronic Patient Record
NOA	National Orthopaedic Alliance
STAMP tool	Screening Tool for the Assessment of Malnutrition in Paediatrics
US	Ultrasound

Human Tissue Authority update

0. Reference Information

Author:	Lisa Newton- Assistant Chief Nurse Specialist Unit	Meeting date:	11 January 2023
Senior Leader Sponsor:	Sara Ellis Anderson- Chief Nurse and Patient Safety Officer	Paper written on:	15th November 2022
Paper Reviewed by:	N/A	Paper Type:	Governance and Quality Performance
Forum submitted to:	Quality and Safety Committee	Paper FOIA Status:	Full
Paper to support CQC Evidence:	No	Purpose of Paper:	Noting

Executive Summary

The Human Tissue Authority (HTA) is an executive non-departmental public body of the Department of Health. It regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training. Under the Human Tissue Act 2004 (HT Act) the HTA has a statutory responsibility to make judgements about the suitability of: the Designated Individual; Licence Applicant (Holder); premises and practices in relation to the licensed activities.

The HTA must satisfy itself that the Designated Individual (DI) is a suitable person to supervise the activity to be authorised by the licence and that they will undertake the following duties:

- Secure that other persons to whom the licence applies are suitable persons to participate in the licensed activities.
- Secure that suitable practices are used while carrying on the activity.
- Secure that the conditions of the licence are complied with.

The HTA must also be able to:

- Satisfy itself that the applicant for the licence is a suitable person to be a holder of the licence.
- Satisfy itself that the premises are suitable for the activity to be authorised by the licence.
- Assess whether an establishment is suitable to carry out one or more of the activities regulated by the HTA.

Progress / Impact on Patient Care

An announced inspection was undertaken on the 25th and 28th July 2022- 4 minor shortfalls were identified. 2 were resolved during the inspection with 2 being transferred to a CAPA plan.

1) Third party agreement with the testing laboratory has expired – on going review of SLA deadline 31st March 2023
2) Manual temperature monitoring gaps in daily monitoring of a fridge- now added to EMS electronic monitoring system

We also received 3 advisories

1) rewrite the SOP regarding temperature recording which is underway
2) The 2nd and 3rd have been addressed as the temperature recording is now online.

Risk and Issues

SLA finalisation for laboratories – deadline 361st March 2023

Next Steps and Actions

SLA with laboratory needs to be agreed- deadline 31st March 2023
SOP to be updated to incorporate online temperature monitoring – current version refers to manual recording

Human Tissue Authority update

Conclusion
An announced inspection was undertaken on the 25th and 28th July 2022 and the report is attached.

Appendix Acronyms

HTA	Human Tissue Act
DI	Designated Individual
CAPA	Corrective and preventable action plan
SLA	Service level agreement

Inspection report on compliance with HTA licensing standards
Inspection dates: **25 and 28 July 2022**

Robert Jones and Agnes Hunt Orthopaedic Hospital

HTA licensing number 11064

Licensed under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended)
and
Licensed under the Human Tissue Act 2004

Licensable activities carried out by the establishment
Licensed activities – Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended)
'E' = Establishment is licensed to carry out this activity and is currently carrying it out.
'E*' = Establishment is licensed to carry out this activity but is not currently carrying it out.
'TPA' = Third party agreement; the establishment is licensed for this activity but another establishment (not licensed by the HTA) carries out the activity on their behalf.

Site	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Robert Jones and Agnes Hunt Orthopaedic Hospital	E		E*/TPA	E			

Tissue types authorised for licensed activities

Authorised = Establishment is authorised to carry out this activity and is currently carrying it out.
Authorised* = Establishment is authorised to carry out this activity but is not currently carrying it out.

Tissue Category; Tissue Type	Procurement	Processing	Testing	Storage	Distribution	Import	Export
Musculoskeletal, Bone; Bone	Authorised		Authorised*	Authorised			
Musculoskeletal, Tendon & Ligament; Tendons				Authorised			
Other, Bone Marrow (ATMP)	Authorised		Authorised*				
Other, Cartilage (ATMP)	Authorised		Authorised*				

Licensed activities – Human Tissue Act 2004

The establishment is licensed for the storage of relevant material which has come from a human body for use for a scheduled purpose.

Summary of inspection findings

The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation.

Although the HTA found that The Robert Jones and Agnes Hunt Orthopaedic Hospital (the 'establishment') had met the majority of the HTA's standards that were assessed during the inspection, four minor shortfalls were found against standards for Governance and Quality, and Premises, Facilities and Equipment.

The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

Compliance with HTA standards
Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) standards

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.		
p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells.	At the time of the inspection the third party agreement with the testing laboratory had expired and was under review.	**Minor**

GQ4 There is a systematic and planned approach to the management of records.		
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.	A review of manual temperature monitoring records identified several instances where the daily temperatures had not been recorded, including one fridge where temperatures had not been recorded for 16 days in January 2022. Whilst the record had not been annotated it was confirmed this was due to staff absences due to COVID-19.	**Minor**

GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.		
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 001/2021.	The donor selection questionnaire did not include a question regarding transplantation with xenografts. *The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*	**Minor**

PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues, cells, consumables and records.		
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.	Consumables used during the procurement of bone are stored at room temperature in a secured storage room. Whilst daily temperatures are manually recorded during weekdays, this does not include a record of the minimum and maximum temperatures reached between readings, or the humidity in the room. This does not provide an assurance that the temperature and humidity have been maintained within the ranges specified by the manufacturer. In addition, serology blood samples may be stored in a fridge in the Arthritis Research Centre prior to transfer to the testing laboratory. Whilst temperatures are recorded daily during weekdays, the minimum and maximum temperatures are not recorded. There is no assurance that the temperature has been maintained within acceptable ranges between readings. *The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*	**Minor**

The HTA requires the DI to submit a completed corrective and preventative action (CAPA) plan setting out how the shortfalls will be addressed, within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

Advice
The HTA advises the DI to consider the following to further improve practices:

Number	Standard	Advice
1.	GQ1b	Staff at the establishment regularly review freezer and room temperature monitoring records. The DI is advised to include these processes in relevant documentation, such as the standard operating procedure (SOP) 38 related to services and maintenance.
2.	GQ3k	The DI is advised to consider contingency plans for recording and monitoring storage temperatures during unforeseen staff absences.
3.	PFE5c	The DI is advised to consider implementing a process to review temperature plots of the -80ºC freezers over time, as changes in the running temperature may provide advance warning of any potential freezer failures. This is particularly relevant to older freezers, such as that used to store femoral heads available for use.

Background
The Robert Jones and Agnes Hunt Orthopaedic Hospital operates a bone bank and a cellular therapy unit which is jointly regulated by the HTA and the Medicines and Healthcare products Regulatory Agency (MHRA) as a manufacturer of Advanced Therapy Medicinal Products (ATMPs). In addition to being licensed for procurement, testing and storage under the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended), the establishment is licensed for storage of relevant material under the Human Tissue Act 2004 (HT Act). While the majority of samples stored for research have approval from recognised research ethics committees (REC), the establishment does hold a collection of samples under the HT Act.

The establishment has been licensed by the HTA since August 2006. This was the eighth site visit inspection of the establishment. This was a targeted inspection aimed at assessing compliance with a subset of licensing standards relevant to the establishment's activities. A list of the assessed standards can be found in Appendix 3. The previous inspection took place in March 2019.

Since the last inspection the establishment has changed the Corporate Licence Holder named contact (CLHc) and added a new Persons Designated (PD) to the licence.

Description of inspection activities undertaken

The HTA's regulatory requirements are set out in Appendix 1. The following areas were covered during the inspection:

Review of governance documentation

A review of selected documentation relevant to the establishment's licensable activities was undertaken, including key procedural documents, agreements with third parties, staff training records, temperature monitoring records and maintenance records.

Visual inspection

The inspection included a review of the areas where tissue is received, procured and stored. In addition, storage areas for consumables and reagents were also inspected.

Audit of records

Records were reviewed for two procurements of ATMP starting material (one cartilage and one bone marrow), two femoral heads that were currently in storage, and two femoral heads that had been released from storage and implanted. Records reviewed included donor eligibility and consent documentation, procurement records, timing and results of blood sample collection for mandatory serology testing, 180-day repeat testing if applicable, sterility testing results, records of release, and confirmation of implantation in the recipient records (if applicable).

Meetings with establishment staff

Discussions were held with the DI, Persons Designated, and other staff working under the licence.

The establishment is also licensed for the storage of relevant material for use in a scheduled purpose. Discussions included two scientists responsible for relevant material held under the licence for scheduled purposes. It was confirmed that while maintained, relevant material held under the licence was a static collection that had not been accessed since the last inspection. Therefore, this activity was not reviewed as part of this inspection.

Report sent to DI for factual accuracy: 19 August 2022

Report returned from DI: No factual accuracy or request for redaction comments were made by the DI

Final report issued: 23 September 2022

Appendix 1: The HTA's regulatory requirements

The HTA must assure itself that the DI, Licence Holder, premises and practices are suitable.

The statutory duties of the DI are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. The HTA inspects the establishments it licences against four groups of standards:

- consent
- governance and quality systems
- premises facilities and equipment
- disposal.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a standard is not met, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is given to the DI.

Reports of HTA inspections carried out from 1 November 2010 are published on the HTA's website.

Appendix 2: Classification of the level of shortfall

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as ‘Critical’, ‘Major’ or ‘Minor’. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue Act 2004, Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended), or associated Directions.

1. **Critical shortfall:**

   A shortfall which poses a significant direct risk of causing harm to a recipient patient or to a living donor,

   or

   A number of ‘major’ shortfalls, none of which is critical on its own, but viewed cumulatively represent a systemic failure and therefore are considered ‘critical’.

   A critical shortfall may result in one or more of the following:

   - A notice of proposal being issued to revoke the licence
   - Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
   - A notice of suspension of licensable activities
   - Additional conditions being proposed
   - Directions being issued requiring specific action to be taken straightaway

2. Major shortfall:

A non-critical shortfall.

A shortfall in the carrying out of licensable activities which poses an indirect risk to the safety of a donor or a recipient

or

A shortfall in the establishment's quality and safety procedures which poses an indirect risk to the safety of a donor or a recipient;

or

A shortfall which indicates a major deviation from the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) or the HTA Directions;

or

A shortfall which indicates a failure to carry out satisfactory procedures for the release of tissues and cells or a failure on the part of the designated individual to fulfil his or her legal duties;

or

A combination of several 'minor' shortfalls, none of which is major on its own, but which, viewed cumulatively, could constitute a major shortfall by adversely affecting the quality and safety of the tissues and cells.

In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. Minor shortfall:

A shortfall which cannot be classified as either critical or major and, which can be addressed by further development by the establishment.

This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by

the HTA either by desk-based review or at the time of the next on-site inspection.

In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with the final inspection report. Establishments must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine inspection.

After an assessment of the proposed action plan establishments will be notified of the follow-up approach the HTA will take.

Appendix 3: HTA standards
The HTA standards applicable to this establishment are shown below; those not assessed during the inspection are shown in grey text. Individual standards which are not applicable to this establishment have been excluded.

Human Tissue (Quality and Safety for Human Application) Regulations 2007 Standards (as amended)

Consent

Standard
C1 Consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) and as set out in the HTA's Codes of Practice.
a) If the establishment acts as a procurer of tissues and / or cells, there is an established process for acquiring donor consent which meets the requirements of the HT Act 2004 the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (as amended) and the HTA's Codes of Practice.
c) The establishment or the third party's procedure on obtaining donor consent includes how potential donors are identified and who is able to take consent.
d) Consent forms comply with the HTA Codes of Practice.
e) Completed consent forms are included in records and are made accessible to those using or releasing tissue and / or cells for a Scheduled Purpose.
C2 Information about the consent process is provided and in a variety of formats.
a) The procedure on obtaining consent details what information will be provided to donors. As a minimum, the information specified by Directions 001/2021 is included.
c) Information is available in suitable formats and there is access to independent interpreters when required.

d) There are procedures to ensure that information is provided to the donor or donor's family by trained personnel.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.
a) Staff involved in obtaining consent are provided with training on how to take informed consent in accordance with the requirements of the HT Act 2004 and Code of Practice on Consent.
b) Training records are kept demonstrating attendance at training on consent.

Governance and Quality

Standard
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process.
a) There is an organisational chart clearly defining the lines of accountability and reporting relationships.
b) There are procedures for all licensable activities that ensure integrity of tissue and / or cells and minimise the risk of contamination.
c) There are regular governance meetings, for example health and safety, risk management and clinical governance committees, which are recorded by agendas and minutes.
d) There is a document control system to ensure that changes to documents are reviewed, approved, dated and documented by an authorised person and only current documents are in use.
e) There are procedures for tissue and / or cell procurement, which ensure the safety of living donors.

g) There are procedures to ensure that an authorised person verifies that tissues and / or cells received by the establishment meet required specifications.
h) There are procedures for the management and quarantine of non-conforming consignments or those with incomplete test results, to ensure no risk of cross contamination.
i) There are procedures to ensure tissues and / or cells are not released from quarantine until verification has been completed and recorded.
j) There are procedures detailing the critical materials and reagents used and where applicable, materials and reagents meet the standards laid down by the Medical Devices Regulation 2002 (SI 2002 618, as amended) (UK MDR 2002) and United Kingdom Conformity Assessed (UKCA).
k) There is a procedure for handling returned products.
l) There are procedures to ensure that in the event of termination of activities for whatever reason, stored tissues and / or cells are transferred to another licensed establishment or establishments.
m) The criteria for allocating tissues and / or cells to patients and health care institutions are documented and made available to these parties on request.
o) There is a complaints system in place.
p) There are written agreements with third parties whenever an activity takes place that has the potential to influence the quality and safety of human tissues and / or cells.
q) There is a record of agreements established with third parties.
r) Third party agreements specify the responsibilities of the third party and meet the requirements set out in Directions 001/2021.
s) Third party agreements specify that the third party will inform the establishment in the event of a serious adverse reaction or event.

t) There are procedures for the re-provision of service in an emergency.
GQ2 There is a documented system of quality management and audit.
a) There is a quality management system which ensures continuous and systematic improvement.
b) There is an internal audit system for all licensable activities.
c) An audit is conducted in an independent manner at least every two years to verify compliance with protocols and HTA standards, and any findings and corrective actions are documented.
d) Processes affecting the quality and safety of tissues and / or cells are validated and undergo regular evaluation to ensure they continue to achieve the intended results.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.
a) There are clearly documented job descriptions for all staff.
b) There are orientation and induction programmes for new staff.
c) There are continuous professional development (CPD) plans for staff and attendance at training is recorded.
d) There is annual documented mandatory training (e.g. health and safety and fire).
e) Personnel are trained in all tasks relevant to their work and their competence is recorded.
f) There is a documented training programme that ensures that staff have adequate knowledge of the scientific and ethical principles relevant to their work, and the regulatory context.
g) There is a documented training programme that ensures that staff understand the organisational structure and the quality systems used within the establishment.

h) There is a system of staff appraisal.
i) Where appropriate, staff are registered with a professional or statutory body.
j) There are training and reference manuals available.
k) The establishment is sufficiently staffed to carry out its activities.
GQ4 There is a systematic and planned approach to the management of records.
a) There are procedures for the creation, identification, maintenance, access, amendment, retention and destruction of records.
b) There is a system for the regular audit of records and their content to check for completeness, legibility and accuracy and to resolve any discrepancies found.
c) Written records are legible and indelible. Records kept in other formats such as computerised records are stored on a validated system.
d) There is a system for back-up / recovery in the event of loss of computerised records.
e) The establishment keeps a register of the types and quantities of tissues and / or cells that are procured, tested, preserved, processed, stored and distributed or otherwise disposed of, and on the origin and destination of tissues and cells intended for human application.
f) There are procedures to ensure that donor documentation, as specified by Directions 001/2021, is collected and maintained.
g) There is a system to ensure records are secure and that donor confidentiality is maintained in accordance with Directions 001/2021.
h) Raw data which are critical to the safety and quality of tissues and cells are kept for 10 years after the use, expiry date or disposal of tissues and / or cells.

i) The minimum data to ensure traceability from donor to recipient as required by Directions 001/2021 are kept for 30 years after the use, expiry or disposal of tissues and / or cells.
j) Records are kept of products and material coming into contact with the tissues and / or cells.
k) There are documented agreements with end users to ensure they record and store the data required by Directions 001/2021.
l) The establishment records the acceptance or rejection of tissue and / or cells that it receives and in the case of rejection why this rejection occurred.
m) In the event of termination of activities of the establishment a contingency plan to ensure records of traceability are maintained for 10 or 30 years as required.
GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.
a) Donors are selected either by the establishment or the third party acting on its behalf in accordance with the criteria required by Directions 001/2021.
b) The testing of donors by the establishment or a third party on behalf of the establishment is carried out in accordance with the requirements of Directions 001/2021.
c) In cases other than autologous donors, donor selection is carried out by authorised personnel and signed and reviewed by a qualified health professional.
d) There is a system in place either at the establishment or at a third party acting on its behalf to record results of donor selection and associated tests.
e) Testing of donor samples is carried out using UKCA or CE marked diagnostic tests, in line with the requirements set out in Directions 001/2021.
f) Samples taken for donor testing are clearly labelled with the time and place the sample was taken and a unique donor identification code.

GQ6 A coding and records system facilitates traceability of tissues and / or cells, ensuring a robust audit trail.
a) There is a donor identification system which assigns a unique code to each donation and to each of the products associated with it.
b) An audit trail is maintained, which includes details of when the tissues and / or cells were acquired and from where, the uses to which the tissues and / or cells were put, when the tissues and / or cells were transferred elsewhere and to whom.
c) The establishment has procedures to ensure that tissues and / or cells imported, procured, processed, stored, distributed and exported are traceable from donor to recipient and vice versa.
GQ7 There are systems to ensure that all adverse events, reactions and/or incidents are investigated promptly.
a) There are procedures for the identification, reporting, investigation and recording of adverse events and reactions, including documentation of any corrective or preventative actions.
b) There is a system to receive and distribute national and local information (e.g. HTA regulatory alerts) and notify the HTA and other establishments as necessary of serious adverse events or reactions.
c) The responsibilities of personnel investigating adverse events and reactions are clearly defined.
d) There are procedures to identify and decide the fate of tissues and / or cells affected by an adverse event, reaction or deviation from the required quality and safety standards.
e) In the event of a recall, there are personnel authorised within the establishment to assess the need for a recall and if appropriate initiate and coordinate a recall.
f) There is an effective, documented recall procedure which includes a description of responsibilities and actions to be taken in the event of a recall including notification of the HTA and pre-defined times in which actions must be taken.
g) Establishments distributing tissue and / or cells provide information to end users on how to report a serious adverse event or reaction and have agreements with them specifying that they will report these events or reactions.

h) Establishments distributing tissues and / or cells have systems to receive notifications of serious adverse events and reactions from end users and notify the HTA.
GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.
a) There are documented risk assessments for all practices and processes.
b) Risk assessments are reviewed regularly, as a minimum annually or when any changes are made that may affect the quality and safety of tissues and cells.
c) Staff can access risk assessments and are made aware of local hazards at training.
d) A documented risk assessment is carried out to decide the fate of any tissue and / or cells stored prior to the introduction of a new donor selection criteria or a new processing step, which enhances the quality and safety of tissue and / or cells.

Premises, Facilities and Equipment

Standard
PFE1 The premises are fit for purpose.
a) A risk assessment has been carried out of the premises to ensure that they are fit for purpose.
b) There are procedures to review and maintain the safety of staff, visitors and patients.
c) The premises have sufficient space for procedures to be carried out safely and efficiently.
e) There are procedures to ensure that the premises are secure, and confidentiality is maintained.
f) There is access to a nominated, registered medical practitioner and / or a scientific advisor to provide advice and oversee the establishment's medical and scientific activities.

PFE2 Environmental controls are in place to avoid potential contamination.
a) Tissues and / or cells stored in quarantine are stored separately from tissue and / or cells that have been released from quarantine.
c) There are procedures for cleaning and decontamination.
d) Staff are provided with appropriate protective clothing and equipment that minimise the risk of contamination of tissue and / or cells and the risk of infection to themselves.
PFE3 There are appropriate facilities for the storage of tissues and / or cells, consumables and records.
a) Tissues, cells, consumables and records are stored in secure environments and precautions are taken to minimise risk of damage, theft or contamination.
b) There are systems to deal with emergencies on a 24-hour basis.
c) Tissues and / or cells are stored in controlled, monitored and recorded conditions that maintain tissue and / or cell integrity.
d) There is a documented, specified maximum storage period for tissues and / or cells.
PFE4 Systems are in place to protect the quality and integrity of tissues and / or cells during transport and delivery to its destination.
PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored.
a) Critical equipment and technical devices are identified, validated, regularly inspected and records are maintained.
b) Critical equipment is maintained and serviced in accordance with the manufacturer's instructions.
c) Equipment affecting critical processes and storage parameters is identified and monitored to detect malfunctions and defects and procedures are in place to take any corrective actions.

d) New and repaired equipment is validated before use and this is documented.
e) There are documented agreements with maintenance companies.
f) Cleaning, disinfection and sanitation of critical equipment is performed regularly, and this is recorded.
g) Instruments and devices used for procurement are sterile, validated and regularly maintained.
h) Users have access to instructions for equipment and receive training in the use of equipment and maintenance where appropriate.
i) Staff are aware of how to report an equipment problem.
j) For each critical process, the materials, equipment and personnel are identified and documented.
k) There are contingency plans for equipment failure.

Disposal

Standard
D1 There is a clear and sensitive policy for disposing of tissues and / or cells.
a) The disposal policy complies with HTA's Codes of Practice.
b) The disposal procedure complies with Health and Safety recommendations.
c) There is a documented procedure on disposal which ensures that there is no cross contamination.
D2 The reasons for disposal and the methods used are carefully documented.
a) There is a procedure for tracking the disposal of tissue and / or cells that details the method and reason for disposal.

b) Disposal arrangements reflect (where applicable) the consent given for disposal.

Human Tissue Act 2004 standards

Consent

Standard
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the code of practice
a) Consent procedures are documented and these, along with any associated documents, comply with the HT Act and the HTA's Codes of Practice.
b) Where applicable, there are agreements with other parties to ensure that consent is obtained in accordance with the requirements of the HT Act and the HTA's Codes of Practice.

c) Where applicable, there are agreements with other parties to ensure that consent is obtained in accordance with the requirements of the HT Act and the HTA's Codes of Practice.
d) Written information is provided to those from whom consent is sought, which reflects the requirements of the HT Act and the HTA's Codes of Practice.
e) Language translations are available when appropriate.
f) Information is available in formats appropriate to the situation.
C2 Staff involved in seeking consent receive training and support in the essential requirements of taking consent
a) There is suitable training and support of staff involved in seeking consent, which addresses the requirements of the HT Act and the HTA's Codes of Practice.
b) Records demonstrate up-to-date staff training.
c) Competency is assessed and maintained.

Governance and Quality

Standard
GQ1 All aspects of the establishments work are governed by documented policies and procedures as part of the overall governance process
a) Ratified, documented and up-to-date policies and procedures are in place, covering all licensable activities.
b) There is a document control system.
c) There are change control mechanisms for the implementation of new operational procedures.

d) Matters relating to HTA-licensed activities are discussed at regular governance meetings, involving establishment staff.
e) There is a system for managing complaints.
GQ2 There is a documented system of audit
a) There is a documented schedule of audits covering licensable activities.
b) Audit findings include who is responsible for follow-up actions and the timeframes for completing these.
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills
a) Qualifications of staff and all training are recorded, records showing attendance at training.
b) There are documented induction training programmes for new staff.
c) Training provisions include those for visiting staff.
d) Staff have appraisals and personal development plans.
GQ4 There is a systematic and planned approach to the management of records
a) There are suitable systems for the creation, review, amendment, retention and destruction of records.
b) There are provisions for back-up / recovery in the event of loss of records.
c) Systems ensure data protection, confidentiality and public disclosure (whistleblowing).
GQ5 There are systems to ensure that all adverse events are investigated promptly

a) Staff are instructed in how to use incident reporting systems.
b) Effective corrective and preventive actions are taken where necessary and improvements in practice are made.
GQ6 Risk assessments of the establishment's practices and processes are completed regularly, recorded and monitored
a) There are documented risk assessments for all practices and processes requiring compliance with the HT Act and the HTA's Codes of Practice.
b) Risk assessments are reviewed regularly.
c) Staff can access risk assessments and are made aware of risks during training.

Traceability

Standard
T1 A coding and records system facilitates the traceability of bodies and human tissue, ensuring a robust audit trail
a) There is an identification system which assigns a unique code to each donation and to each of the products associated with it.
b) A register of donated material, and the associated products where relevant, is maintained.
c) An audit trail is maintained, which includes details of: when and where the bodies or tissue were acquired and received; the consent obtained; all sample storage locations; the uses to which any material was put; when and where the material was

transferred, and to whom.
d) A system is in place to ensure that traceability of relevant material is maintained during transport.
e) Records of transportation and delivery are kept.
f) Records of any agreements with courier or transport companies are kept.
g) Records of any agreements with recipients of relevant material are kept.
T2 Bodies and human tissue are disposed of in an appropriate manner
a) Disposal is carried out in accordance with the HTA's Codes of Practice.
b) The date, reason for disposal and the method used are documented.

Premises, facilities and equipment

Standard
PFE1 The premises are secure and fit for purpose
a) An assessment of the premises has been carried out to ensure that they are appropriate for the purpose.
b) Arrangements are in place to ensure that the premises are secure and confidentiality is maintained.
c) There are documented cleaning and decontamination procedures.

PFE2 There are appropriate facilities for the storage of bodies and human tissue
a) There is sufficient storage capacity.
b) Where relevant, storage arrangements ensure the dignity of the deceased.
c) Storage conditions are monitored, recorded and acted on when required.
d) There are documented contingency plans in place in case of failure in storage area.
PFE3 Equipment is appropriate for use, maintained, validated and where appropriate monitored
a) Equipment is subject to recommended calibration, validation, maintenance, monitoring, and records are kept.
b) Users have access to instructions for equipment and are aware of how to report an equipment problem.
c) Staff are provided with suitable personal protective equipment.

Corrective and preventative action (CAPA) plan

Establishment name: Robert Jones and Agnes Hunt Orthopaedic Hospital

Licensing Number: 11064

Inspection date: 25 and 28 July 2022

Date CAPA plan submitted by establishment: 29/09/22

Date CAPA plan agreed by HTA:

Date CAPA plan completed:

This CAPA plan template is designed to assist Designated Individuals (DI) address shortfalls against HTA licensing standards identified on inspection, and to provide assurance to the HTA that shortfalls will be addressed in a timely manner.

The CAPA plan was drawn up in agreement with the HTA. The HTA will determine the actions to be taken for each CAPA:

- A follow-up inspection
- A request for information that shows completion of actions
- Advising the HTA once the action has been carried out

HTA Standard	GQ1p	**Level of Shortfall (major or minor only)**	Minor
Inspection finding: At the time of the inspection the third party agreement with the testing laboratory had expired and was under review.			
Corrective and Preventative Action: There are ongoing discussions between RJAH and the supplier. The Pathology manager has stated that due to the complexity of the entire service this will be completed and renewed by March 2023. The prior contract will roll over until then.			
Deadline for completion of corrective and preventative action:	31st March 2023		
Action for HTA:			
Notes:			
Date CAPA completed:			
Outcome/Closure statement:			

HTA Standard	GQ4b	**Level of Shortfall (major or minor only)**	Minor
Inspection finding: A review of manual temperature monitoring records identified several instances where the daily temperatures had not been recorded, including one fridge where temperatures had not been recorded for 16 days in January 2022. Whilst the record had not been annotated it was confirmed this was due to staff absences due to COVID-19.			
Corrective and Preventative Action: There is now monitoring and recording of the outstanding fridge with online access via EMS. Link and login information can be provided. This commenced 21/09/2022 but there is email confirmation on 29/09/22. This fridge, along with other mechanisms under the HTA banner, is connected to the 'HTA Alarm', should this alarm sound, the 24hr attended switchboard service will action the 'HTA Alarm' protocol informing RJAH HTA personnel.			
Deadline for completion of corrective and preventative action:			
Action for HTA:			
Notes:			
Date CAPA completed:			
Outcome/Closure statement:			

HTA Standard	GQ5a	**Level of Shortfall (major or minor only)**	Minor
Inspection finding: The donor selection questionnaire did not include a question regarding transplantation with xenografts.			
Corrective and Preventative Action: The establishment submitted sufficient evidence to address this shortfall before the report was finalised			
Deadline for completion of corrective and preventative action:	Closed		
Action for HTA:			
Notes:			
Date CAPA completed:			
Outcome/Closure statement:			

HTA Standard	PFE3a	Level of Shortfall (major or minor only)	Minor

Inspection finding:

Consumables used during the procurement of bone are stored at room temperature in a secured storage room. Whilst daily temperatures are manually recorded during weekdays, this does not include a record of the minimum and maximum temperatures reached between readings, or the humidity in the room. This does not provide an assurance that the temperature and humidity have been maintained within the ranges specified by the manufacturer.

In addition, serology blood samples may be stored in a fridge in the Arthritis Research Centre prior to transfer to the testing laboratory. Whilst temperatures are recorded daily during weekdays, the minimum and maximum temperatures are not recorded. There is no assurance that the temperature has been maintained within acceptable ranges between readings.

Corrective and Preventative Action:

The establishment submitted sufficient evidence to address this shortfall before the report was finalised

Deadline for completion of corrective and preventative action:	Closed
Action for HTA:	

Notes:

Date CAPA completed:	

Outcome/Closure statement:

0. Reference Information

Author:	Elizabeth Hammond, Freedom to Speak Up Guardian	Paper date:	11th of January 2023
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee	Paper Ref:	N/A
Forum submitted to:	Trust Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

This paper is an annual review for 2021/22 of the Trust's raising concerns processes and the role of the Freedom to Speak Up Guardian. It provides the Board assurance that concerns raised are robustly managed in line with current best practice.

It benchmarks the Trust against the principal recommendations set out in Sir Robert Francis' report in 2014; data submitted quarterly to the National Guardian's Office.

2. Executive Summary

2.1. Context

The purpose of this report is to provide the Board with an overview and of the Freedom to Speak Up (FTSU) data during 2021/22. The report was reviewed and approved by People Committee.

2.2 Summary

- There has been an increase in concerns raised via the FTSU process to 45 in 21/22 compared to 28 in 20/21
- An increase in anonymous concerns in Q4 related to one issue that was escalated and investigated externally
- All concerns raised were accessed and acknowledged within 48 hours
- No people reporting FTSU concerns reported suffering detriment as a result.

2.3 Conclusion

The Board of Directors are asked to note the report and recommendations for 22/23.

3.0 Introduction

The purpose of creating a speaking up culture is to keep our patients safe, improve the working environment of staff and to promote learning and improvement. The staff survey results 2020 and previous years confirm that the Trust has a CQC 'Good' rated safety culture; we will keep on building on that positive culture.

2020/21 was dominated by the global Covid-19 pandemic and this brought some changes to speaking up channels. Staff continued to raise concerns; however, speaking up arrangements had been adapted in response to the pandemic. Due to the restrictions to reduce the spread of Covid the Guardians were unable to visit department and facilitate face-to-face conversations. This report provides a summary of activity, feedback and themes of concerns raised to the Freedom to Speak Up (FTSU) Guardians. It also looks at comparative organisations and the volumes of concerns raised with similar sized Trusts.

3.1 Freedom to Speak Up Accountability Arrangements

The Trust is committed to providing outstanding care to service users and staff and to achieving the highest standards of conduct, openness and accountability. The Chief Executive is accountable for ensuring that FTSU arrangements meet the needs of the staff across the Trust.

FTSU has recently moved from the Chief of People and is ow has the Chief Nurse as the Executive Lead for FTSU. The Lead provides leadership and oversees the supportive arrangements for speaking up within the Trust. The FTSU independent Non-Executive Director (NED) holds the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy and acts as an independent advisor and is available to the FTSU Guardian.

4.0 Freedom to Speak Up Reporting

FTSU Guardian reports to the Trust Board on a yearly basis. A six-monthly report is presented to the People and Culture Committee.

These reports update the Board of Freedom to Speak Up activities

Quarterly data returns are made to the National Guardian Office and the information from all trusts making submissions is published on the National Guardian's website: https://www.nationalguardian.org.uk/

The data to be reported includes the following:

- Total number of cases reported
- Number of concerns:
    - raised anonymously
    - with an element of patient safety/quality of care
    - with an element of worker safety
    - elements of behaviour including bullying and harassment
- Number of incidents where disadvantageous and or demeaning treatment (often referred to as detriment) is identified as a result of speaking up.

5. Who is speaking up?

The FTSU team have received concerns from a broad range of professional groups across the Trust. Nurses and Anonymous concerns, accounted for the largest portion of speaking up cases raised during 2021. In comparison to the previous year (2020) the number of anonymous concerns raised has reduced by 50%.

From January to March 2022 there has been an increase in anonymous concerns raised.

6. The Main Report

During this reporting period, Jan 2021- March 2022 Freedom to Speak Up received a total of 45 concerns in 2020/21 compared to 28 reported in 2020/21. No staff reported experiencing a detriment as a result of speaking up.

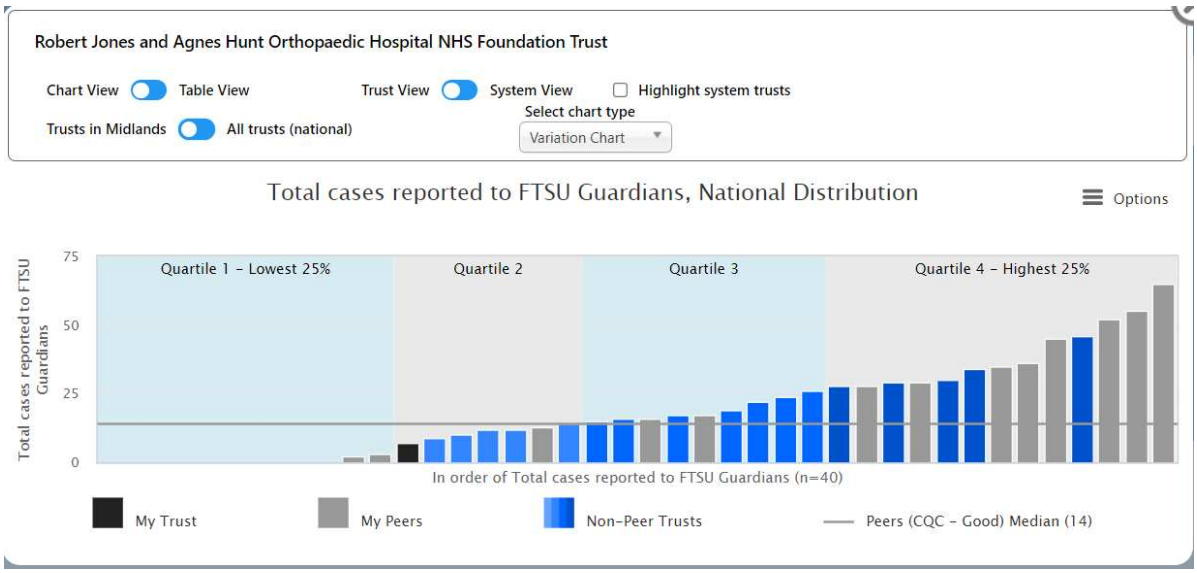
Reviews for each concern are independent, fair, and objective. Recommendations are designed to promote staff welfare, patient safety and learning.

Data table 1 shows the 2021- 2022 data submitted to the National Guardianship

	Quarterly FTSU Data April 2021 - March 2022				
Size of organisation	Less than 5,000 (small)				
		Q1	Q2	Q3	Q4
		April-June	July-Sept	Oct - Dec	Jan- March
Number of cases brought to FTSUGs / Champions per quarter		13	7	4	21
Of which there is an element of					
Number of cases raised anonymously		2	1	1	16
Number of cases with an element of patient safety/quality		0	1	1	0
Number of cases with an element of bullying or harassment		7	2	1	18
Number of cases where people indicate that they are suffering detriment as a result of speaking up		0	0	0	0
Worker Safety		0	0	1	1
Numbers of cases brought by professional group					
Administrative/clerical staff		2	2	0	2
Allied Healthcare Professionals (other than pharmacists)		1	1	0	2
Board members		0	0	0	0
Cleaning/Catering/Maintenance/Ancillary staff		0	0	0	0
Corporate services		1	0	1	1
Dentists		0	0	0	0
Doctors		1	0	0	0
Healthcare assistants		3	1	0	0
Midwives		0	0	0	0
Nurses		2	3	2	1
Not Known		3	0	1	15
Pharmacists		0	0	0	0
'Given your experience, would you speak up again?					
Total number of responses		1	1	0	1
The number of these that responded 'Yes'		0	1	0	1
The number of these that responded 'No'		1	0	0	0
The number of these that responded 'Maybe'		0	0	0	0
The number of these that responded 'I don't know'		0	0	0	0

In the Jan- March quarter 4 there was a marked rise in the number of staff raising a concern anonymously and the number of bullying and harassment themes. These all relate to one issue which has been escalated and has been externally investigated.

Below is the total number of cases reported to the National Guardians from Trusts in the Midlands in 2021. The grey boxes are our Peer group. Peer groups are CQC rated Good.



Below is the reported data for from the 1st April 2021- 31st March 2022. The NHS Trusts in the table below are all from the Midlands and categorised as small (under 5,000 employees)

Up Data 2021/22 (1st April 2021 - 31st March 2022)

Organisation	Organisation Type	Size	Region	Total Number of Cases				Number of cases raised anonymously				Number of Cases with an element of patient safety/quality				Number of cases related to behaviours, including bullying/harassment				Number of cases where people indicate that they are suffering detriment as a result of speaking up				Number of cases with an element of worker safety			
				Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Birmingham Community Healthcare NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	35	19	35	22	4	3	2	0	2	1	11	0	8	2	3	3	0	0	0	0	2	3	7	1
Shropshire Community Health NHS Trust	NHS Trust/Foundation Trust	*No data received*		*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*	*No data received*
Black Country Healthcare NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	33	16	19	19	9	1	0	0	5	4	0	4	5	6	4	1	0	0	0	0	0	1	4	0
Chesterfield Royal Hospital NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	46	52	56	27	5	0	2	0	4	10	0	4	9	8	5	7	0	1	0	0	6	9	4	1
Derbyshire Community Health Services NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	28	46	24	26	3	1	0	1	3	10	7	6	14	7	3	3	2	1	0	0	5	14	7	4
Derbyshire Healthcare NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	47	29	33	37	8	6	3	3	1	2	3	0	14	9	8	14	3	0	4	1	13	11	17	16
NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	6	2	0	6	3	0	*No data received*	1	1	0	*No data received*	1	1	1	*No data received*	4	*No data received*	*No data received*	*No data received*	*No data received*	1	1	*No data received*	*No data received*	
George Eliot Hospital NHS Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	4	9	18	10	0	0	0	0	1	2	6	0	0	3	1	5	0	1	0	1	0	2	6	3
Herefordshire and Worcestershire Health and Care NHS Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	6	*No data received*	9	15	3	*No data received*	3	7	1	*No data received*	3	3	2	*No data received*	5	5	2	*No data received*	1	3	1	*No data received*	5	7
Lincolnshire Community Health Services NHS Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	21	19	24	30	1	2	1	3	6	5	5	1	12	9	18	8	0	0	*No data received*	1	1	2	3	3
Lincolnshire Partnership NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	15	17	22	19	0	0	5	1	5	9	10	6	4	2	7	1	0	0	0	0	2	6	7	9
North Staffordshire Combined Healthcare NHS Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	13	14	7	13	0	0	*No data received*	0	3	5	1	1	1	3	3	3	0	1	1	3	2	2	0	1
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	13	7	4	21	3	1	1	16	0	0	1	0	9	1	1	18	0	0	0	0	0	0	1	1
Walsall Healthcare NHS Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	35	10	33	31	0	0	1	9	11	0	3	5	10	2	12	12	0	0	0	0	6	0	0	0
Wye Valley NHS Trust	NHS Trust/Foundation Trust	Small (up to 5,000 workers)	Midlands	17	16	26	15	2	1	1	3	1	3	2	2	6	6	7	7	0	0	1	*No data received*	3	2	4	*No data received*

Number of cases reported to the FTSU. In general, we have a low number in comparison to other Trusts. This could be for several reasons.

1) Some of the comparators have a considerable number of staff in comparison to RJAH

2) During the last 2 years the Guardians have been unable to access the departments due to Covid restrictions.

3) Lack of awareness of FTSU and how to raise a concern. The induction programme for staff is now in a booklet form instead of a face-to-face presentation.

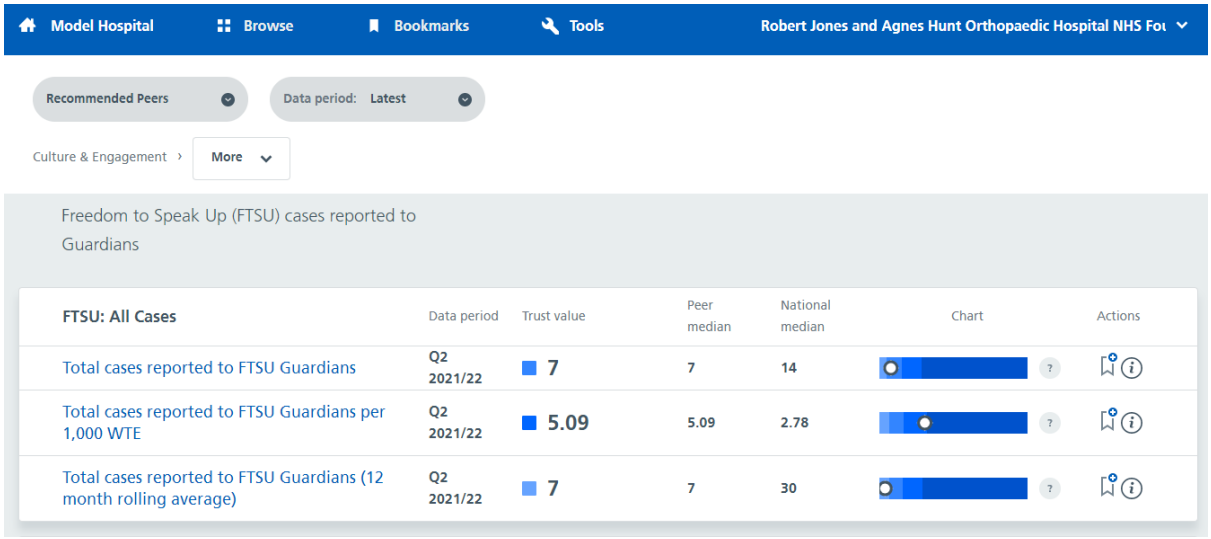
4) Few, established, staff have received any FTSU presentations. However, during the 2021 'Listen Up' events have been presented, with the support from department managers. The 'Listen Up' presentation outlines the role and process of FTSU and encourages them to Speak UP and for the Guardian to Listen Up! These have been presented face to face with small groups of staff.

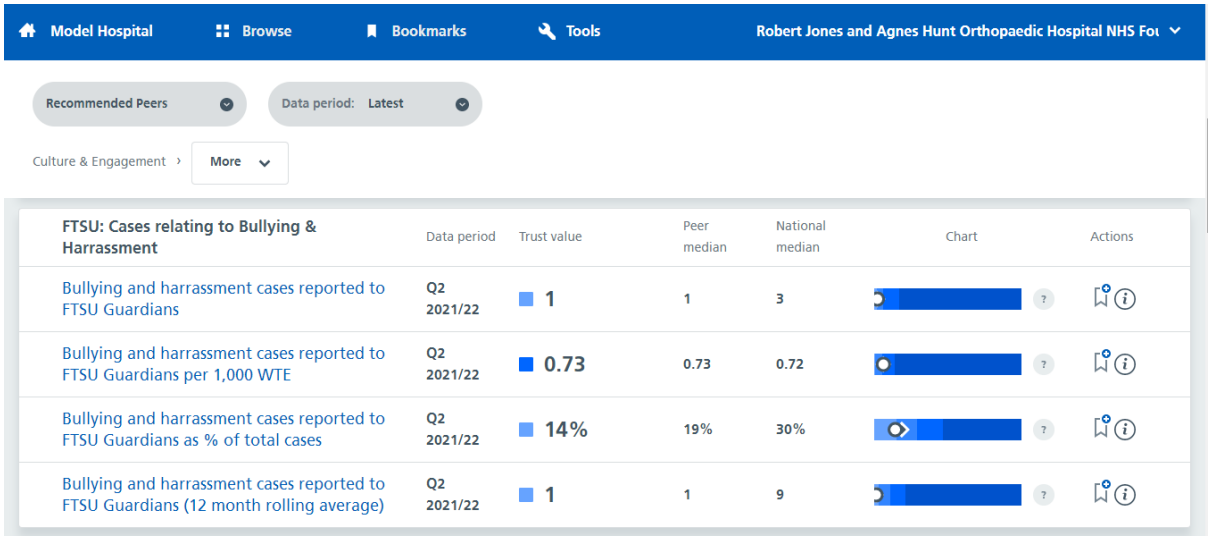
5) Limited facility time to engage with staff.

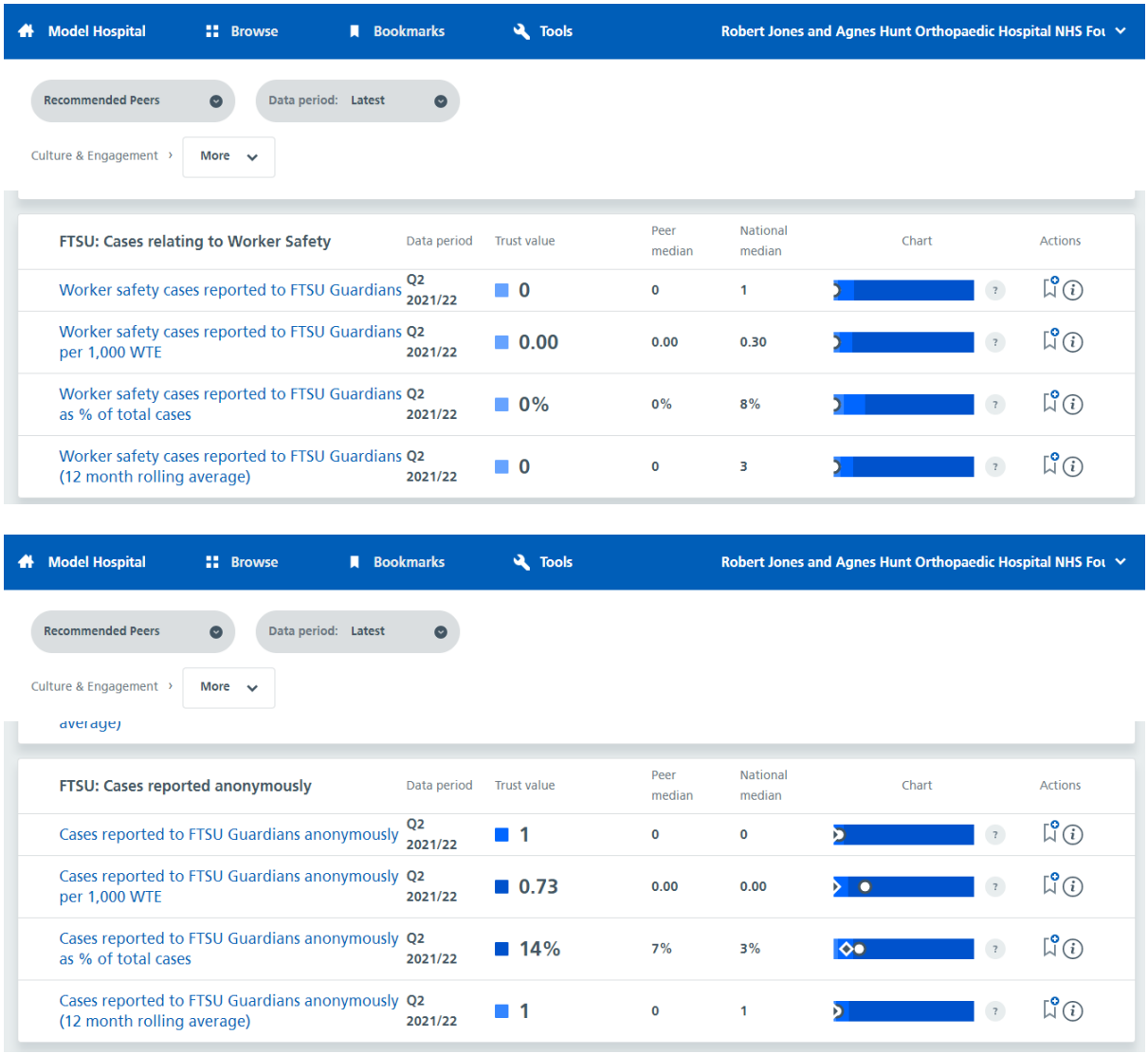
Below is the current data available, taken from the Model Hospital, which draws comparisons with our recommended peers, Royal Orthopaedic Hospital Birmingham and the Royal National Orthopaedic Hospital for quarter 2, July- September 2021. Worker's safety is a new addition to the data required by the National Guardianship.

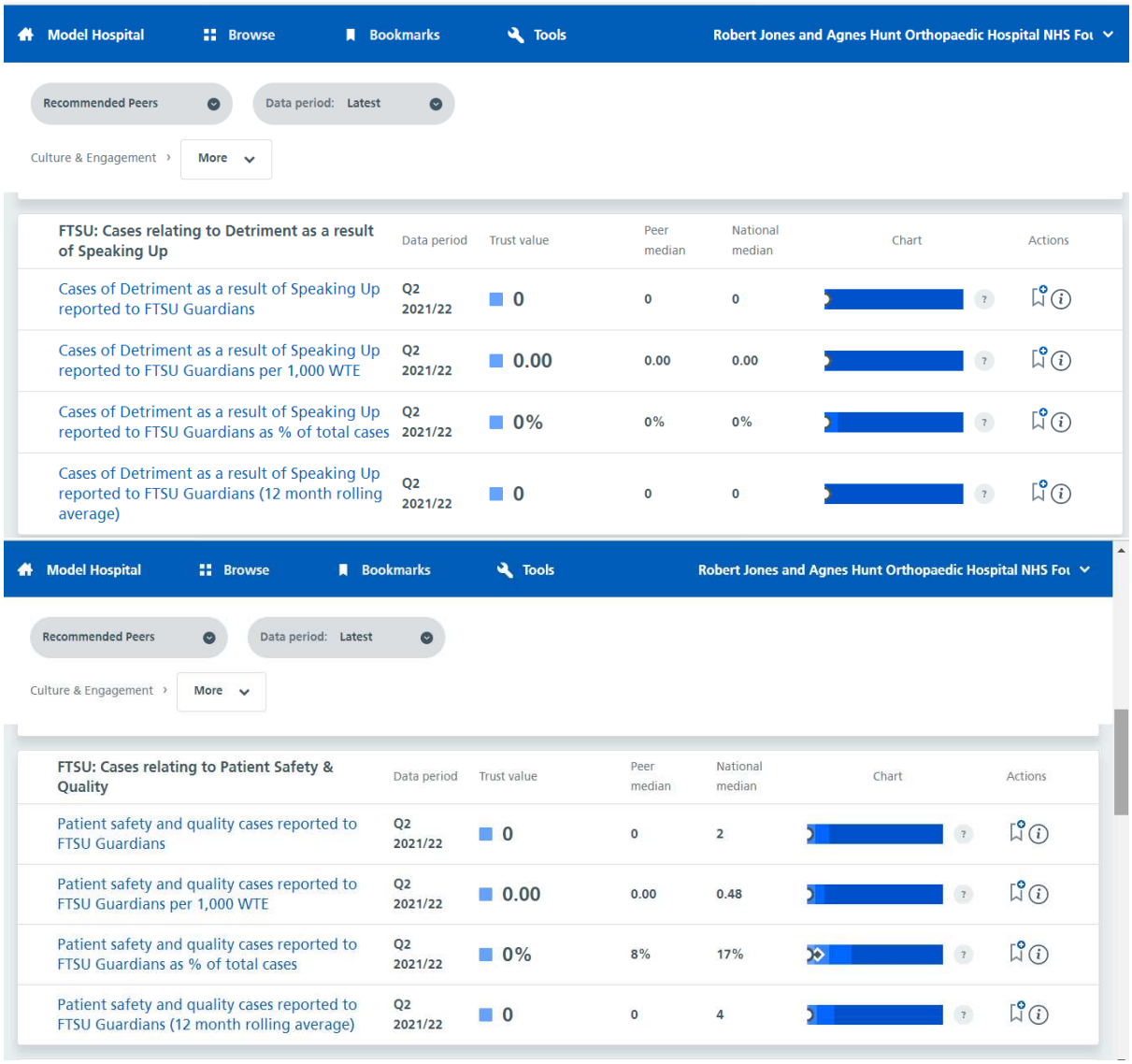
Bullying and harassment category increased during the second quarter which also correlated with the same increase in the percentage value for the anonymous concerns received.

In the third Quarter (Oct-Dec) the number of concerns received relating to bully and harassment was one.






Model Hospital
Browse
Bookmarks
Tools
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Fou
Recommended Peers
Data period: Latest
Culture & Engagement
More
FTSU: Cases relating to Worker Safety
Data period
Trust value
Peer median
National median
Chart
Actions
Worker safety cases reported to FTSU Guardians
Q2 2021/22
0
0
1
Worker safety cases reported to FTSU Guardians per 1,000 WTE
Q2 2021/22
0.00
0.00
0.30
Worker safety cases reported to FTSU Guardians as % of total cases
Q2 2021/22
0%
0%
8%
Worker safety cases reported to FTSU Guardians (12 month rolling average)
Q2 2021/22
0
0
3
Model Hospital
Browse
Bookmarks
Tools
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Fou
Recommended Peers
Data period: Latest
Culture & Engagement
More
average)
FTSU: Cases reported anonymously
Data period
Trust value
Peer median
National median
Chart
Actions
Cases reported to FTSU Guardians anonymously
Q2 2021/22
1
0
0
Cases reported to FTSU Guardians anonymously per 1,000 WTE
Q2 2021/22
0.73
0.00
0.00
Cases reported to FTSU Guardians anonymously as % of total cases
Q2 2021/22
14%
7%
3%
Cases reported to FTSU Guardians anonymously (12 month rolling average)
Q2 2021/22
1
0
1



7. Summary of Activity

Most concerns, raised by staff, have been raised confidentially. This has enabled the Guardian's to speak to the person who raised the concern, to gain information and clarity around the concern raised and to enable the Guardian to feedback actions and learning.

All concerns have been accessed within 48 hours. Concerns are then reviewed and escalated/directed as appropriate.

Where possible, the person who raised the concern has been given feedback on actions taken and regular one to ones arranged with the guardian/ manager to update the person and re-evaluate the concern.

All concerns have been logged as required by the national Guardianship. Data required by the Guardianship has been submitted quarterly via the National Guardian Database.

The Lead Guardian has attended the monthly Teams meetings regionally, the quarterly National Guardian meetings and the yearly conference.

Face to face presentations given to the International Nurses and preceptor groups.

8. Actions Taken

All behavioural issues escalated to appropriate managers.

The National Guardianship produced a generic NHS FTSU policy which has just been published. All Guardians were asked for input.

Development of a workbook for managers on how to deal with FTSU issues which have been escalated to them as well as how to ensure psychological safety for staff when they speak up to managers directly.

Regular Comms promotion of FTSU. Information page on the Trusts Intranet.

Refreshed FTSU face to face presentations to staff, when Covid restrictions are relaxed. Encourage staff to take ownership of their actions/practice, help prevent harm to patients and learn from raised concerns

9. Recommendations for 22/23

- FTSU Quarterly report to People Committee and Trust Board to align to the National Guardian Office reporting
- Recruitment to FTSU champion roll across all disciplines
- Continue roll out of FTSU training
- Review FTSU Guardian capacity and benchmark against similar sized organisations

10. Conclusion

As Guardians we require the full backing of the executives and managers to encourage and enable staff to raise concerns, without detriment as well as been supportive of changes to procedures which would enhance patient safety and staff welfare.

The FTSU guardian will continue to promote FTSU within the Trust. Monitor the different types of concerns and pinpoint areas of concern. Escalate and refer concerns as appropriate.

A key focus will be to continue to update the FTSU Data, teaching packages, policies, and general communication around FTSU as well as re-introduce face to face presentations and mini drop-in sessions to all departments.

Acronyms

FTSU	Freedom to Speak Up
NED	Non- Executive Director

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

NHSROBERTJONES AND AGNES HUNT TRUST

WORKFORCE REPORT

~~2022~~

Contents

Executive Summary

This annual Workforce Equality Data and Analysis Report has been produced to provide a detailed analysis of our workforce by the protected characteristics of age, gender, disability, race, religion or belief, sexual orientation and maritalstatus.

This report will include:

- Workforce Race Equality Standard report and action plan
- Workforce Disability Equality Standard report and action plan
- Gender Pay Gap report

The reports included within this wider workforce report fulfils the trusts legal obligation to the Equality Act 2010 by completing these NHSE mandated standards.

Workforce Race Equality Standard (WRES)

Introduction

This section of the workforce report describes the Trust's approach to and performance against the Workforce Race Equality Standard (WRES) in 2021.

WRES was mandated by the NHS from April 2015 and was included within the NHS Standard Contract from 2015-16. WRES baseline data has been provided and published on a yearly basis by the NHS since July2015.

The main purpose of the WRES is to help local and national NHS organisations review their data across nine WRES indicators and to produce an action plan to improve workplace experiences of Black, Asian and Minority Ethnic (BAME) staff. The WRES places an obligation on NHS organisations to improve BAME representation at board and senior level.

The WRES is applicable to providers and commissioners alike.

The Trust has two roles in relation to the WRES – as a provider of NHS services and as an employer. In both roles, our work is shaped by key statutory requirements and policy drivers including those arising from:

- The NHS Constitution
- The Equality Act and Public Sector Equality Duty
- The NHS Standard Contract
- The NHS Oversight Framework (this has replaced the CCG Improvement and Assessment Framework).

The NHS Standard Contract and NHS Oversight Framework both require CCGs to give assurance to the NHS England and Improvement (NHSE/I) WRES Team that their providers are implementing and using the WRES.

The Trust has monitoring arrangements in place to provide the above assurance through contract monitoring work, equality audits and performance reporting.

The Nine WRES Indicators

Workforce indicators

For each of these four workforce indicators, compare the data for White and BAME staff

Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 or Medical and Dental sub-groups and Very Senior Managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.
Note: Organisations should undertake this calculation separately for non-clinical and clinical staff.

Relative likelihood of staff being appointed from shortlisting across all posts.

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
Note: This indicator will be based on data year end data.

Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD).

National NHS Staff Survey indicators (or equivalent)

For each of the four staff survey indicators, compare the outcomes of the responses for White and **BAME** staff.

Percentage of staff experiencing harassment, bullying or abuse from patients/ service users, relatives, or the public in last 12 months.

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Percentage believing that the organisation provides equal opportunities for career progression or promotion.

Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months.

Board representation indicator

For this indicator, compare the difference for White and BAME staff.

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

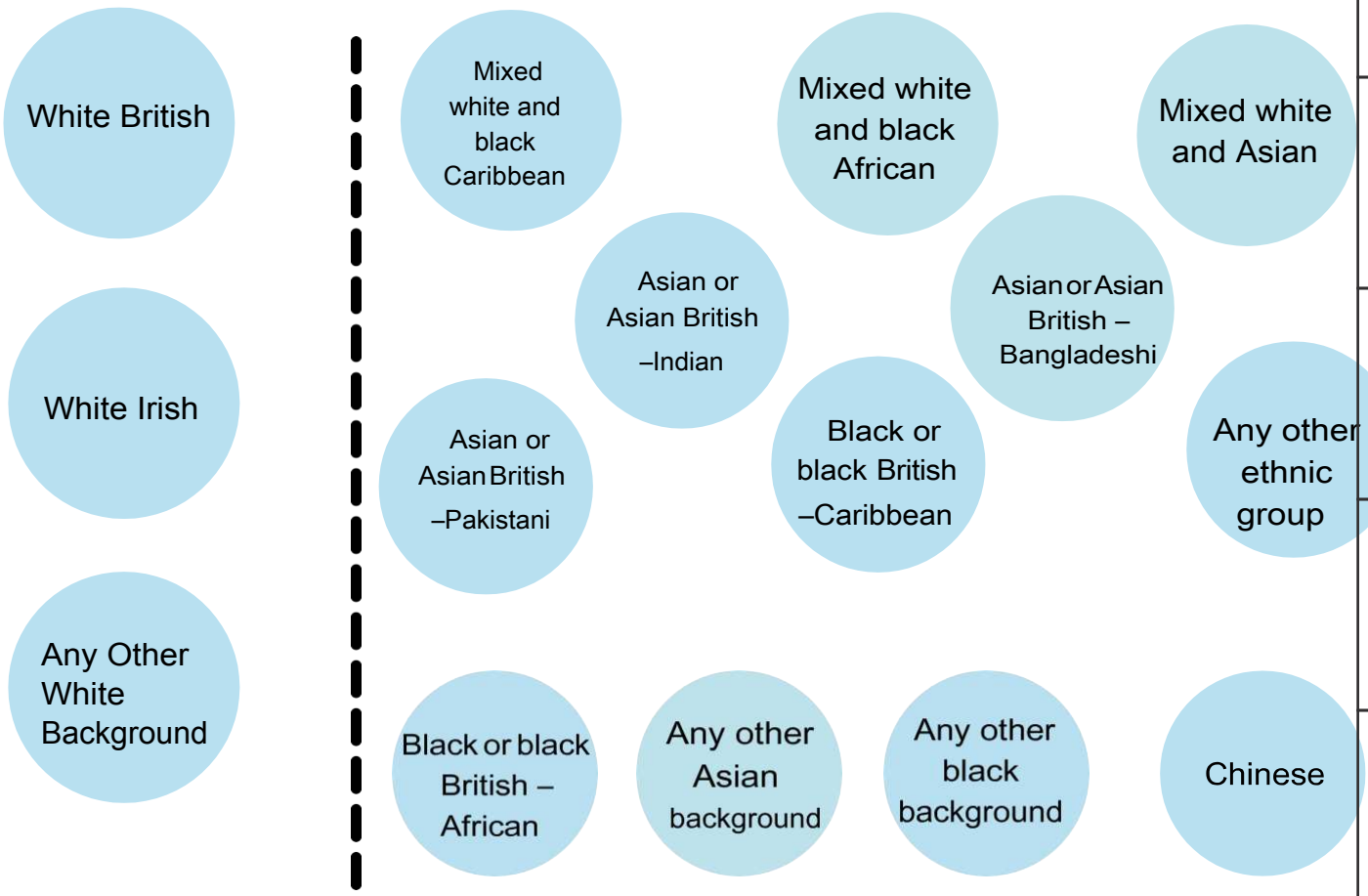
- By voting membership of the Board
- By executive membership of the Board

Definitions of ethnicity – people covered by the WRES:

Within the WRES, BAME refers to Black, Asian and Minority Ethnic groups. WRES publications often cite the term 'BME' which refers to Black and Minority Ethnic groups.

Data regarding BAME within the WRES relates to staff in the following groups which are categorised by the Office of National Statistics and cited within the WRES technical guidance:

BAME includes:



Implementation of the WRES, Trusts should:

- Collect workforce data for the period April 2021 – March 2022 and submit through the Strategic Data Collection Service by 31st August 2022.
- Publish its WRES report and action plan by 31st October 2022.
- The Trust's reporting information and data has been collated from its staff Electronic Staff Records (ESR) and internal data sets.

WRES technical guidance is available which notes that certain 'white groups' such as Gypsies and Travellers and Eastern European staff may be a significant minority group within an organisation and experience discrimination. Where this is the case, organisations should explore tackling such discrimination using workforce data, surveys and employing the principles of the WRES.

Our WRES data sets

The following tables show WRES reporting from the last 2 reporting periods for each of the indicators. The following data has been collated from the WRES submission templates for Robert Jones and Agnes Hunt Orthoepic Hospital NHS Foundation Trust - which are in excel format.

Table 1 below shoes summary workforce data – relating to the indications 1-9:

- Indicator 1: Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 OR Medical and Dental sub-groups and Very Senior Managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.

- Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

    - By voting membership of the Board

    - By executive membership of the Board

These indicators link to domain 3 of the NHS Equality Delivery System 2022.

The Robert and Jones Agnes Hunt Trust	2022	2021
No. of staff employed within the organisation - headcount	1685 ↑	1626
Proportion of BAME staff %	5.9% ↑	5.7%
Proportion of BAME staff in VSM %	5.6% ↑	0%
Total Board Members headcount and %	1 from 11 9.1% ↑	0 from 11 0%
Proportion of BAME Executive Board members headcount and %	0 from 5, 0% ↑	0 from 4 0%
Proportion of staff self-reporting their ethnicity %	94.8% ↓	95.1%

About this data:

The data sets shows a slight increase in staffing since last year, and BAME representation has increased slightly from 5.7% to 5.9% of staff.

Context – local BAME population: Await data from SW

According to the JSNA, the local BAME population of Telford and Wrekin is 10.5%. The local BAME population of Shropshire is 4.6%.

(Source: https://www.telford.gov.uk/download/downloads/id/10502/chapter_2_population_and_household_characteristics.pdf https://www.shropshire.gov.uk/media/3415/2011-census-digest-ethnicity.pdf)

Very Senior Managers (VSM):

The proportion of BAME staff in VSM across the Trust has increased from 0% to 5.6f%. The proportion of BAME staff in VSM is below the local population. This can affect the confidence levels BAME staff as they do not see representation at the senior levels.

Board Members:

The proportion of BAME staff in Board level roles has increased from 0% to 9.1%.

Proportion of BAME executive Board members:

The number of executive Board members is relatively small – with a total of 5 people in 2022. For this period and previous reporting period, the BAME proportion remains at 0%. BAME representation for executive Board members is lower than both local population and BAME overall staff representation.

Self-reporting of ethnicity:

The self-reporting of ethnicity on staff records is lower than 2021 but remains high with overall reporting at 94.8%.

Table showing Recruitment data relating to indicator 2: The relative likelihood of staff being appointed from shortlisting across all posts

These indicators link to domain 3 of the NHS Equality Delivery System 2022.

The Robert and Jones Agnes Hunt Trust	2022	2021
Number of short-listed applicants (headcount)	623 ↓	779
BAME short listed applicants – headcount and %	77 12.4% ↑	51 6.5%
Number appointed from shortlisting	174 ↓	190
BAME appointed from shortlisting – headcount and % from total appointed	11 6.3% ↑	5 2.6%
Relative likelihood of white staff being appointed from shortlisting compared to BAME staff	1.85 ↑	2.46

The above data shows:

The number of appointments has decreased from 190 in the last reporting period to 174 in 2022.

The % of BAME staff appointed from shortlisting has increased from 2.6% to 6.3% however this is a lower % than BAME staff shortlisted which was 12.4%. This may affect the confidence levels in the likelihood date of appointments across white, BAME and unknown backgrounds.

Table 3 shows Disciplinary data relating to indicator 3: Relative likelihood of BAME staff entering the formal disciplinary process,as measured by entry into a formal disciplinary investigation.

This indicator links to domain 3 of the Equality Delivery System 2022.

The Robert and Jones Agnes Hunt Trust	2022	2021
Number of staff entering into formal disciplinary process	REDACTED	REDACTED
Likelihood of staff entering the formal disciplinary process as a % a) White staff b) BAME staff c) Unknown	 0.47% 1.00% 0.00%	 0.07% 0.00% 0.00%

The above data shows:

This data set has been redacted within this report due to possible identifiable data.

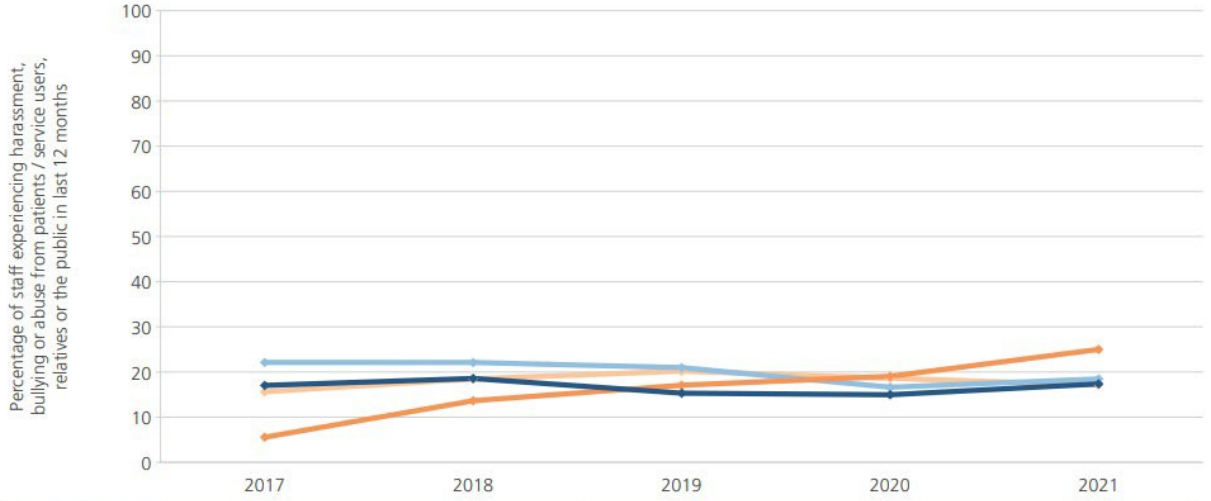
The data shows that in 2022, 1% of BAME staff entered into a disciplinary process compared to 0.47% of white staff.

Staff Survey – experience

Survey Coordination Centre

2021 NHS Staff Survey Results > WRES > **Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months**

NHS



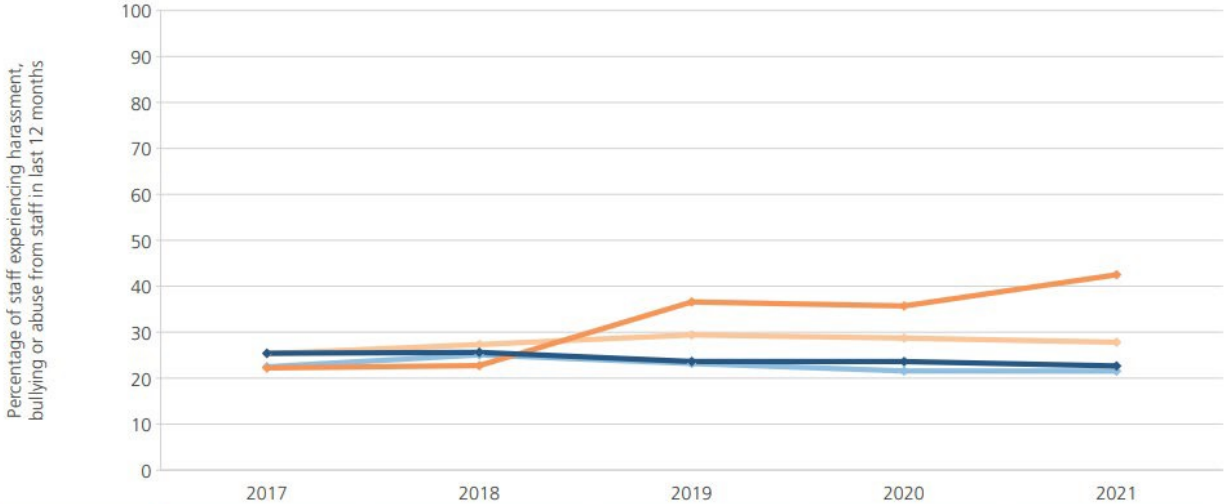
	2017	2018	2019	2020	2021
White: Your org	17.0%	18.6%	15.3%	15.0%	17.4%
BME: Your org	5.6%	13.6%	17.1%	19.0%	25.0%
White: Average	22.1%	22.1%	21.0%	16.6%	18.5%
BME: Average	15.6%	18.5%	20.2%	18.6%	17.1%
White: Responses	546	614	875	842	783
BME: Responses	18	22	41	42	40

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WRES > **Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

NHS



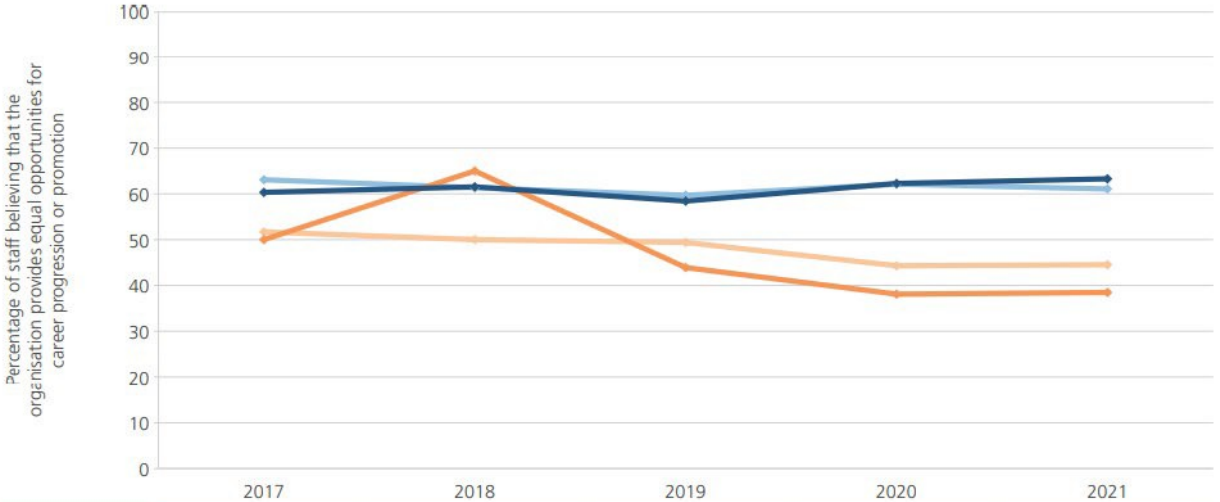
	2017	2018	2019	2020	2021
White: Your org	25.4%	25.6%	23.6%	23.6%	22.7%
BME: Your org	22.2%	22.7%	36.6%	35.7%	42.5%
White: Average	22.5%	25.1%	23.2%	21.6%	21.5%
BME: Average	25.3%	27.3%	29.4%	28.7%	27.8%
White: Responses	547	613	876	847	790
BME: Responses	18	22	41	42	40

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WRES > **Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

NHS



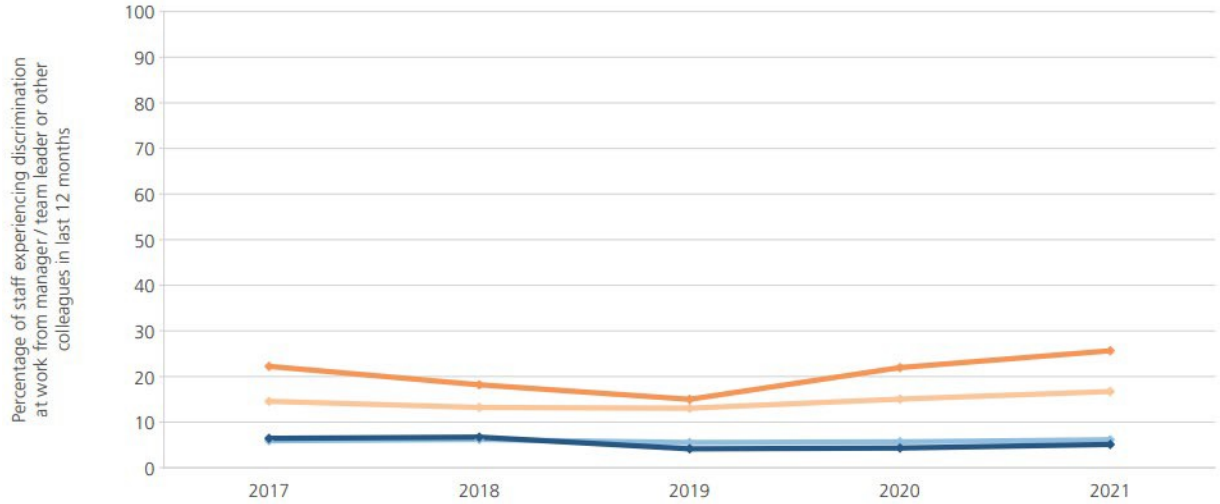
	2017	2018	2019	2020	2021
White: Your org	60.3%	61.5%	58.4%	62.3%	63.3%
BME: Your org	50.0%	65.0%	43.9%	38.1%	38.5%
White: Average	63.1%	61.4%	59.7%	62.1%	61.1%
BME: Average	51.7%	50.0%	49.4%	44.3%	44.5%
White: Responses	547	616	873	843	787
BME: Responses	18	20	41	42	39

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WRES > **Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months**

NHS



	2017	2018	2019	2020	2021
White: Your org	6.4%	6.7%	4.1%	4.3%	5.1%
BME: Your org	22.2%	18.2%	15.0%	22.0%	25.6%
White: Average	5.9%	6.2%	5.5%	5.7%	6.1%
BME: Average	14.6%	13.2%	13.0%	15.0%	16.7%
White: Responses	543	611	869	834	783
BME: Responses	18	22	40	41	39

Average calculated as the median for the benchmark group

WRES Action Plan

Trusts are required to produce an action plan based on the WRES findings. We will produce a Trust WRES action plan which will be published on the Trust's website. This will outline the steps to be taken by the Trust to improve inclusion and ensure that support is in place to meet the needs of all staff including BAME staff that are at higher risk of experiencing discrimination at work.

The Trust's action plan will also make reference to the Equality Delivery System (EDS)goals.

The NHS EDS is an equality performance and evaluation tool to help improve equality performance across three domains:

1. Commissioned or Provider services
2. Workforce health and wellbeing
3. Inclusive Leadership

WRES relates directly to all domains but specifically domains 2 and 3.

Our action plan and progress will be regularly reviewed throughout the year with oversight from our governance processes. This is documented separately to this report.

The Executive Management Team will have overall oversight for monitoring with Trust's Chief People and Culture Officer holding overall responsibility for reducing equalities. A non-executive director has also been appointed to lead on the Equality, Diversity and Inclusion Agenda.

Progress will be reported and published within:

- 2022/23 Equality and Inclusion Annual Report
- 2023 WRES report

Red	Behind plan
Amber	In Progress
Green	Complete
Blue	Implemented
NS	Not Started

WRES Action Plan 2022

Ref	Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
1	**E,D& I Strategy**	To be scheduled for discussion at a 2023 Board Strategy session	Sep-23	NS	Board	CPO
2	**Board statement - anti-racism**	To be scheduled for discussion at a 2023 Board Strategy session	Sep-23	NS	Board	CPO
3	**NED EDI lead**	To be confirmed at People and Culture Committee	Dec-22	In Progress	Board	Chair
4	**Review Trust E,D&I resource and expertise**	Trust People Team structure has been reviewed and recommendations made to strengthen E,D&I resource and expertise. Short-term support options to be discussed with STW ICB and NOA colleagues.	Jan-22	In Progress	People	CPO/ CEO
5	**EDI Committee**	Extraordinary committee met 29th September 2022, terms of reference have been agreed and ongoing meetings will be established.	Dec-22	In Progress	People	CPO
6	**System EDI network**	AM to attend System EDI network meeting going forward to link in with partners. DH to attend EDI development session with the ICS.	Sep-23	In Progress	People	CPO
7	**Staff story at Board**	EDI Committee to consider	Sep-23	NS	People	CPO
8	**Board training**	CPO and CEO to consider	Sep-23	NS	People	CPO/ CEO
9	**EDI training**	Since April 2020, staff have been required to complete the HEE national e-learning module "Equality and Diversity and Human Rights Level 1", which has a 3-year validity period. This is a core subject and mandatory for all staff. Other training is also available including: optional STW ICS EDI training (not recorded on RJAH ESR records) and HEE podcasts on health inequalities training. The ICS is creating videos for a new EDI learning module for 2023/22 (approx. 1 hour) - bespoke to local learning requirements rather than the generic national module.	Sep-23	In Progress	People	CPO
10	**Allyship**	NHS Providers have produced a toolkit of questions for Boards to consider and also provide a series of events for directors to attend.	Sep-23	NS	People	CPO/ CEO
11	**Review BAME staff network effectiveness**	Trust IJC network is not currently active, consider revamping or moving to a system wide network.	Sep-23	NS	People	CPO

12	**Keeping in Touch conversations**	Framework for keeping in touch conversations has been agreed and is currently being rolled out.	Mar-23	In Progress	People	CPO
13	**Leadership development programme**	A Leadership Development Programme has been agreed and will be rolled out from 2023.	Mar-23	In Progress	People	CPO
14	**FTSU/Whistle Blowing awareness**	Additional FTSU guardians have now been appointed and new training has been rolled out (starting at Board level). The Whistle Blowing Policy is also currently being reviewed.	Feb-23	In Progress	People	CPO
15	**Induction process**	Ensure induction process has sufficient focus on E,D&I	Sep-23	NS	People	CPO
16	**Consider use of Trust buddy programme to discuss EDI with staff to understand and explore staff experience**	To be considered by Executive Team and People Committee	Mar-23	In Progress	People	CPO
17	**Listening Events**	Revised framework to be drafted.	Mar-23	In Progress	People	CPO
18	**Review calendar of events to celebrate**	Communications team to lead	Mar-23	NS	People	CPO
19	**Improve recording of ethnicity data**	Trust Workforce Information Lead has identified actions to improve capture of ethnicity data.	Mar-23	In Progress	People	CPO
20	**Encourage increased uptake of staff survey**	52% completion rate of 2022 staff survey.	Sep-23	Complete	People	CPO
21	**EDI newsletter**	Consider roll out and liaise with ICS	Jun-23	NS	People	CPO

Workforce Disability Equality Standard (WDES)

Introduction

This report has been compiled following the 2022 submission of the Trust's data against the Workforce Disability Equality Standard.

This report therefore sets out The Robert Jones and Agnes Hunt Orthopaedic Hospital NHSFT's performance information against the mandatory WDES metrics and our actions.

The Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and applies to all NHS Trust and Foundation Trusts.

The WDES is a data-based standard that uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. Four of the indicators focus on the workforce data, four are based on data from the national NHS Staff survey questions and one indicator focuses on disability representation on Board.

The Nine WDES Indicators

Workforce indicators

The WOES is a data-based standard that uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. Four of the indicators focus on the workforce data, four are based on data from the national NHS Staff survey questions and one indicator focuses on disability representation on Board.

Percentage of staff in AFC pay bands or medical and dental sub-groups and very senior leaders (including Executive Board Members) compared with the percentage staff in the overall workforce.

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: based on a two-year rolling average (April 2020-March 2022).

a) Percentage of disabled staff, compared to non-disabled staff experiencing harassment, bulling or abuse. (Patients/public, managers or colleagues). b) percentage of staff reporting it.

Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work

a) The staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation.

b) b) Action taken to facilitate the voices of your disabled staff to be heard.

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated by voting membership and executive membership of the Board (snapshot of March 2022).

Metric 1 - Percentage of staff in AFC pay-bands or medical subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff overall

	Disabled Staff			Non-Disabled Staff		
	2022 %	2021 %	Difference %	2022 %	2021 %	Difference %
Bands 1 - 4	3.47	3.01	+0.45	69.87	63.29	+6.58
Bands 5 - 7	3.20	2.84	+0.35	56.98	52.54	+4.43
Bands 8a - 8b	2.82	3.33	-0.52	70.00	53.57	+16.43
Bands 8c - 9 &VSM	5.00	3.57	+1.43	71.43	73.33	-1.90
Medical Staff, Consultants)	0	0	0	50	47.96	+2.04
Medical Staff, non-career grades	0	0	0	78.57	69.57	+9.01
Medical staff trainee grades)	0	0	0	63.64	52.63	+11.0

Metric 2 - Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

		2021	2021
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	↑	1.07	1.58

Metric 3 - Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process

	2022	2021
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability process.	0.00	0.00

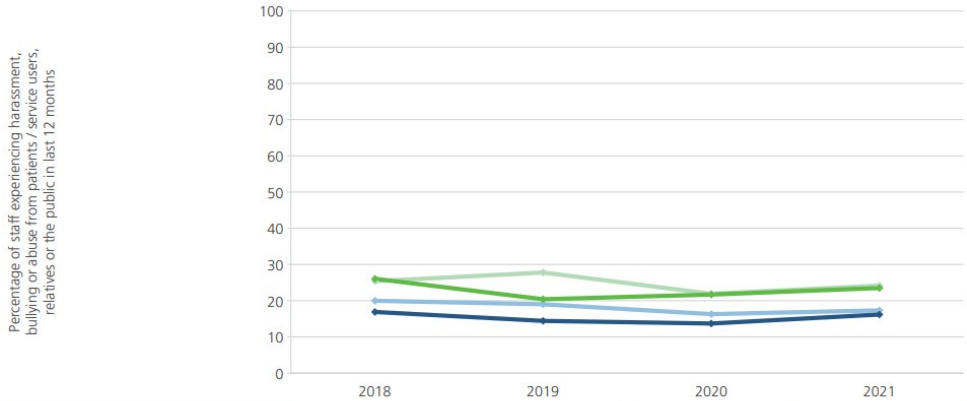
Metric 4 – 9 extracts from 2021 staff survey results

4a i)

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

NHS

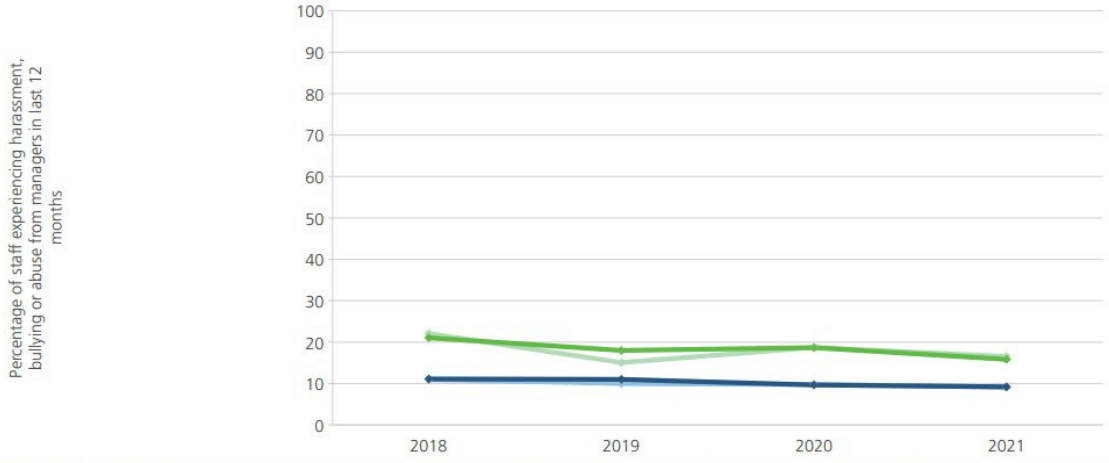


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	26.0%	20.4%	21.7%	23.5%
Staff without a LTC or illness: Your org	16.9%	14.4%	13.7%	16.2%
Staff with a LTC or illness: Average	25.4%	27.8%	21.9%	24.1%
Staff without a LTC or illness: Average	20.0%	19.0%	16.3%	17.3%
Staff with a LTC or illness: Responses	96	152	166	183
Staff without a LTC or illness: Responses	545	770	723	643

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

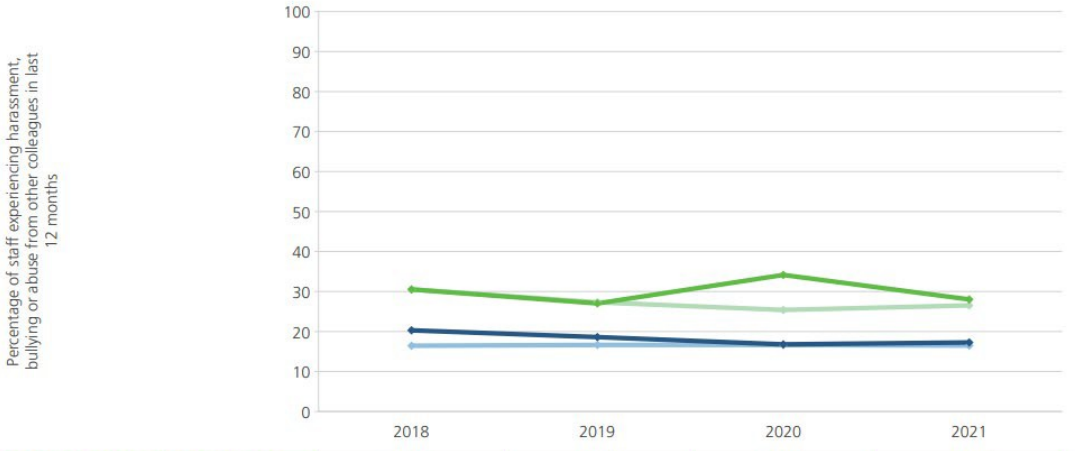


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	21.1%	18.0%	18.7%	15.8%
Staff without a LTC or illness: Your org	11.1%	11.0%	9.7%	9.2%
Staff with a LTC or illness: Average	22.1%	15.1%	18.7%	16.6%
Staff without a LTC or illness: Average	11.0%	10.0%	9.8%	9.1%
Staff with a LTC or illness: Responses	95	150	166	183
Staff without a LTC or illness: Responses	540	763	724	641

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

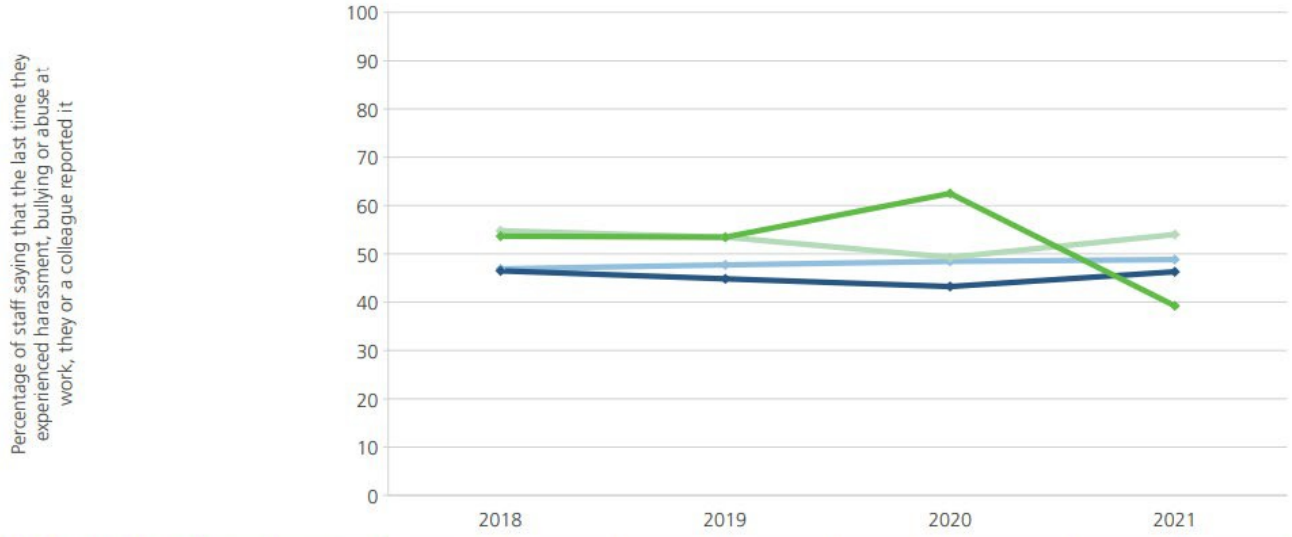


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	30.5%	27.0%	34.1%	28.0%
Staff without a LTC or illness: Your org	20.3%	18.6%	16.8%	17.3%
Staff with a LTC or illness: Average	30.5%	27.3%	25.4%	26.5%
Staff without a LTC or illness: Average	16.4%	16.6%	16.6%	16.5%
Staff with a LTC or illness: Responses	95	148	164	182
Staff without a LTC or illness: Responses	542	758	721	643

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

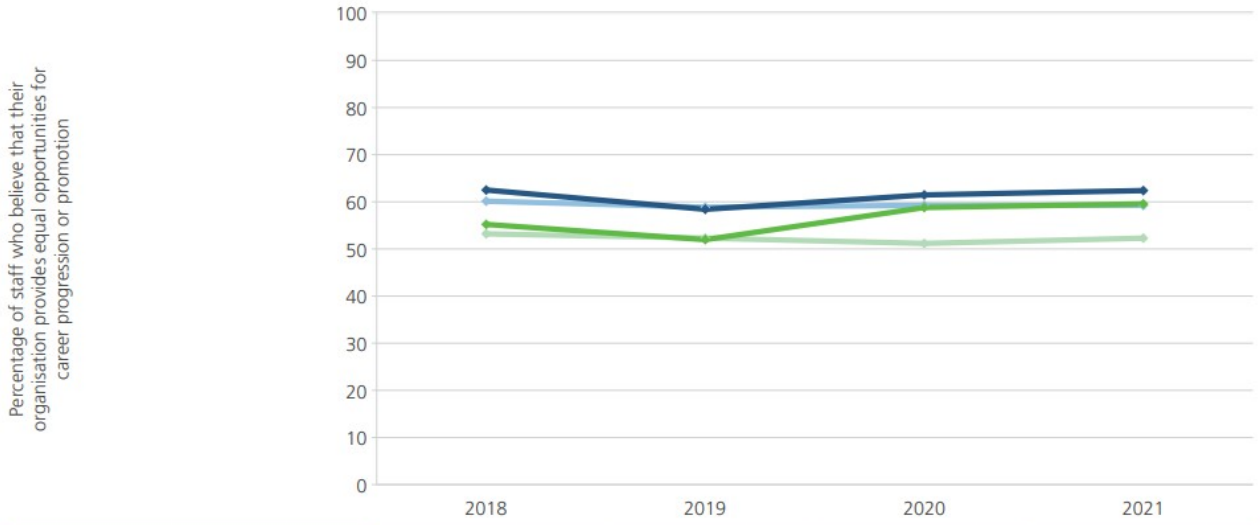


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	53.7%	53.4%	62.5%	39.2%
Staff without a LTC or illness: Your org	46.5%	44.8%	43.2%	46.3%
Staff with a LTC or illness: Average	54.8%	53.4%	49.3%	54.0%
Staff without a LTC or illness: Average	46.9%	47.7%	48.4%	48.8%
Staff with a LTC or illness: Responses	41	58	72	79
Staff without a LTC or illness: Responses	142	203	192	175

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

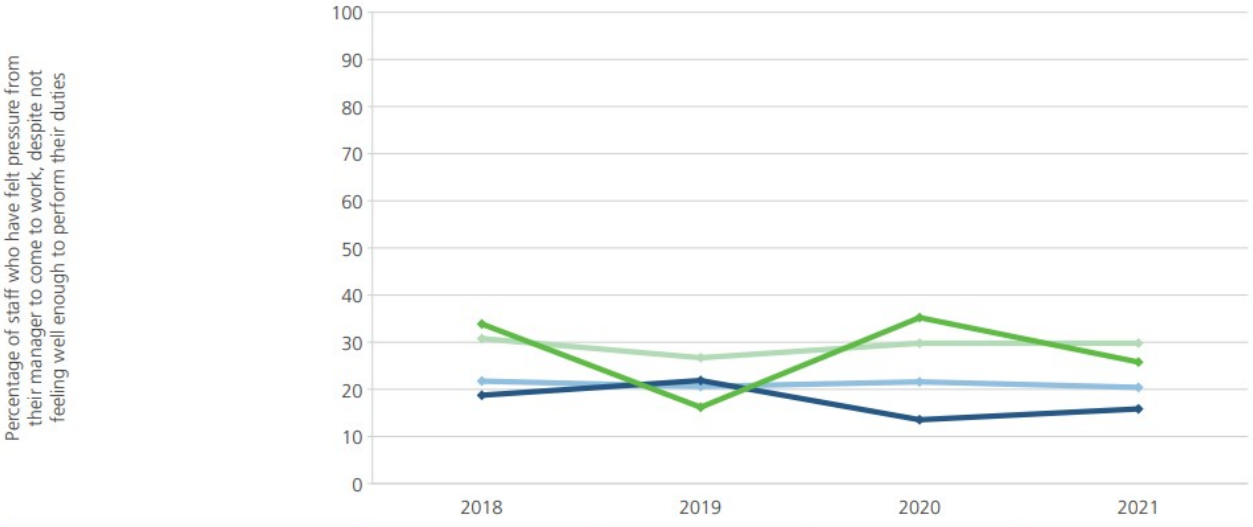


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	55.2%	52.0%	58.8%	59.6%
Staff without a LTC or illness: Your org	62.5%	58.4%	61.5%	62.4%
Staff with a LTC or illness: Average	53.2%	52.3%	51.2%	52.3%
Staff without a LTC or illness: Average	60.1%	58.9%	59.3%	59.3%
Staff with a LTC or illness: Responses	96	152	165	183
Staff without a LTC or illness: Responses	544	767	724	646

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

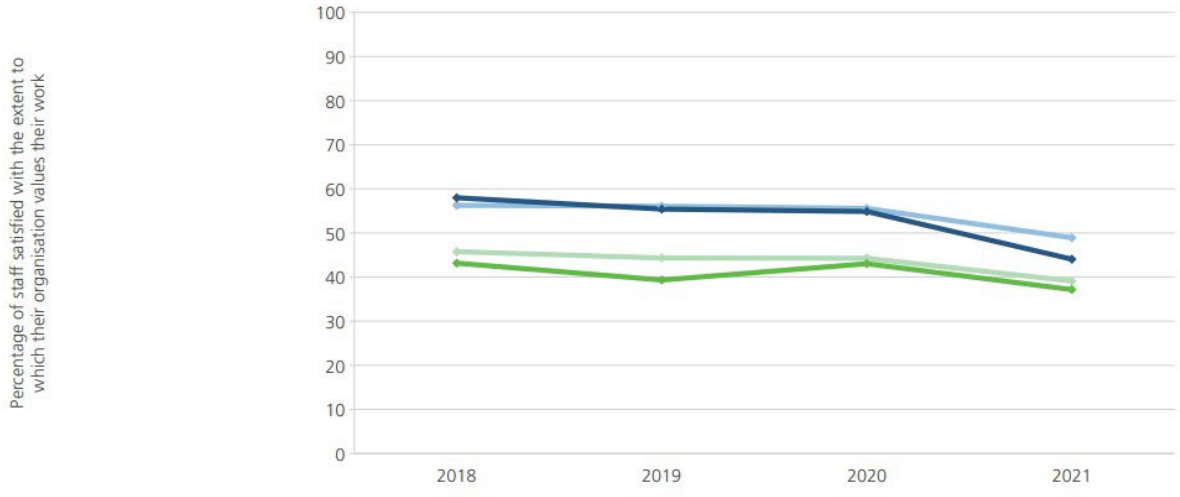


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	33.9%	16.2%	35.2%	25.8%
Staff without a LTC or illness: Your org	18.8%	21.9%	13.5%	15.8%
Staff with a LTC or illness: Average	30.8%	26.7%	29.8%	29.8%
Staff without a LTC or illness: Average	21.7%	20.6%	21.6%	20.4%
Staff with a LTC or illness: Responses	62	105	88	128
Staff without a LTC or illness: Responses	240	320	251	265

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff satisfied with the extent to which their organisation values their work

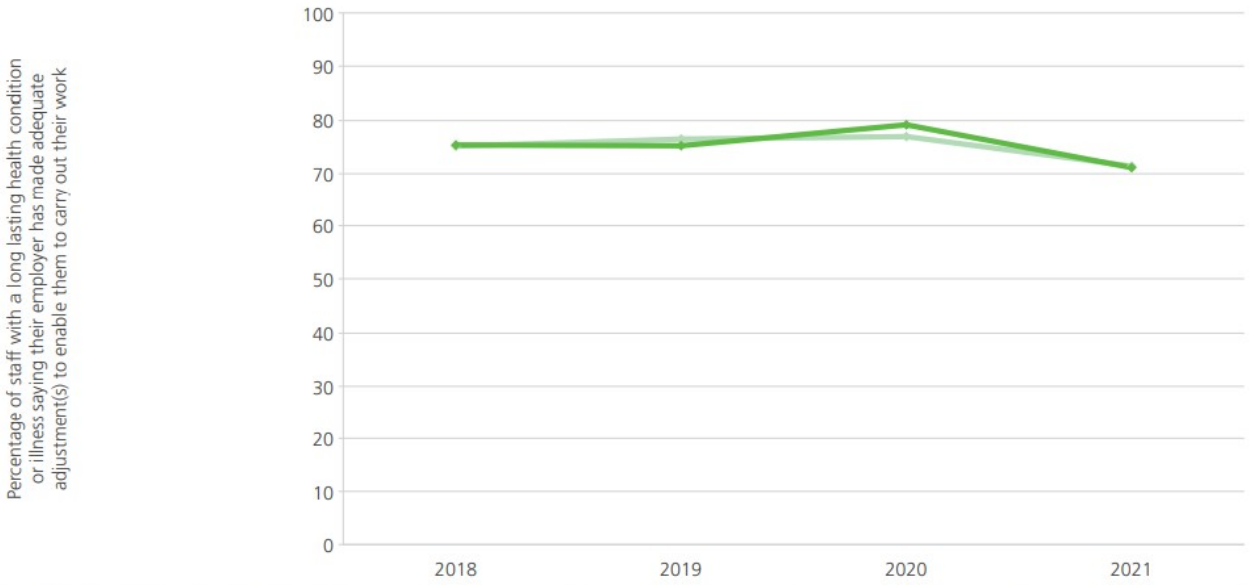


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	43.2%	39.3%	43.0%	37.2%
Staff without a LTC or illness: Your org	58.0%	55.4%	54.9%	44.0%
Staff with a LTC or illness: Average	45.8%	44.3%	44.3%	39.1%
Staff without a LTC or illness: Average	56.3%	56.1%	55.6%	48.9%
Staff with a LTC or illness: Responses	95	150	165	183
Staff without a LTC or illness: Responses	545	767	718	647

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work

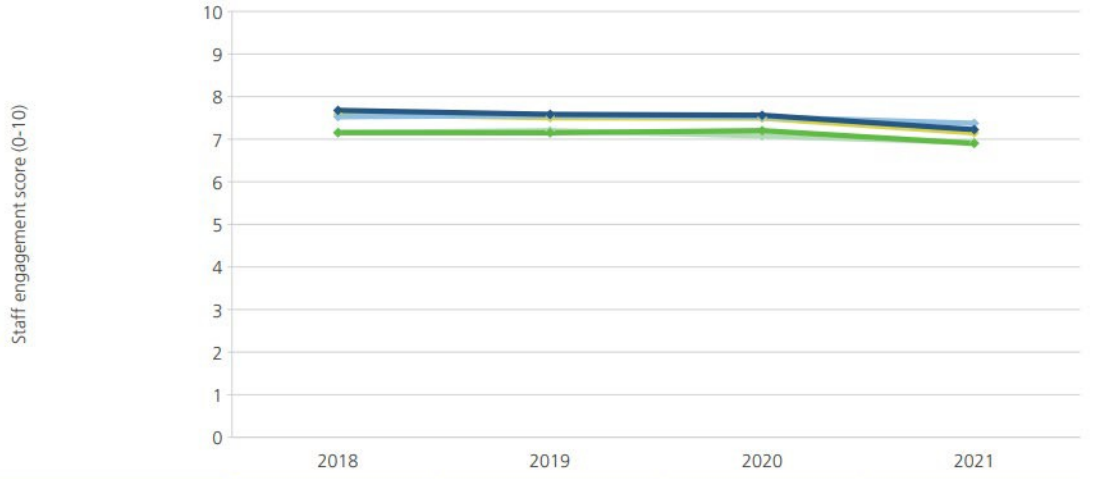


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	75.4%	75.3%	79.2%	71.2%
Staff with a LTC or illness: Average	75.2%	76.5%	77.0%	71.4%
Staff with a LTC or illness: Responses	61	93	101	104

Average calculated as the median for the benchmark group

Survey Coordination Centre

2021 NHS Staff Survey Results > WDES > Staff engagement score (0-10)



	2018	2019	2020	2021
Organisation average	7.6	7.5	7.5	7.1
Staff with a LTC or illness: Your org	7.2	7.2	7.2	6.9
Staff without a LTC or illness: Your org	7.7	7.6	7.6	7.2
Staff with a LTC or illness: Average	7.2	7.2	7.1	6.9
Staff without a LTC or illness: Average	7.5	7.6	7.5	7.4
Organisation Responses	657	948	897	841
Staff with a LTC or illness: Responses	97	152	165	184
Staff without a LTC or illness: Responses	548	774	726	648

Average calculated as the median for the benchmark group

Metric 9b – Has your organisation taken action to facilitate the voices of your disabled staff to be heard?

Yes – The STW ICS Disability Network Meeting is chaired by Meredith Vivian OBE, Non-Executive Director of NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB).

The network will be asking colleagues from across the system to complete a short confidential survey, to help shape the disability equality and inclusion agenda.

Metric 10 - Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

	2021			2022		
Area	Disabled	Non - Disabled	Non-Known	Disabled	Non - Disabled	Non-Known
Executive	0	9	2	0	3	2
Non-Executive	0	5	1	0	3	4
Voting	0	8	2	0	6	5
Non-Voting	0	1	0	0	0	1

WDES Action Plan

Trusts are required to produce an action plan based on the WDES findings. We will produce a Trust WDES action plan which will be published on the Trusts website. This will outline the steps to be taken by the Trust to improve inclusion and ensure that support is in place to meet the needs of all staff including disabled staff that are at higher risk of experiencing discrimination at work.

The Trust's action plan will also make reference to the Equality Delivery System (EDS)goals.

The NHS EDS is an equality performance and evaluation tool to help improve equality performance across three domains:

1 Commissioned or Provider services
2 Workforce health and wellbeing
3 Inclusive Leadership

WDES relates directly to all domains but specifically domains 3 and 4.

Our action plan and progress will be regularly reviewed throughout the year with oversight from our governance processes. This is documented separately to this report.

The Executive Management Team will have overall oversight for monitoring with Trust's Chief People and Culture Officer holding overall responsibility for reducing equalities. A non-executive director has also been appointed to lead on the Equality, Diversity and Inclusion Agenda.

Progress will be reported and published within:
• 2022/23 Equality and Inclusion Annual Report
• 2023 WDES report

Red	Behind plan
Amber	In Progress
Green	Complete
Blue	Implemented
NS	Not Started

WDES Action Plan

Ref	Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
	E,D& I Strategy	To be scheduled for discussion at a 2023 Board Strategy session	Sep-23	NS	Board	CPO
	NED EDI lead	To be confirmed at People and Culture Committee	Dec-22	In Progress	Board	Chair
	Review Trust E,D&I resource and expertise	Trust People Team structure has been reviewed and recommendations made to strengthen E,D&I resource and expertise. Short-term support options to be discussed with STW ICB and NOA colleagues.	Jan-22	In Progress	People	CPO/ CEO
	EDI Committee	Extraordinary committee met 29th September 2022, terms of reference have been agreed and ongoing meetings will be established.	Dec-22	In Progress	People	CPO
	System EDI network	AM to attend System EDI network meeting going forward to link in with partners. DH to attend EDI development session with the ICS.	Sep-23	In Progress	People	CPO
	Staff story at Board	EDI Committee to consider	Sep-23	NS	People	CPO
	Board training	CPO and CEO to consider	Sep-23	NS	People	CPO/ CEO
	EDI training	Since April 2020, staff have been required to complete the HEE national e-learning module "Equality and Diversity and Human Rights Level 1", which has a 3-year validity period. This is a core subject and mandatory for all staff. Other training is also available including: optional STW ICS EDI training (not recorded on RJAH ESR records), Veterans Aware and HEE podcasts on health inequalities training. The ICS is creating videos for a new EDI learning module for 2023/22 (approx. 1 hour) - bespoke to local learning requirements rather than the generic national module.	Sep-23	In Progress	People	CPO
	Disability Network	The STW ICS Disability Network Meeting is chaired by Meredith Vivian OBE, Non-Executive Director of NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB). The network will be asking colleagues from across the system to complete a short confidential survey during December 2022, to help shape the disability equality and inclusion agenda.	Dec-23	In Progress	People	CPO
	Keeping in Touch conversations	Framework for keeping in touch conversations has been agreed and is currently being rolled out.	Mar-23	In Progress	People	CPO

	Leadership development programme	A Leadership Development Programme has been agreed and will be rolled out from 2023.	Mar-23	In Progress	People	CPO
	FTSU/Whistle Blowing awareness	Additional FTSU guardians have now been appointed and new training has been rolled out (starting at Board level). The Whistle Blowing Policy is also currently being reviewed.	Feb-23	In Progress	People	CPO
	Induction process	Ensure induction process has sufficient focus on E,D&I	Sep-23	NS	People	CPO
	Consider use of Trust buddy programme to discuss EDI with staff to understand and explore staff experience	To be considered by Executive Team and People Committee	Mar-23	In Progress	People	CPO
	Listening Events	Revised framework to be drafted.	Mar-23	In Progress	People	CPO
	Review calendar of events to celebrate	Communications team to lead	Mar-23	NS	People	CPO
	Improve recording of disability data	Trust Workforce Information Lead has identified actions to improve capture of disability data.	Mar-23	In Progress	People	CPO
	Encourage increased uptake of staff survey	52% completion rate of 2022 staff survey.	Sep-23	Complete	People	CPO
	EDI newsletter	Consider roll out and liaise with ICS	Jun-23	NS	People	CPO
	AccessAble awareness	Consider working with AccessAble to create Access Guides to facilities, wards and departments across the hospital.	Jun-23	NS	People	CPO

Gender Pay Gap

Introduction

We can use the results of this Gender Pay Gap report to assess:

- the levels of gender equality in our workplace
- the balance of male and female employees at different levels
- how effectively talent is being maximised and rewarded

Through analysis of the report's findings the challenge in our organisation and across Great Britain is to eliminate any gender pay gap. However, the gender pay gap should not be confused with equal pay.

Equal pay deals with the pay differences between male and females who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of their gender. Robert Jones and Agnes Hunt Hospital Trust supports the fair treatment and reward of all staff irrespective of gender or any other protected characteristic.

In producing this report we recognise that we have more to do to reduce the gender pay gap and we remain committed to a workplace that respects and harnesses equality and diversity. We will work to improve the gender pay gap by undertaking the actions set out at the end of this report.

What is the Gender Pay Gap?

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

What is the difference between the gender pay gap and equal pay?

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value.

It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are. In some cases, the gender pay gap may include unlawful inequality in pay but this is not necessarily the case.

Gender Profile across the Robert Jones and Agnes Hunt Trust

The Trust is required by law to carry out Gender Pay reporting under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. This involves carrying out six calculations that show the difference between the average earnings of men and women in our organisation; it does not involve publishing individual employees' data.

Average & Median Hourly Rates						
	Avg. Hourly Rate	2022	2021	Median Hourly Rate	2022	2021
Male		24.25	23.7		16.84	16.72
Female		15.46	15.15		13.14	13.27
Difference		8.79	8.55		3.7	3.45
Pay Gap %	⬇	36.26%	36.06%	⬇	21.95%	20.63%

Number of employees | Q1 = Low, Q4 = High highest rate of pay at 31/03/22

Quartile	Female	Male	Female %	Male %
1	344.00	87.00	79.81	20.19
2	359.00	72.00	83.29	16.71
3	346.00	72.00	82.78	17.22
4	265.00	179.00	59.68	40.32

Bonus Pay Figures At 31/3/22 CEAs

	Avg. Pay	Median Pay
Male	9,999.22	7,452.03
Female	10,254.41	9,048
Difference	-255.19	-1,595.97
Pay Gap %	- 2.55	- 21.42

Gender	Employees Paid Bonus	Total Relevant Employees	
Female	5.00	1434.00	0.35
Male	33.00	438.00	7.53