The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 28.01.2021

MEETING
28 January 2021 09:30

PUBLISHED
27 January 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	28/01/21		09:30

1. Part One - Public Meeting		
1.1. Minutes of the Previous Meeting	Chair	09:30
1.2. Matters Arising	Chair	
1.3. Declarations of Interest	Chair	
2. Patient Story	Chief Nurse	09:35
3. Chief Executive Update (verbal)	Chief Executive	09:45
4. Quality & Safety		
4.1. Chair Report: Quality and Safety Committee	Non Executive Director	09:55
4.2. Learning From Deaths	Clinical Chair, MSK Unit	10:00
4.3. Infection Control Report	Chief Nurse	10:05
4.4. Infection Prevention Control Board Assurance Framework	Chief Nurse	10:10
4.5. Nursing Workforce Roles Presentation	Chief Nurse	10:15
5. People Update		
5.1. Chair Report: People Committee	Non Executive Director	10:20
5.2. Guardian of Safe Working	Clinical Chair, MSK Unit	10:25

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Agenda

Location	*Date*	*Owner*	*Time*
Teams	28/01/21		09:30

6. Performance & Governance		
6.1. Chair Report Audit Committee	Non Executive Director	10:30
6.2. Chair Report: Finance, Planning and Digital Committee	Non Executive Director	10:35
6.3. Performance Report M9	Chief Performance, Improvement and OD Office	10:40
6.4. Annual Plan Planning (2021/22)	Chief Performance, Improvement and OD Officer	10:50
6.5. Standing Financial Instructions and Schemes of Delegation	Chief Finance and Planning Officer	10:55
6.6. Governors Update (verbal)	Trust Secretary	11:00
7. To Note		
7.1. Ockenden Report		
7.2. Chair Report: Quality and Safety Committee November 2020		
8. Any Other Business	All	11:05
8.1. Questions from the Public		
9. Next meeting: 25th March 2021		

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The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC BOARD
26 NOVEMBER 2020
MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive	MB
Stacey-Lea Keegan	Chief Nurse	SLK
Harry Turner	Non-Executive Director	HT
David Gilburt	Non-Executive Director	DG
Steve White	Chief Medical Officer	SW
Craig Macbeth	Chief of Finance	CM
Rachel Hopwood	Non-Executive Director	RH
Paul Kingston	Non-Executive Director	PK
Chris Beacock	Non-Executive Director	CB

In Attendance:

Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Chief of People	SS
Hilary Pepler	Board Adviser	HP
Nia Jones	Managing Director for Specialist Services	NJ
Laura Peill	Managing Director for Support Services	LP
Debbie Kadum	Managing Director for MSK	DK
Jo Banks	Managing Director for Clinical Support Services	JB

FC welcomed everyone to the meeting. FC welcomed Emma Foreman who was observing from Niche Consulting as part of the well led review and confirmed the extension of HP's tenure until March 2022

MINUTE NO	TITLE
26/11/1.0	**APOLOGIES** None
26/11/2.0	**MINUTES OF PREVIOUS MEETING** The minutes of the previous meeting were accepted as an accurate record of the meeting held.
26/11/3.0	**MATTERS ARISING** No matters arising were noted
26/11/4.0	**DECLARATIONS OF INTEREST** None
26/11/5.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • The Covid position in Shropshire was 170 per 100,000, for West Midlands it was 317 per 100,000 and nationally 230 per 100,000. The wave two situation has been much more challenging as attempts are being made to protect elective care. MB

paid tribute to staff that are wearing heavy PPE and providing healthcare in a difficult environment and expressed his appreciation to the management and leadership teams' work to care for staff.

- Staff testing is now available via lateral flow tests. The Trust has received 1000 tests and so far has given out just over 750. Staff are now using these twice a week with a positive result triggering a full Covid test. So far these tests have picked up one or two asymptomatic staff.
- The uptake of the flu vaccine stood at about 74% of staff, the highest proportion the Trust has had but there is still more to do. The Trust has received more vaccine and is still encouraging staff to get this. Preparations are underway for the national rollout of the Covid vaccine. SaTH are taking the lead with this and will be in the first cohort of vaccine hubs.
- The Trust is dealing with a Covid related staffing issue in Theatres which will impact on Theatre activity this week and through to December. MB thanked patients who have been understanding of their surgery being rearranged. The activity will return to normal on 2nd December.
- Welcome to Patricia Davies who has been appointed as the new CEO of Shropshire Community NHS Trust, she is currently the Accountable Officer for the CCG in Bedford and Luton and will be joining in April 2021.
- Congratulations to Sandra Evans, Therapy Support Worker on MCSI who is this month's Health Hero.

FC reiterated the thanks to staff for their continued commitment and also commented on the Trusts professional and appropriate response to the issue in Theatres impacting on staff and patients to make sure everyone safe.

Virtual Visits

MB reflected on the usefulness of the visits and would like to run them again with involvement from the Governors.

FC thought it was a successful event; he spent an hour in the operating theatre complex with DK and a further hour in IT and Information. It was very informative and good to have that link with the shop floor; he had been sceptical about this being done virtually but thought it worked well.

HT commented on the way staff have responded to the challenge of Covid and the pressures they are working under. HT asked if there was a way of extending this to staff who do not have laptops and reference was made to SLKs Facebook updates.

FC felt it was important to recognise those working at home as there is a growing concern from staff that they are missing out on work setting interactions and looking forward to returning to the work place.

SS commented that during the event there was a lot of talk about the pressure staff are under, the groups of staff working at home are working under pressure and working in different ways without the collective team feel, so ongoing work is needed to on support them.

PK agreed with regard to the stress staff are working under and particularly felt support was needed for staff dealing with patient deaths as this is not common at the hospital. He commented on how the Access Team have worked really hard to keep things running and have found innovative ways of working.

RH advised that she was due to visit Ludlow Ward but they had to cancel due to operational pressures she was however able to visit the IT Department. It was clear that these were unprecedented times for them in terms of the switch to virtual working and she

	commended their efforts and highlighted that the reliance on them has come to the fore. In response to the comments about maintaining team working RH shared how the IT Team had virtual connections set up by the manager to ensure social connection within the team. The Board ***noted*** the update.
26/11/6.0	**QUALITY AND SAFETY COMMITTEE CHAIR'S REPORT** CB presented the Chair's Report highlighted the following: • The meeting was well attended • The Committee reviewed a Serious Incident which had occurred in the Spinal Unit and the learning from this was noted to be continuing • There was discussion and agreement on the need to focus on collecting more accurate outcome data. • The Committee received an update on the Trust's harms review process for delayed patients and noted that none had been reported but was cognisant that there may be harms that had not yet come to light and this therefore remained a risk. • The Committee was informed that the Trust has finalised the signed SLA agreement for pathology with SaTH. The Board ***noted*** the Chair's Report
26/11/7.0	**NOSOCOMIAL OUTBREAK UPDATE** SLK reminded the Board that nosocomial is around hospital transmission of Covid and the ambition is to reduce such outbreaks. The national definition of an outbreak is two or more people in an area whether staff or patients and this would trigger an outbreak response which is nationally driven and reporting is a statutory requirement. The Trust has reported two outbreaks and both are still undergoing full investigation. The key partners have been involved in the outbreak meetings with contact tracing and testing enacted. The Infection Control Committee has oversight of the investigations with upward reporting to the Quality and Safety Committee The Board ***noted*** the report.
26/11/8.0	**FLU PREPAREDNESS** SLK presented an update on the Trust's flu preparedness. She highlighted that the work against flu is important because infections can make people susceptible to further infections. All Trust have used best practice self –assessments and this has been included in the Board Pack. An evaluation was undertaken of last years of campaign with areas for improvement identified and put in place as follows: • A significantly increased number of peer vaccinators from 9 last year to 47 this year. • Improved reporting data. SLK confirmed the campaign started on 15th October and significant progress has been made to date. FC commented on the link between the timing of the flu vaccine and the Covid vaccine as it was not possible to have the flu vaccine in between the two doses of Covid vaccine. SLK confirmed this was correct as there needs to be a 28 day gap between the flu vaccine and the Covid vaccine. The Board ***noted*** the update.
26/11/9.0	**LEARNING FROM DEATHS** SW presented the Learning from Deaths Report which covered the period May to August. He confirmed that there were no unexpected deaths and all deaths were related to trauma

	with one linked to Covid. The Board ***noted*** the report.
26/11/10.0	**INFECTION CONTROL REPORT Q2** SLK presented the Quarter 2 Infection Control Report and confirmed that this has been presented through Quality and Safety Committee. SLK highlighted the following: • There has been positive progress with the maintenance schedule and estates work • Green, amber and red pathways have been introduced • Post infection review documentation and review processes have been introduced • Routine place inspections have been suspended due to Covid but looking within the organisation these could still be undertaken • Social distancing and observation tools rolled out to assess compliance • Due to the step down of surgery there is no surgical site surveillance data but this will be in the Q4 report • Covid activities are outlined in the report HT asked if there are any lessons or best practices from Covid that can incorporated into infection control practices. SLK advised that Covid has heightened the importance and awareness of infection control, not just for clinical staff but also for non-clinical staff, a good example is the cleaning for confidence campaign that has been launched. There is also learning from outbreaks that needs to be taken forward, not just from the Trust's own outbreaks but across the infection control network. The Board ***noted*** the report.
26/11/11.0	**CHAIR'S REPORT - PEOPLE COMMITTEE** PK presented the People Committee Chair's Report and highlighted the following: • The meeting was well attended, • There had been good progress on all actions • The work plan was being aligned to the new frequency of meeting as a monthly meeting has been agreed with FC • The Committee received updates on Covid workforce information, the People Plan, Recruitment, the People Pulse, Freedom to Speak Up and Guardian of Safe Working. • No risks were identified for escalation to the Board. The Board ***noted*** the report.
26/11/12.0	**PEOPLE PLAN** SS provided an update on the detailed paper discussed at September Board with continuing emphasis on the importance of the workforce agenda. It is a challenging agenda but progress is steady and encouraging. There were two areas of focus SS wished to draw to the Board's attention around rest areas for staff and opportunities for staff to take exercise during the day. The overall message was that the Trust must keep prioritising keeping its staff well. SS confirmed that she will continue to update the Board on progress with the People Plan. The Board ***noted*** the update.
26/11/13.0	**NEXT DIRECTOR SCHEME** SS presented an overview of the NeXT Director Scheme and sought agreement to support the development programme with a particular focus on BAME communities. The Board supported the application going forward.

26/11/14.0	**SAFE WORKING HOURS REPORT** SW presented the Safe Working Hours Report and thanked Chris Marquis, Consultant Orthopaedic Surgeon for his continued support with this work. SW highlighted that the report is evidence of the additional effort made by its doctors to support the Trust with its services during Covid and the running of the Trauma service. There is recognition that the quality of training has been impacted during the reduction in elective surgery and online training has been provided but opportunities to enhance this are being explored. SW confirmed that no exception reports or fines in relation to the working hours have been received. SS commented on the fact the doctors have gone above and beyond, the need to make sure their training is properly supported. The Board ***noted*** the report.
26/11/15.0	**STRATEGIC DEVELOPMENT SUMMARY** KR presented a summary of the Strategic Development Session held. This was being provided in the interests of openness and transparency and outlines the programmes of work being taken forward and the Senior Lead for each. The Board ***noted*** the summary.
26/11/16.0	**KPI ASSURANCE COMMITTEE ALIGNMENT** KR presented the paper which outlined the changes made to reduce the duplication across the assurance committees. The changes were also felt to provide greater balance to ensure alignment with Committee terms of reference. KR highlighted that the Staff Friends and Family Test had been moved to People Committee but on reflection this was a quality metric and would therefore be changed to Quality and Safety Committee. The Board was supportive of the changes.
26/11/17.0	**CHAIR'S REPORT - AUDIT COMMITTEE** DG presented the Chair's Report for Audit Committee and highlighted the following: The meeting was well attended There were risks noted around the delay with internal audit due to Covid. A low income risk was noted again linked to Covid The Committee identified risks to bring to Boards attention in relation to restoration and the timings of ICS governance and the impact this has on the Board's own governance arrangements. The Board ***noted*** the report.
26/11/18.0	**CHAIR'S REPORT - RISK MANAGEMENT COMMITTEE** HT presented the Chair's Report for Risk Management Committee and highlighted the following: • The Committee discussed risk appetite against the backdrop of Covid • The Committee received an update on overdue investigations into incidents and was confident these were being actioned • There was full assurance on business continuity • There were deep dives received into support services and clinical support services • There were issues identified with compliance with the Sharps Regulations but assurance was obtained that full compliance will be achieved by the end of the financial year. • There was a further meeting of committee members to look at the Board Assurance Framework and preparation for exiting the EU. Full assurance was obtained that there was no exposure with customs issues, reciprocal healthcare and workforce issues all adequately mitigated. CM is connecting with the national team.

	FC asked about the system position on EU with or without a deal and CM confirmed that the system is trying to consolidate the information and response to the national team. The Board ***noted*** the report.
26/11/19.0	**BOARD ASSURANCE FRAMEWORK** SR presented the first draft of the Board Assurance Framework and confirmed that this has been aligned to the objectives agreed for the remainder of the financial year. Place makers are indicated where risks have been identified that require further work up. DG confirmed that the draft has been through a Joint Audit and Risk Committee prior to its presentation. The Board ***noted*** the report.
26/11/20.0	**RISK APPETITE AND TOLERANCE** SR presented an updated risk appetite and tolerance statement and confirmed the only change was in relation to the tolerance of non-compliance with regulation where there was a quality consideration which had to be prioritised. The example was patients breaching national waiting time targets to allow for clinical prioritisation. The Board noted the difficult balance of safety vs non-compliance but agreed that the safety consideration had to be the priority. The proposed governance around a 'conscious' non-compliance was noted. The Board ***approved*** the risk appetite and tolerance statement.
26/11/21.0	**EPRR UPDATE** SLK confirmed that the NHS is back in level 4 which is the highest level of major incident and instigates national control. The Trust has put in place gold strategic command and silver tactical in place, there is 7 day incident management through the co-ordination centre. The Board ***noted*** the update.
26/11/22.0	**FINANCE PLANNING AND DIGITAL COMMITTEE – CHAIR'S REPORT** RH provided a summary of the truncated meeting held earlier this week. She advised the Board that shortened meeting was due to balancing committee assurance and executive workload. The meeting covered a performance overview and financial report. The Board ***noted*** the report.
26/11/23.0	**PERFORMANCE REPORT** KR presented the report which is more focussed. *Caring for Staff* SS highlighted the following: • Staff absence line is still in place with staff able to access testing within 24 hours. • Staff Turnover – there are a couple of areas the team are deep diving into to understand the reasons for increased turnover and these will be reported back via the People Committee. FC asked who manned the line and SS confirmed that it was the People Team *Caring for Patients* SLK highlighted the following: • No serious incidents • Complaints have increased slightly but within threshold • 2 E.coli bacteraemia infections with post infection reviews undertaken which identified improvement opportunities resulting in policy changes

	SW confirmed there had been no unexpected deaths. JB highlighted the following: • 5 out of 6 cancer targets were met. For the 62 day standard there were two patients who breached but no performance issues were identified for the Trust. • There has been a 3% improvement in RTT 18 weeks and clinical prioritisation work to prevent harm will continue to impact on this • 52 week waiters have decreased for both Welsh and English patients and should improve through the restoration work • Performance for both 6 week and 8 week diagnostics were below expectations with a 15% increase for English patients and 17% for Welsh patients. • Theatre activity was at 53.1% compared to 19/20 activity with Covid continuing to impact • Bed occupancy was down at 78.1% due to lower activity. • Outpatient activity is behind for M7 but just over 70% of activity is using core capacity with ongoing work to increase clinics including 'super Saturdays'. • Virtual and telephone clinics at 27% against a phase 3 target of 25% and the team are working to increase this where possible • The overdue follow up backlog has reduced by 5.3% • The forward look for November and December has been forecast using a set of assumptions. Currently 72% of outpatient appointments have been booked for November with the best case being 86% and most likely 75%. Outpatients is likely to be at 70% for December. For MRI the best case is 86% for November but most likely is 75% and for December the most likely is 70%. For CT 112% most likely for November and 120% for December, USS most likely is 90% for November and 96% for December. Total elective activity for November is expected to be 63.5% 73.7% for December DG asked if the % was against the plan or 19/20 activity and JB confirmed it is against the 19/20 activity. CB commented that it might be helpful to have an indication of what impact this has on the overall number of patients waiting. JB confirmed that the work is ongoing and the forecasting work will go through Restoration Committee. *Caring for Finances* CM highlighted the following: • M7 was the start of a new financial planning period for the second half of the year and he reminded the Board of the requirement to achieve a break even position, as set for the whole NHS. • The Trust recorded a surplus against plan • Costs were much lower than expected due to reduced activity, the new financial framework means there is no income impact for M7 • Private patient activity has been restored and the planned trajectory assumed a minimal impact in M7 but the progress made was better than anticipated • The forecast position is positive at the moment but the big risk is around income flexing and the claim back where national targets are not achieved this this is being kept under review. The Board ***noted*** the performance report.
26/11/24.0	**POLICY COMMITTEE CHAIRS REPORT** DG presented Chair's Report from the Policy Committee and reminded the Board that following the CQC visit in 2018 it was highlighted that many Trust policies were out of date. The Policy Committee was set up look at and review policies that were out of date to

	minimise the burden on the other Committees. The Policy Committee has reviewed 75 policies in total with a handful still being reviewed and going forward the policies will be aligned to Committees. There is another Policy Committee scheduled in two months' time and following this a report will be produced to outline the progress made and recommend standing down the Committee. The policy tracker that has been developed will go to Audit Committee going forward. The Board ***noted*** the report.
26/11/25.0	**GOVERNORS UPDATE** SR provided an update to the Board and highlighted the following: • The Governors have been involved in recent recruitment • A Members Newsletter has been produced and issued • The informal meetings with the Senior Independent Director are continuing and are well received • The Lead Governor continues to take an active role as a Freedom to Speak Up Guardian HT confirmed that the issues raised with him in the recent meeting with the Governors are covered in the Council of Governors meeting taking place later today. The Board ***noted*** the update.
26/11/26.0	**BOARD MEETING COMMITTEE DATES** SR presented the proposed meeting dates for the year ahead. CB asked about the gaps in August and December gaps which he understood were historical but in the current climate he questioned whether meetings should be held. FC confirmed that he would pick this up with SR. **ACTION: FC and SR to agree dates for August and December meetings so place holders can be put in diaries.**
26/11/27.0	**ONLINE APPOINTMENTS** LP advised the Board that Healthwatch Shropshire has issued a report on patient experience linked to changed appointments. The paper outlines the changes the Trust has made in response to this. The Board ***noted*** the report.
26/11/28.0	**HEALTH AND SAFETY ANNUAL REPORT** SLK presented the Health and Safety Annual Report and confirmed this has been through Risk Management Committee. The Board ***noted*** the report.
26/11/29.0	**AOB** None
26/11/30.0	**QUESTIONS FROM THE PUBLIC** None
	DATE OF NEXT MEETING IN PUBLIC: Thursday 28 January 2021 9.30 via Teams
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

26 NOVEMBER 2020

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
Actions from Last Meeting	**Lead Responsibility**	**Progress**
26/11/26.0 BOARD MEETING COMMITTEE DATES FC and SR to agree dates for August and December meetings so place holders can be put in diaries.	FC/SR	Completed

Chair's Assurance Report
Quality and Safety Committee

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	28th January 2021
Executive Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:		Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Quality and Safety Committee Agenda for the meeting of 21st January 2021. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of 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

Due to the timing of the committee it is not possible to provide a paper Chair's Report. The Non-Executive Director Chair of the committee will provide a verbal report covering the attached agenda from the committee but to summarise:

- The meeting was well attended
- There was a focus on serious incidents and enhancing the learning from these
- The Committee considered the performance report
- The Committee considered the quality report from the Clinical Support Services Unit and noted the improvement actions being taken
- The Committee received and approved the Terms of Reference for the newly formed Clinical Effectiveness Committee
- The Committee received and approved Referral Guidelines and Policy for Imaging Examinations with attendance from a representative from the Radiology Department
- The Committee received and approved the Trust's Research Strategy
- A number of Chairs' Reports were received from the Committee's sub-committees and there were no concerns raised

2.3 Risks

The Committee considered the top risks discussed during the meeting and felt that these were around the safe management of waiting lists in particular in outpatients and follow up appointments. The Committee will receive further updates on these areas.

2.4 Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	21/01/21		14:00

1. Introduction		14:00
1.1. Apologies	All	14:01
1.2. Minutes from the previous meeting	Chris Beacock	14:02
1.3. Action Log / Matters Arising	Chris Beacock	14:04
1.4. Declaration of Interests	All	14:09
2. Caring for Patients		
2.1. Serious Incidents & Never Events	Shelley Ramtuhul	14:10
2.2. Learning from Incidents	Shelley Ramtuhul	14:15
2.3. Infection Control BAF	Kirsty Foskett	14:20
2.4. Legal Claims Update Quarter 3	Shelley Ramtuhul	14:25
2.5. CIP Quality Impact Assessment Update Q3	Stacey Keegan	14:30
2.6. National Joint Registry Report	Steve White	14:35
3. Committee Management		
3.1. Board Assurance Framework	Shelley Ramtuhul	14:40
3.2. Integrated Performance Report	Stacey Keegan	14:45
3.3. Clincial Services Unit Quality Report	Jo Banks/Sara Ellis	14:50
3.4. Research Strategy, Finanical & Update	Jo Banks	14:55

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Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	21/01/21		14:00

4. Items for Review/Approval

4.1. Clinical Effectiveness Committee Terms of Reference	Steve White	15:05
4.2. Referral Guidelines for Imaging Procedures	Louise Arnold	15:10
4.3. Referral and Justification Policy	Louise Arnold	15:15
4.4. Pro-forma for the Introduction of New Procedure or Drugs Policy	Maryse Mackenzie/Imran Hanif	15:20

5. Items to Note:

5.1. Quality Account Priority 1: Reducing Medication Errors	Maryse Mackenzie/ Sara Ellis	15:25
5.2. Quality Account Priority 3: Pressure Ulcers	Sara Ellis/Kirsty Foskett	15:30
5.3. Quality Account Priority 4: WHO Process	Ian Maclennan	15:35
5.4. Q2 & Q3 Patient Experience Report	Shelley Ramtuhul	15:40
5.5. Harms Review	Steve White	15:45
5.6. Learning from Deaths Report Q3	Steve White	15:50
5.7. Chair Report from Infection Control Committee	Stacey Keegan	15:55
5.8. Chair Report from Research Committee	Jo Banks	15:56
5.9. Chair Report from Safeguarding Committee	Stacey Keegan	15:57
5.10. Chair Report from Patient Safety Committee	Stacey Keegan	15:58
5.11. Chair Report from Patient Experience Committee	Stacey Keegan	15:59
5.12. Review of the Workplan	Chris Beacock	16:00
5.13. Attendance Matrix	Chris Beacock	16:01
5.14. Top Risks	All	16:02

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Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	21/01/21		14:00

6. Any Other Business

6.1. Next Meeting: Thursday 18th February 2021 at 2pm

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	28th January 2021
Executive Sponsor:	Mr Steve White	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report to the Board of Directors.

After deaths are reported on Datix, a decision is made as to whether it is a serious incident 'SI' or not.

A structured judgement review is carried out in timely manner and a report is submitted to The Royal College of Physicians.

Deaths are reported through the Board of Directors.

They are also reported and discussed at the Multi-disciplinary Clinical Audit Meeting.

A detailed discussion occurs in the Mortality Steering Group at four monthly intervals and the Governance team will continue the bereavement process with the family.

2. Executive Summary

2.1. Context

To report the current numbers and trends in last quarter for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No Concerns identified.

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes	Actions
September 2020	1	1	0	0	No theme	Post-death process has learning.
October 2020	0	0	0	0	n/a	None required
November 2020	1	1	0	0	No Theme	None required
December 2020	0	0	0	0	n/a	None required

3.3. Associated Risks

3.4. Next Steps

Discussions on progress with SATH concerning a link with their Medical Examiner system.

LFD lead at RJAH now attends Mortality steering group at SATH.

September post-death process has learning for us in that it was performed and documented very well. I will summarise this and present it at next MDCAM.

3.5. Conclusion

No concerns identified.

Appendix 1: Acronyms

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

Infection Prevention & Control & Cleanliness Annual Report 2019/20

0. Reference Information

Author:	Sue Sayles Phil Davies	Paper date:	28 January 2021
Executive Sponsor:	Stacey Keegan	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality & Safety Committee	Paper Ref:	
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?
1.2. For approval from the Board.

2. Executive Summary

2.1. Context

The IPC Annual Report 2019/20 provides assurance in terms of compliance with the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008).

The annual report has been through the Trusts Infection Control Committee and the Quality and Safety Committee.

2.2. Summary

2019/20 was another year of improvements and new challenges in the continuing campaign to reduce avoidable Health Care Associated Infection (HCAI) at the RJAH Orthopaedic NHS Foundation Trust (See Figure 1). The end of the year saw the Trust begin to implement changes in response to the escalating Covid-19 pandemic.

Successes include:

- Meeting our MRSA bacteraemia target of zero for the fourteenth year.
- No cases of MSSA bacteraemia.
- No cases of C difficile infection.
- Reduction in HCAI reportable infections
- Reduction in needle stick injuries

The increased flu vaccination uptake of 68.17% from 60.8% during 2018/19 against a target of 75%, demonstrated the hard work of our lead Practice Nurse Facilitator to raise awareness of the benefits of the flu vaccination whilst working alongside Team Prevent and additional nurse vaccinators, improving the accessibility and availability of the flu vaccine to all staff.

This annual report needs to be viewed in the context of a severely depleted infection control team; during quarters 3 and 4 due there was sickness and vacancies. The Trust provided mitigation in the form of redeployment. The Infection Control Doctor retired in February 2019 and returned on a 0.4 WTE contract during April 2019.

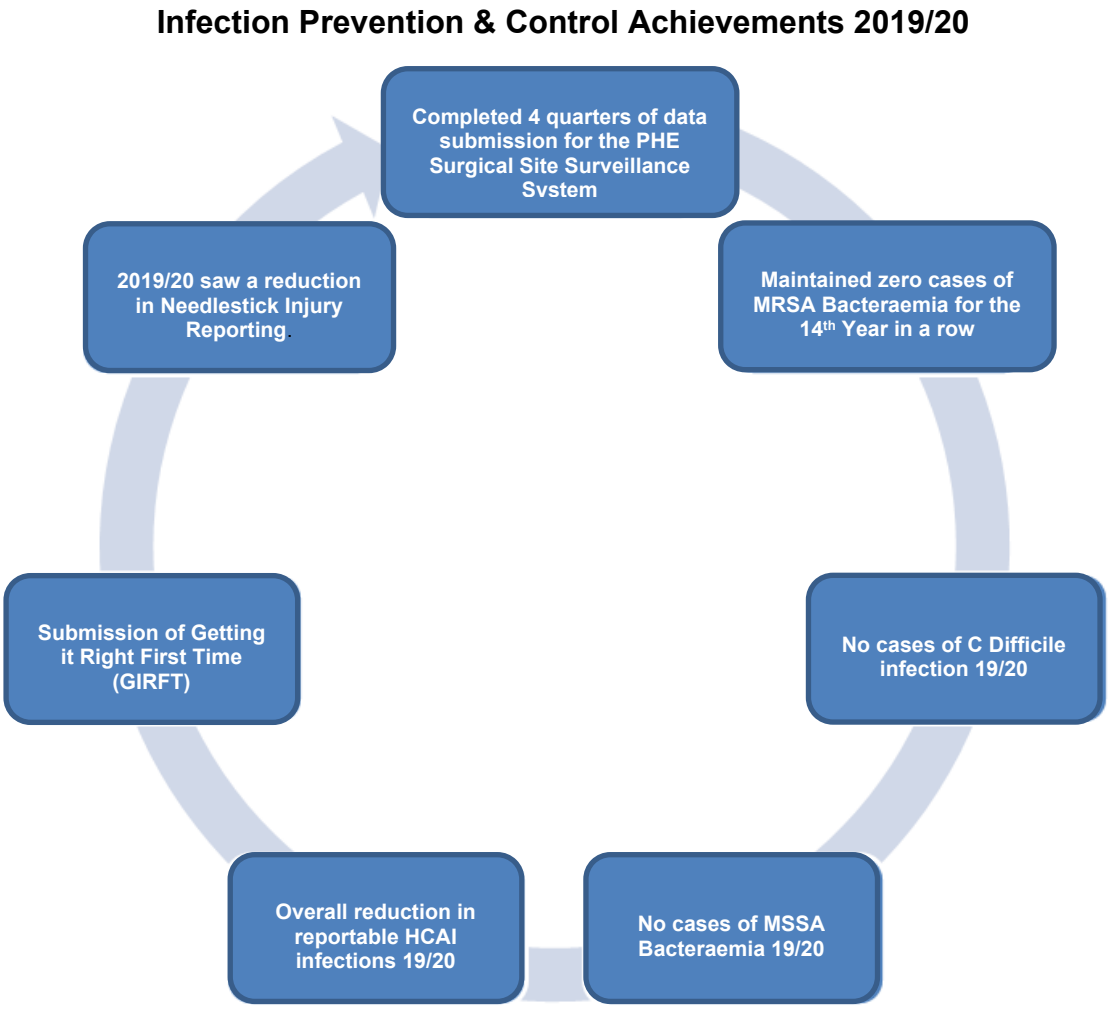
Infection Prevention & Control & Cleanliness Annual Report 2019/20

2.3. Conclusion

The Board is asked to:

(a) To note the IPC Annual report

Figure 1



3. The Main Report

3.1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of Healthcare Associated Infection (HCAI) in the organisation for which she is responsible and release it publicly according to the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008). The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes the activity of the Infection Prevention and Control Team (IPCT) during the year, including progress made against the work plan and targets identified in the Infection Prevention and Control Annual Programme. It also includes Divisional performance against key areas in Infection Prevention & Control. Ward specific audits are reported on a monthly basis through Trust wide key performance indicators (KPI's).

3.2. Health & Social Care Act Code of Practice

The Robert Jones & Agnes Hunt Orthopaedic Hospital has registered with the Care Quality Commission and have acknowledged full compliance with the Health and Social Care Act (2008) Code of Practice (commonly known as the Hygiene Code).

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

3.2.1. Criterion 1 a): Systems to manage and monitor the prevention and control of infection.

IPC Structure

The **Chief Executive Officer** has overall accountability for the control of infection at RJAH.

The **Director of Infection Prevention & Control** is the Executive Lead for the IPC service, and oversees the implementation of the IPC programme of work through her role as Chair of the Trust Infection Prevention and Control and Cleanliness Committee (IPCC). The DIPC approves the Annual IPC report and releases it publicly. She reports directly to the Chief Executive and the board on IPC matters. The DIPC has the authority to challenge inappropriate practice.

The **Infection Control Doctor (ICD)** is the Clinical Lead for the IPC service.

The ICD is employed by SaTH but is contracted by RJAH for four sessions a week to include clinical microbiology advice and reporting, microbiology ward rounds, antimicrobial stewardship and infection prevention and control advice. The ICD:

- Advises and supports the DIPC
- Oversees local IPC policies and their implementation by ensuring that adequate laboratory support is in place
- Attends the Water Safety Group and Decontamination Group
- Chairs the Trust Antimicrobial Stewardship Committee
- Provides expert clinical advice on infection management
- Attends the weekly Infection MDT meetings and provides expert advice on complex/infected cases
- Has the authority to challenge clinical practice including inappropriate antibiotic prescribing.

The ICD reports to the DIPC on IPC matters.

The **Infection Prevention and Control Team** (IPCT)

The Infection Prevention and Control Team (IPCT) are the medical and nursing infection prevention and control specialists responsible for carrying out the work described in the infection control programme of work.

RJAH Orthopaedic Hospital NHS Foundation Trust (RJAH) IPCT currently consists of:

- Infection Prevention and Control (IP&C) Clinical Nurse: (1 WTE) Band 7
- Surgical Site Surveillance Nurses: (1.1 WTE) Band 5
- Infection Control Analyst (0.8 WTE): Band 4
- The Infection Control Doctor (0.4 WTE)

In addition to the contracted sessions from the Infection Control Doctor we also have 24hr infection control advice available from the on-call Consultant Microbiologist at SaTH as part of the Pathology SLA.

The **Antimicrobial Pharmacist**: The Trust employs a part time Antimicrobial Pharmacist who works closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. The role of the antimicrobial pharmacist includes:

- Attending and contributing to the Trust Infection Prevention & Control Committee meetings, weekly Infection MDT Meeting and the Antimicrobial Stewardship Committee meetings
- Supporting antimicrobial stewardship initiatives
- Participating in and contributing to the weekly ward rounds with the ICD
- Lead for the Trust antimicrobial CQUINs
- Maintaining a robust programme of audits in line with national guidance
- Providing training and education regarding antimicrobial stewardship to clinical staff within the Trust

Infection Prevention Control Committee

The RJAH Infection Prevention & Control Committee (IPCC) is a multidisciplinary Trust committee with outside representation from Public Health England and the CCG. The IPCC oversees the activity of the IPCT and supervises the implementation of the infection control programme of work. The IPCC met every 3 months during 2019/2020.

Attendance at IPCC

	Apr 2019	*July 2019*	*Oct 2019*	*Jan 2020*
DIPC	✓	✓	✓	✓
ICD	✓	✓	*apol*	✓
IPCN	✓	✓	✓	✓
Ass. DON	✓	✓	✓	✓
CCDC (PHE Rep)	*apol*	*apol*	*apol*	*apol*
Antimicrobial Pharmacist	*apol*	✓	*apol*	✓
Facilities Manager (Estates & Facilities Representation)	✓	✓	✓	✓
Matron (Medicine)	✓	✓	✓	✓
Matron (Surgery)	✓	✓	✓	✓
Matron (Theatre & OPD)	*apol*	✓	✓	✓
Theatre Manager	*apol*	✓	*apol*	*apol*
Head of IPC SCCG & TWCCG	✓	✓	✓	✓
Clinician Rep	*apol*	✓	*apol*	✓
TSSU Rep	*apol*	✓	*apol*	*apol*

The IPC Programme of Work

The IPC programme of work 2018-21 was specifically designed to focus on achieving full compliance with the standards identified in the Code of Practice, and the achievement of National and local infection related targets, using a template set by the Shropshire & Telford & Wrekin IPC Lead. Tthe Trust has achieved full compliance on all the standards with the exception of having a fit-for-purpose IT system to support surveillance activity. The identification of a most cost-effective solution utilising internal systems and exploring local

solutions continues to be required. This has been highlighted and reported on the Risk Register.

IPC Link Practitioner System

The Infection Control Link Practitioner group meets bi-monthly. The purpose of this meeting is to provide advice and support and disseminate information regarding Infection Prevention and Control to their peers within their wards/departments.

Topics of discussion for 2019/2020 have included:

- Raising the awareness of the signs of sepsis
- Sharps Smart Trial implemented in Spinal and Theatre Teams
- Catheter Associated Urinary Tract Infections (CAUTI) Datix Reporting
- The role of the Surgical Site Surveillence Nurse.
- Medical Devices CAS Alert Mckinley T34
- Plans to implement environmental audits onto i-Auditor
- FIT testing for FFP3 masks
- Wound clinic Tissue Viability Nurse Support
- Safer Sharps

Link Nurse Attendance

Ward	*April 19*	*June 19*	*Aug 19*	*Oct 19*	*Dec 19 No Meeting*	*Feb 20*
Ludlow	✓	✓	✓			
OPD	✓	✓	✓	✓		✓
POAU	✓			✓		✓
Powys	✓		✓			✓
Clwyd	✓	✓	✓			
HDU	✓	✓				
Theatres				✓		
Anaesthetics		✓		✓		
Recovery	✓	✓	✓	✓		
Oswald			✓	✓		✓
Radiology						
TSSU		✓	✓			
Gladstone	✓		✓	✓		
Wrekin	✓		✓	✓		
SIU OPD	✓	✓	✓	✓		
Kenyon				✓		✓

Alice	✓	✓		✓		
Sheldon	✓	✓	✓	✓		✓
Therapies		✓				✓
Baschurch	✓	✓		✓		
ORLAU	✓	✓	✓	✓		
Library personal	✓	✓	✓	✓		✓
Orthotics		✓	✓	✓		

The wards/departments are assessed on their attendance to Infection Control link meetings.

3.2.2. Criterion 1 b): Monitoring the prevention and control of infection

Mandatory Surveillance

Blood Stream Infection

- MRSA
  There were 0 cases of MRSA bacteraemia at RJAH in 2019/20. The target remains at 0 MRSA bacteraemia, any case attributed to RJAH would be considered a never event for the Trust.

- MSSA
  There were 0 cases of MSSA bacteraemia attributed to RJAH in 2019/20.

- Gram Negative bacteraemia
  It is a national requirement to report *E.coli*, Klebsiella and *Pseudonomas aeruginosa* blood stream infections. These are attributed to the trust if they occur in patients more than 72 hours after admission.

  - *E. coli* bacteraemia

    There were 8 episodes of *E.coli* bacteraemia from 7 patients. This compares to 5 cases in 2018/19. All episodes were reviewed individually to determine whether there were common themes to help identify priority areas for action. The patients were across four different wards. All patients had a urinary catheter and had *E.coli* in a urine culture.

  - Klebsiella bacteraemia

    There were 3 episodes of Klebsiella bactaeremia from 3 different patients. 2 of these episodes were caused by *Klebsiella pneumoniae* and 1 was caused by *Klebsiella oxytoca*. All of these patients had urinary catheters and 2 grew Klebsiella from their urine samples on admission.

  - *Pseudomonas aeruginosa* bacteraemia

There was 1 episode of *Pseudomonas aeruginosa* bacteraemia attributed to RJAH This was a spinal injury patient who had a urinary catheter on admission.

- C. *difficile*
  There were no cases of C *difficile* at RJAH in 2019/20

- Extended Spectrum Beta-Lactamase (ESBL)
  There was an increase in number of cases of ESBL urinary tract infection on the Spinal Injuries Unit during quarter 4. These were a mixture of *E coli* and *Klebsiella pneumoniae* from 9 patients, 5 of which were acquired as inpatients at RJAH. Due to the nature of a spinal injury, all of these patients had a urinary catheter which has an increased risk of infection. Patient placements were mapped on a gant chart, there was no association with any particular bed space/side room.

  The patients were cohorted in bays and individual risk assessments performed to enable patients to continue the rehabilitation programme safely to prevent cross infection eg attending the gym.

  HPV fogging decontamination was undertaken following movement and discharge of cohorted patients.

Surgical Site Surveillance (SSI)

Since July 2008, all hospitals are required to have systems in place to identify patients who are included in the surveillance and later develop a surgical site infection.

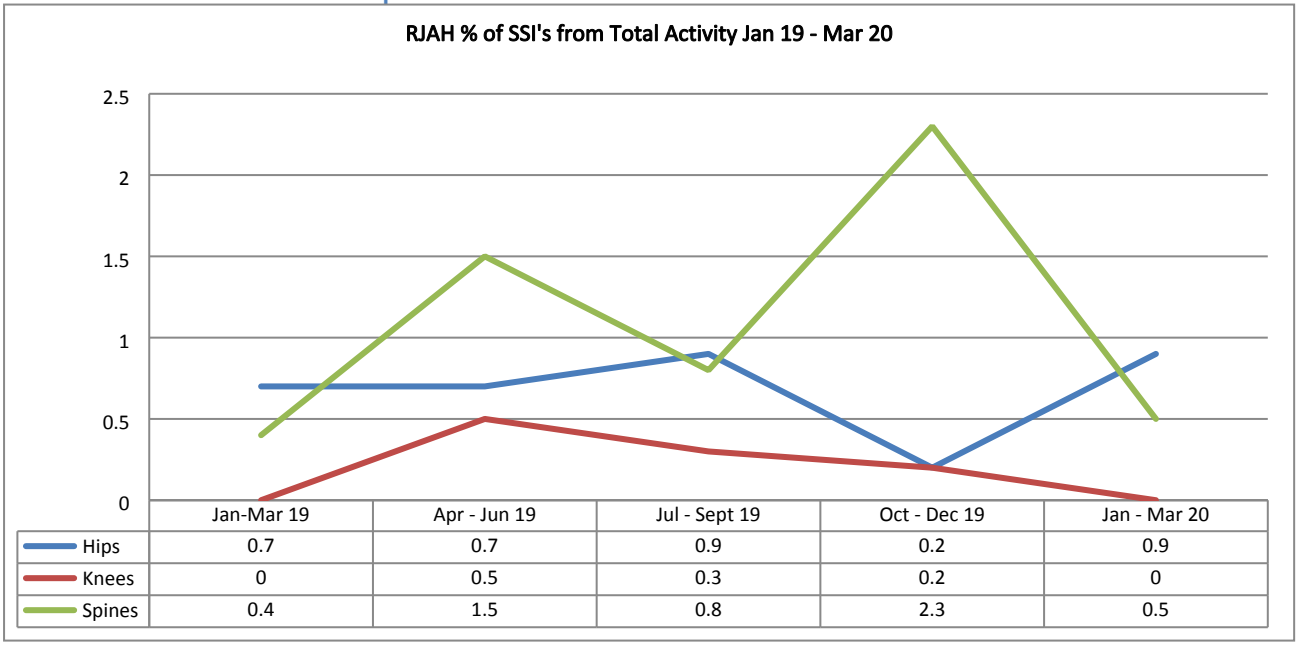
The Trust submits surgical site infection data to the PHE database on a quarterly basis; these reports are always one quarter in arrears to allow a window of time for any infections.

PHE analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence falls above the 90th or below the 10th percentiles nationally for a given surgical category, enabling the Trust to benchmark itself against the national rate of infection.

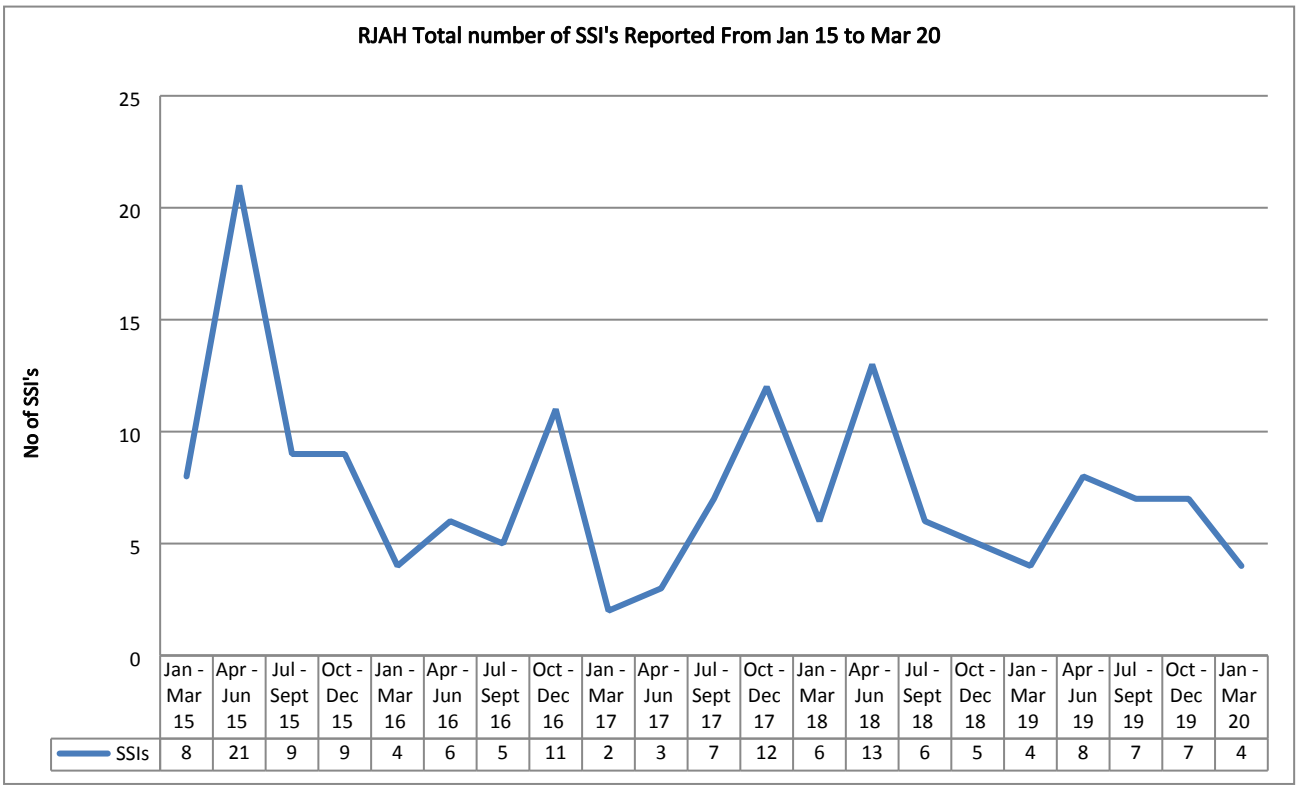
Surgeon specific data allows the surgical site surveillance team to provide analysis of infection rates to individual surgeons as part of their revalidation and appraisal process.

From April 2019 – March 2020, data on 4044 operations – 1587 Total Hip Replacements (THR), 1586 Total Knee Replacements (TKR) and 871 Spinal surgery was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 26 SSIs reported, 11 THR, 4 TKR, 11 Spinal surgeries, compared to a total of 4294 operations with 28 SSI's 12 THR 6 TKR 10 Spinal surgeries, reported April 2018 – March 2019.

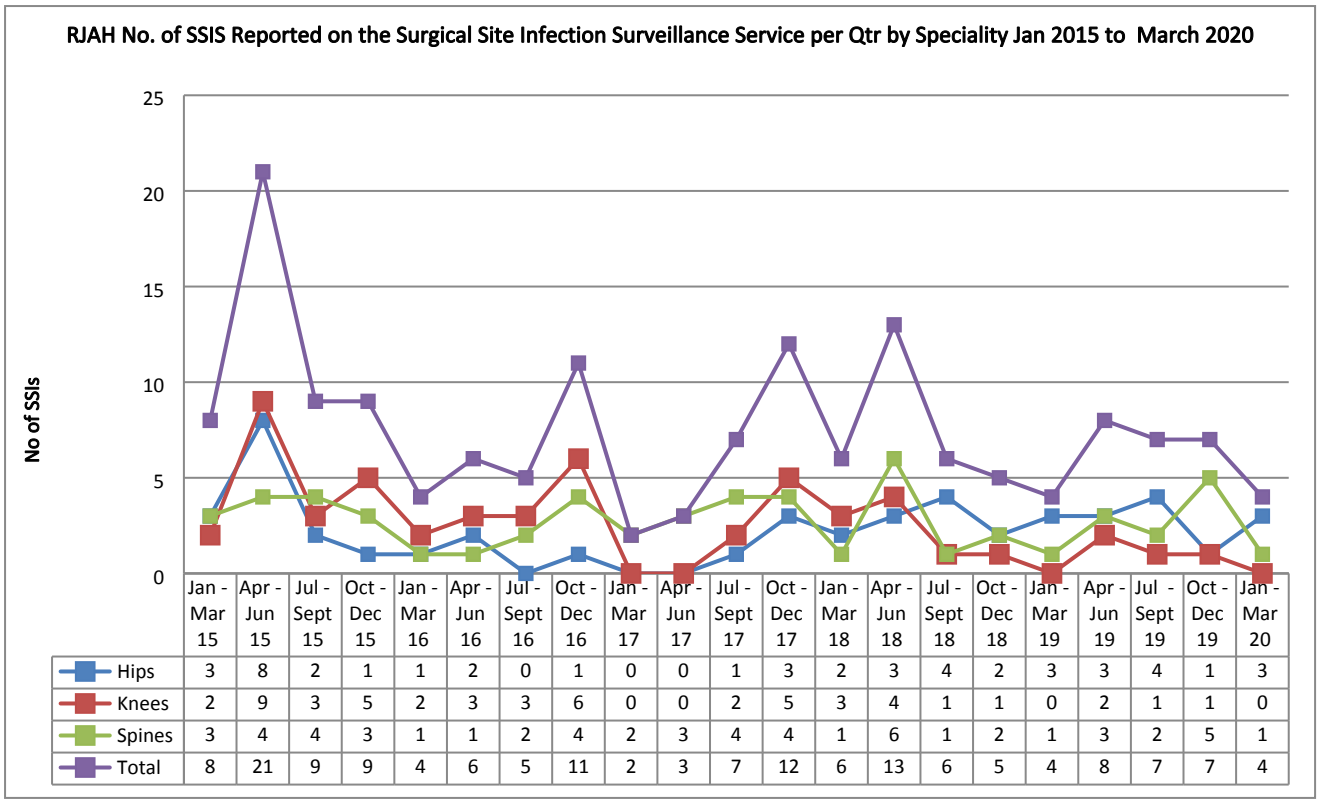
The graph below shows the trends of the total number of SSIs that have been reported to PHE between January 2015 and March 2020. During October 19 to December 19 there were 5 spinal infections which generated an outlier letter from Public Health England. A full investigation of the cases was undertaken there was no correlation between cases however variances in practice were identified including theatre headwear and obtaining intraoperative samples. Full report was submitted to the Medical Director.



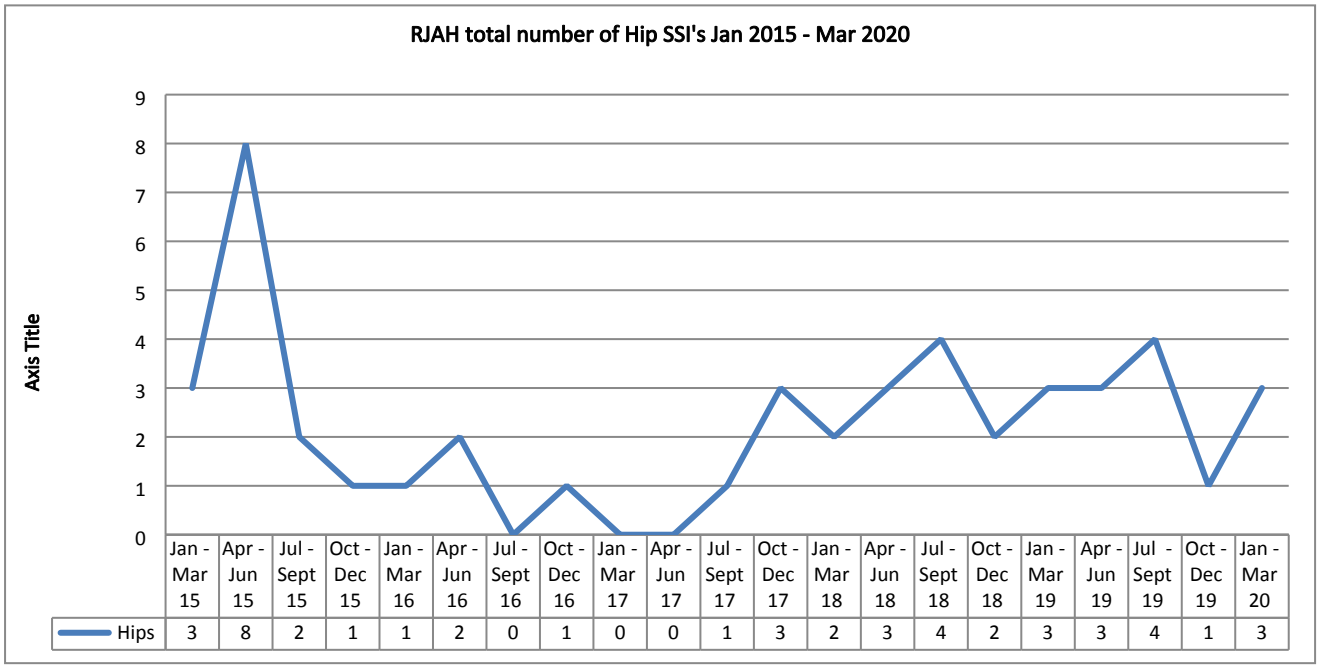
	Jan-Mar 19	Apr - Jun 19	Jul - Sept 19	Oct - Dec 19	Jan - Mar 20
Hips	0.7	0.7	0.9	0.2	0.9
Knees	0	0.5	0.3	0.2	0
Spines	0.4	1.5	0.8	2.3	0.5



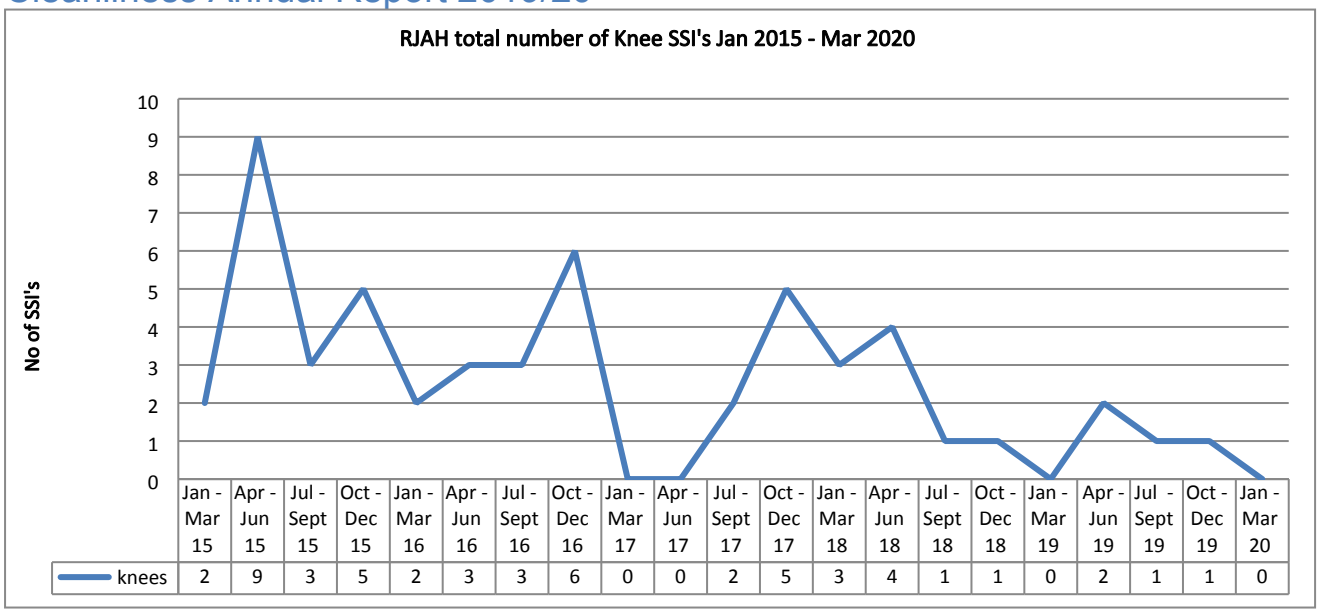
	Jan - Mar 15	Apr - Jun 15	Jul - Sept 15	Oct - Dec 15	Jan - Mar 16	Apr - Jun 16	Jul - Sept 16	Oct - Dec 16	Jan - Mar 17	Apr - Jun 17	Jul - Sept 17	Oct - Dec 17	Jan - Mar 18	Apr - Jun 18	Jul - Sept 18	Oct - Dec 18	Jan - Mar 19	Apr - Jun 19	Jul - Sept 19	Oct - Dec 19	Jan - Mar 20
SSIs	8	21	9	9	4	6	5	11	2	3	7	12	6	13	6	5	4	8	7	7	4

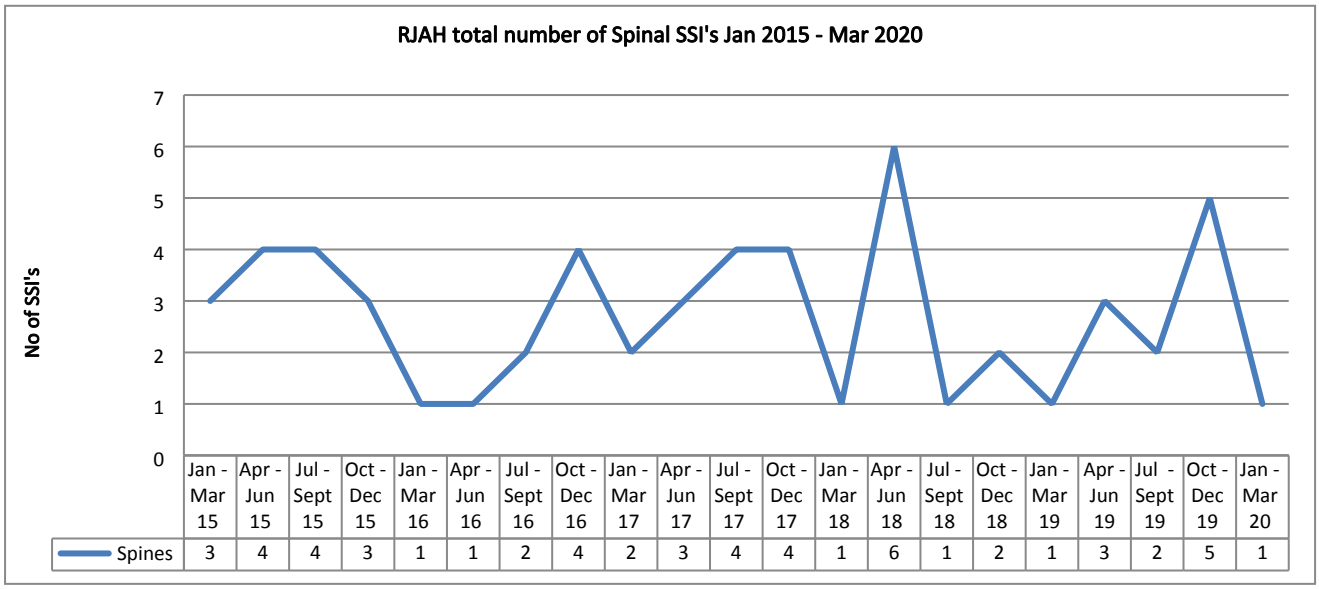


	Jan - Mar 15	Apr - Jun 15	Jul - Sept 15	Oct - Dec 15	Jan - Mar 16	Apr - Jun 16	Jul - Sept 16	Oct - Dec 16	Jan - Mar 17	Apr - Jun 17	Jul - Sept 17	Oct - Dec 17	Jan - Mar 18	Apr - Jun 18	Jul - Sept 18	Oct - Dec 18	Jan - Mar 19	Apr - Jun 19	Jul - Sept 19	Oct - Dec 19	Jan - Mar 20
Hips	3	8	2	1	1	2	0	1	0	0	1	3	2	3	4	2	3	3	4	1	3
Knees	2	9	3	5	2	3	3	6	0	0	2	5	3	4	1	1	0	2	1	1	0
Spines	3	4	4	3	1	1	2	4	2	3	4	4	1	6	1	2	1	3	2	5	1
Total	8	21	9	9	4	6	5	11	2	3	7	12	6	13	6	5	4	8	7	7	4



	Jan - Mar 15	Apr - Jun 15	Jul - Sept 15	Oct - Dec 15	Jan - Mar 16	Apr - Jun 16	Jul - Sept 16	Oct - Dec 16	Jan - Mar 17	Apr - Jun 17	Jul - Sept 17	Oct - Dec 17	Jan - Mar 18	Apr - Jun 18	Jul - Sept 18	Oct - Dec 18	Jan - Mar 19	Apr - Jun 19	Jul - Sept 19	Oct - Dec 19	Jan - Mar 20
Hips	3	8	2	1	1	2	0	1	0	0	1	3	2	3	4	2	3	3	4	1	3





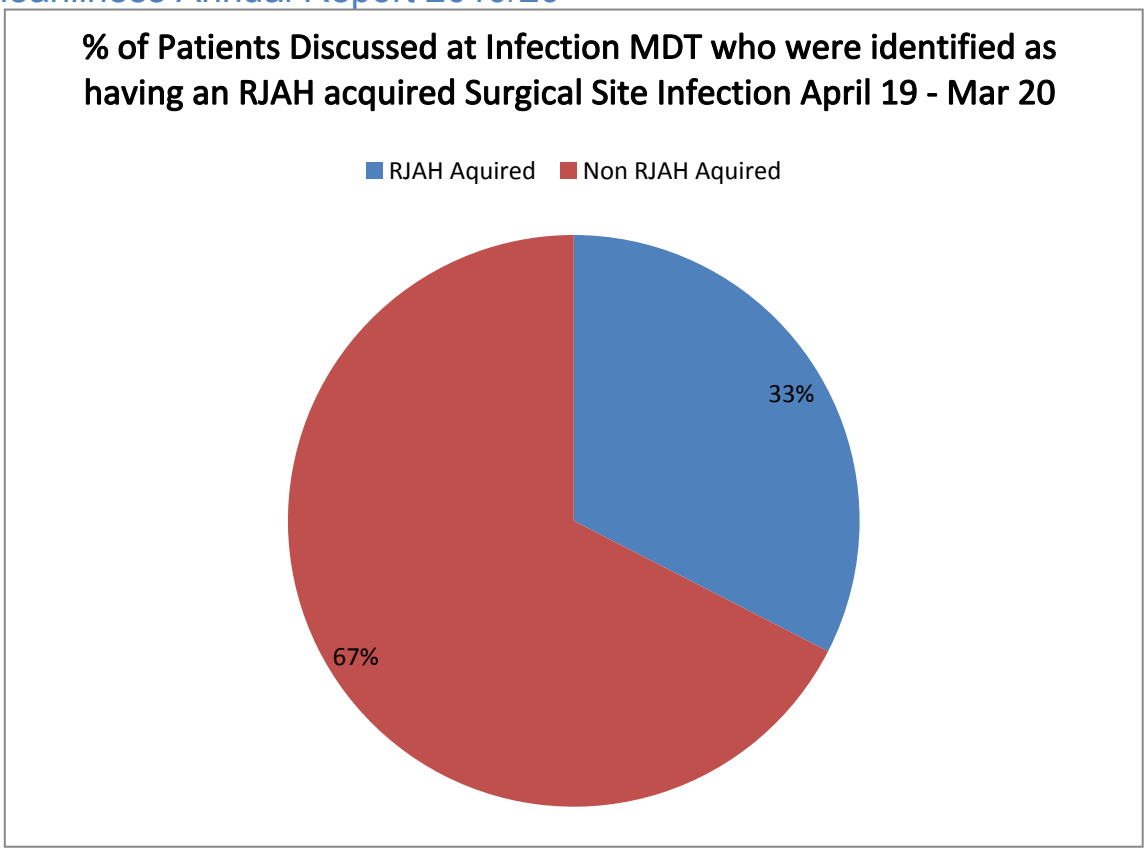
Infection MDT

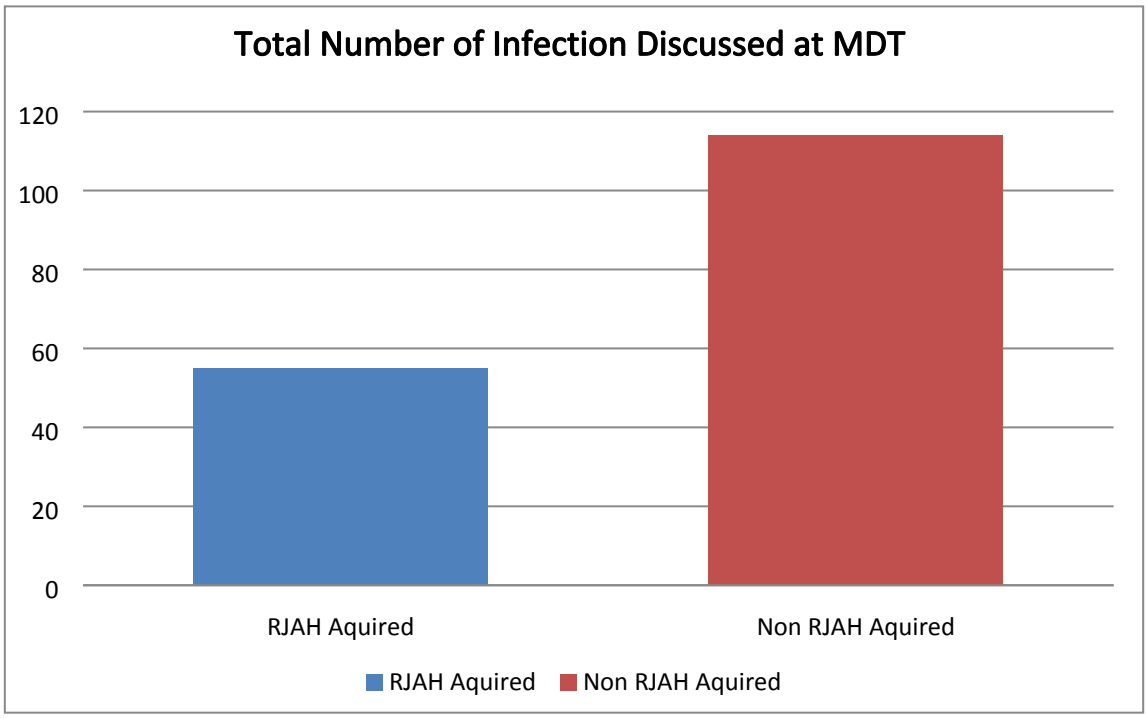
The Infection MDT continues to meet weekly. The purpose of the MDT is to discuss complex infections and to make recommendations for treatment. The Infection MDT is attended by the Consultant Surgeons, the Consultant Microbiologist, Antimicrobial Pharmacist, the Infection Prevention & Control Team, Radiologist and Histopathologist.

PHE's Surgical Site Surveillance System requirements are to report hips, knees and spines; the Infection MDT reviews patients from all orthopaedic specialities,including upper limb, lower limb, sports & spinal injuries.

Of the patients discussed and reviewed during 2019/20, 169 were agreed to have an infection, 55 of these were identified as having a RJAH acquired infection.

The pie chart below shows the split of RJAH and non-RJAH acquired Infections discussed at Infection MDT during this reporting period:


% of Patients Discussed at Infection MDT who were identified as having an RJAH acquired Surgical Site Infection April 19 - Mar 20
RJAH Aquired
Non RJAH Aquired
33%
67%


Total Number of Infection Discussed at MDT
120
100
80
60
40
20
0
RJAH Aquired
Non RJAH Aquired
RJAH Aquired
Non RJAH Aquired

Infection Prevention & Control & Cleanliness Annual Report 2019/20

Getting it Right First Time (GIRFT)

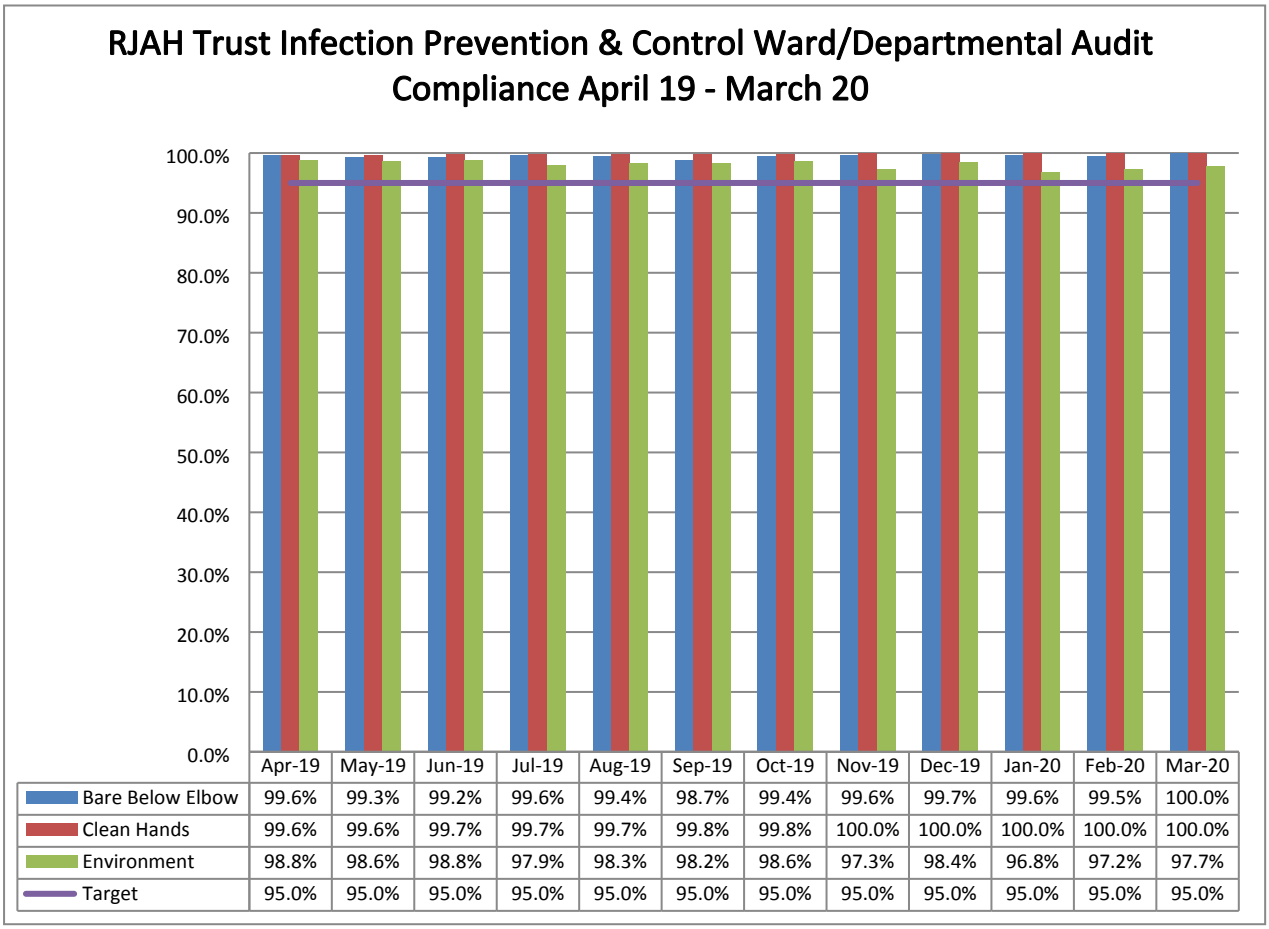
The Trust participated in the 2019 GIRFT (Getting It Right First Time) SSI audit for surgical site infections in hip, knee, shoulder, elbow, ankle replacements and spinal surgery from May -October with an aim to improve the quality of care within the NHS by reducing unwarranted variations.

The survey is now closed and GIRFT is currently analysing the data with a view to observing not only data for the individual site data packs but to observe for any trends in each specialty. The results for each trust will be shared in a data pack together with data on national averages . The focus of the data pack is to encourage each trust / site that took part to review their data and to raise local awareness of SSI rates and their clinical impact by specialty. Once results have been received these will included in the quarterly reports.

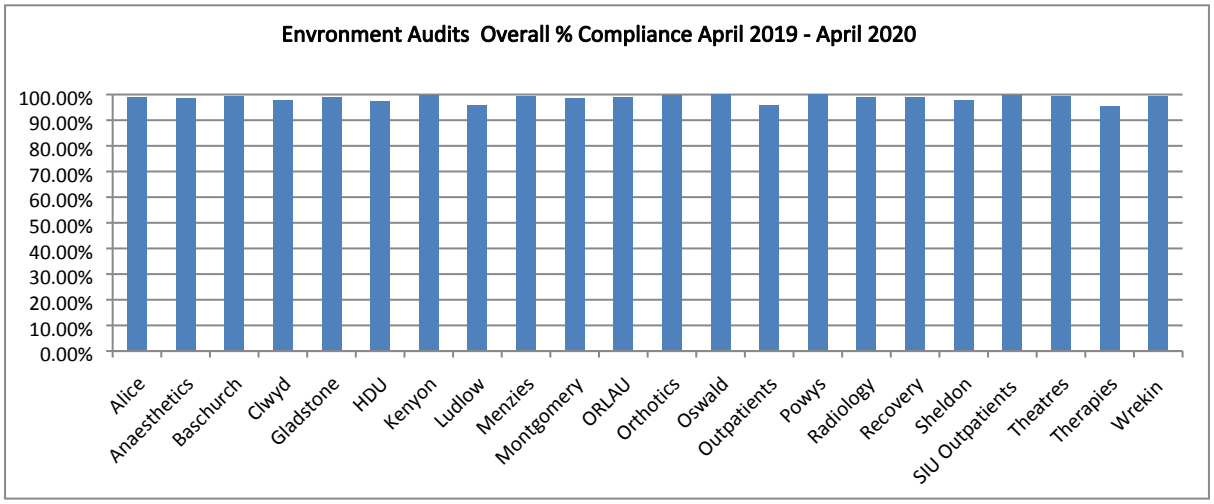
Infection Prevention & Control Ward/Department Audits

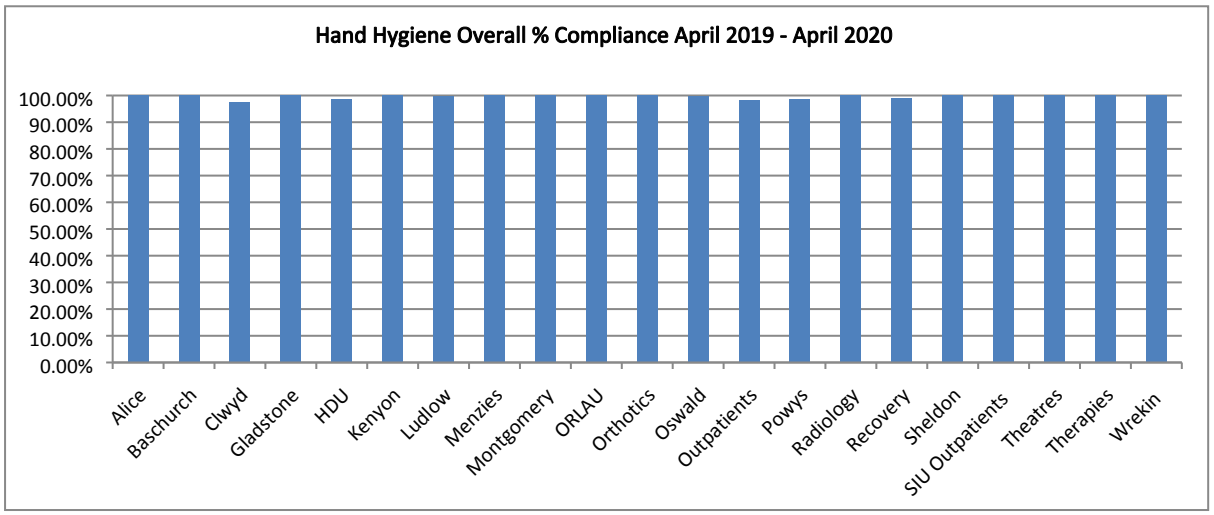
Wards and departments complete a robust package of infection prevention and control audits across the year. The toolkit comprises of environmental auditing, which highlights patterns of non-compliance to be addressed, the hand hygiene audit tool includes bare below the elbows and a revised set of High Impact Interventions (Saving Lives) tool which was implemented in January 2018.

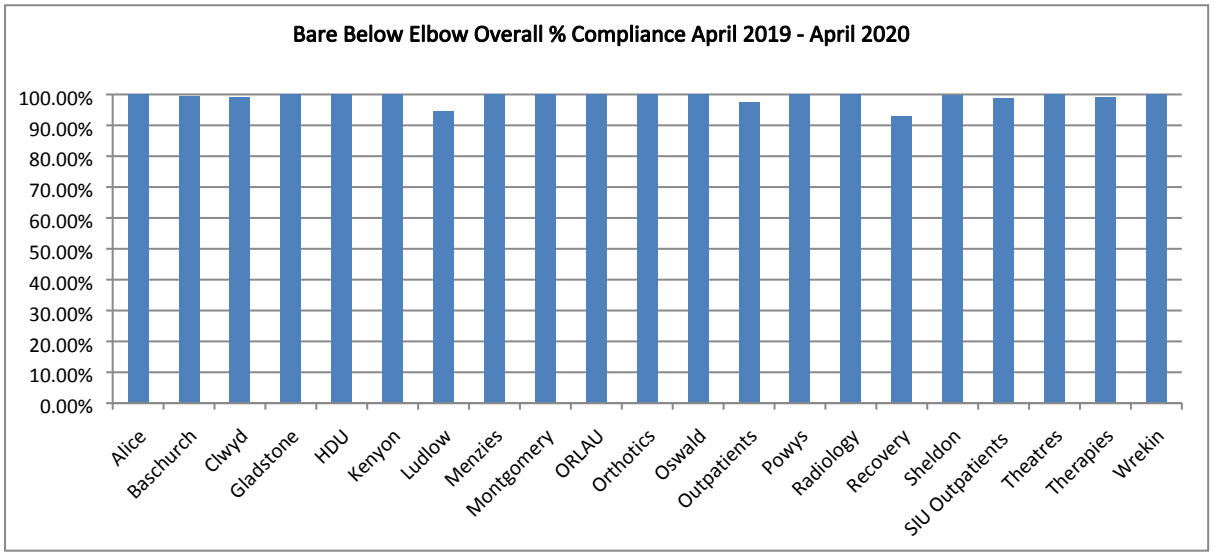
The graph below shows the Trust's compliance against each of the individual audits. The results show how the Trust consistently achieves the 95% target in all areas each month.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Bare Below Elbow	99.6%	99.3%	99.2%	99.6%	99.4%	98.7%	99.4%	99.6%	99.7%	99.6%	99.5%	100.0%
Clean Hands	99.6%	99.6%	99.7%	99.7%	99.7%	99.8%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%
Environment	98.8%	98.6%	98.8%	97.9%	98.3%	98.2%	98.6%	97.3%	98.4%	96.8%	97.2%	97.7%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%


Envronment Audits Overall % Compliance April 2019 - April 2020
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Alice
Anaesthetics
Baschurch
Clwyd
Gladstone
HDU
Kenyon
Ludlow
Menzies
Montgomery
ORLAU
Orthotics
Oswald
Outpatients
Powys
Radiology
Recovery
Sheldon
SIU Outpatients
Theatres
Therapies
Wrekin


Hand Hygiene Overall % Compliance April 2019 - April 2020
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Alice
Baschurch
Clwyd
Gladstone
HDU
Kenyon
Ludlow
Menzies
Montgomery
ORLAU
Orthotics
Oswald
Outpatients
Powys
Radiology
Recovery
Sheldon
SIU Outpatients
Theatres
Therapies
Wrekin


Bare Below Elbow Overall % Compliance April 2019 - April 2020
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Alice
Baschurch
Clwyd
Gladstone
HDU
Kenyon
Ludlow
Menzies
Montgomery
ORLAU
Orthotics
Oswald
Outpatients
Powys
Radiology
Recovery
Sheldon
SIU Outpatients
Theatres
Therapies
Wrekin

Environmental Audit

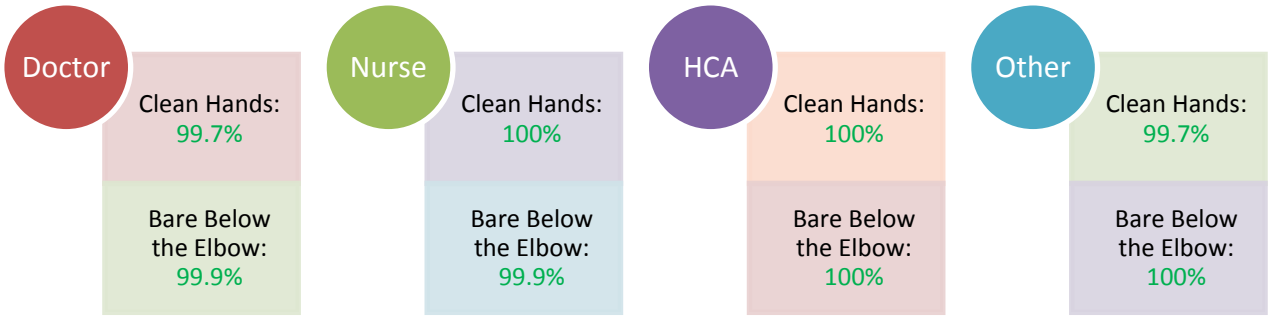
The most common areas of the Environment Audit non-compliance:

- Floors clean and in good state of repair
- Safer sharps devices are not in use.
- Waste, bins are enclosed, foot operated and soft closing
- Furniture clean and in good state of repair. i.e chairs, lockers, tables

Staff are encouraged to raise requisitions with the Estates department, waste and sharps awareness sessions have been held at Link meetings to support staff in raising awareness and educate staff within their departments. A rolling programme of backlog maintenance is in place for floor replacements.

Hand Hygiene & Bare Below the Elbows

The image below shows the hand hygiene and bare below the elbow compliance split by designation. The 'Other' category captures other members of the multi-disciplinary team, such as therapy support, pharmacists and students.



IPC Team Environmental Audits

Orthotics RSH

Areas of improvements identified that required to be addressed:

- The room was malodorous with no ventilation
- No hand wash basin in the office were the secretary's receive dirty soiled footwear,.
- Clinical hand wash basin is being used to pour non gypsonian water down, has a plug and does not have a mixer tap to enable controlled water temperature for hand hygiene
- Carpeted store rooms storing clinical supplies on the floor
- Not enough storage with cluttered areas making it difficult to clean

* The Orthotics department has since been relocated into a suitable area within SaTH

Hydrotherapy Pool

Areas of improvements addressed include:

- Hand hygiene posters required in ladies changing room
- Handrail in poolside shower in poor state of repair
- Arjo trolley on the poolside to be condemned and disposed of and replacement plinths required
- Build-up of rust on the pool floor- to be cleaned/removed

TSSU

Areas of improvements addressed include:

- Theatre wrap and supplies stored on the floor in clean room
- Debris stuck to wheels of trolley in clean room
- Build up of scale to the top and bottom of the washers in the clean room
- Supplies stored on the floor

Ultrasound

Areas of improvements adressed include:

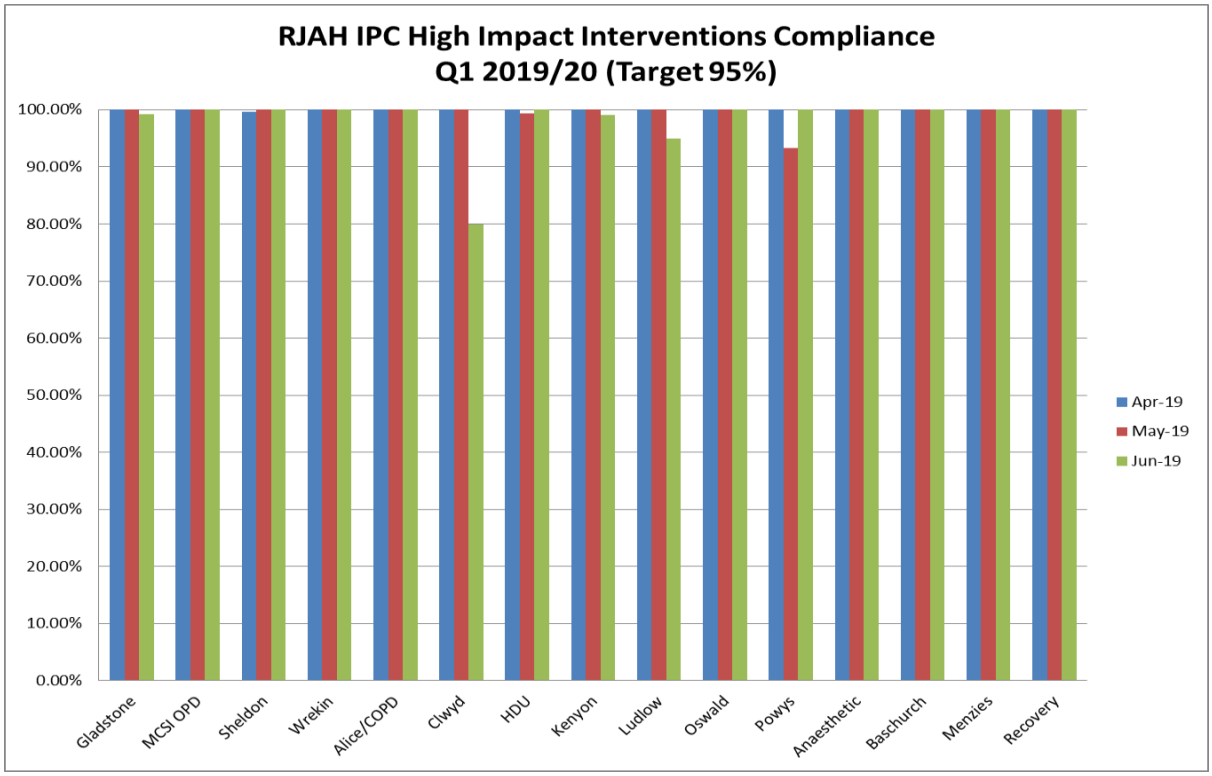
- Scrub sink has cold water only and restricted flow
- Dressing packs /clinical supplies stored on open shelf.
- Damage to wallpaper and walls
- Floors heavily stained and damage

Plaster room

Areas of improvements addressed include:

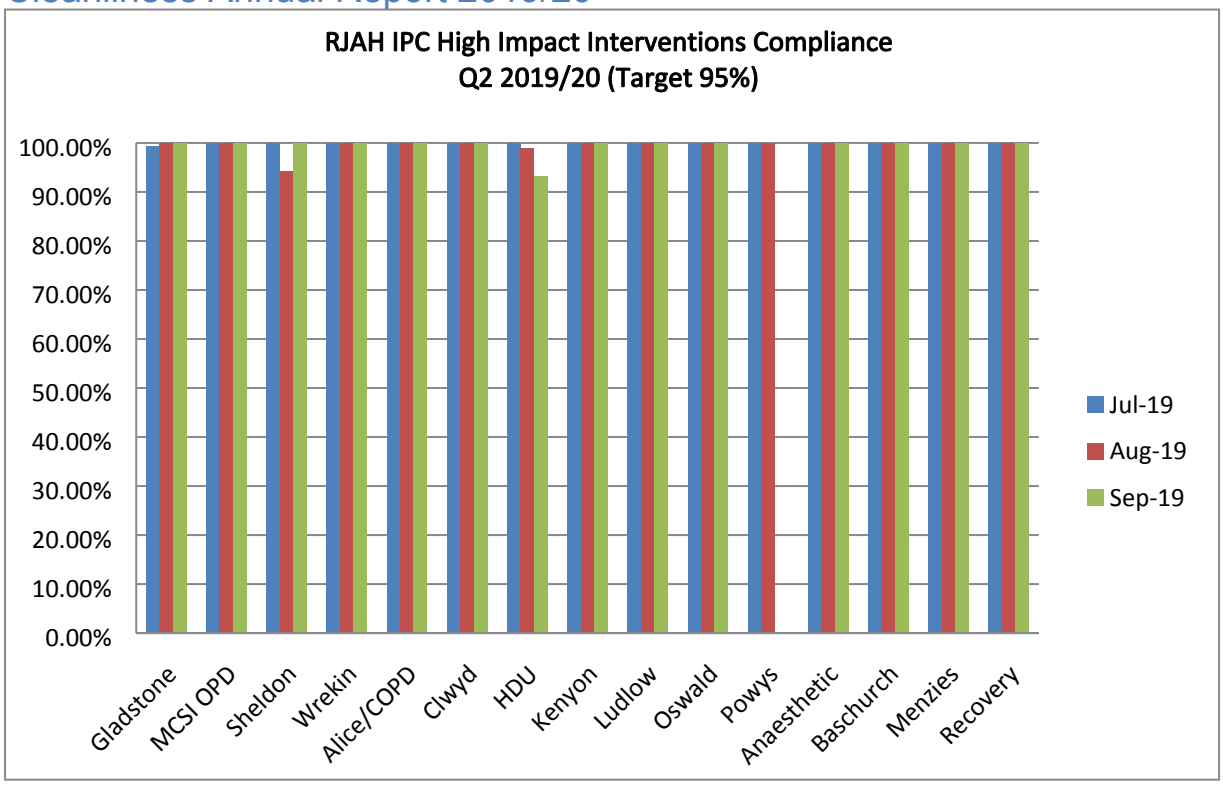
- Inadequate storage for supplies
- Cupboard doors heavily stained and require painting
- Floor repairs required

High Impact Interventions (Saving Lives)



8111 High Impact Intervention audits were undertaken over quarter 1 with an overall score of 99.73% compliance, which is consistently above the Trust target of 95%. These include insertion and care of peripheral, central and PICC lines; insertion and care of urinary catheters; prevention of surgical site infection.

Audit findings are shared with the Ward Managers. For any wards that fall below the 95% target action plans are implemented.



6909 High Impact Intervention audits were undertaken during quarter 2 with a score of 99.77% compliance, which is consistently above the Trust target of 95%. These include insertion and care of peripheral, central and PICC lines; insertion and care of urinary catheters; prevention of surgical site infection.

Audits were undertaken during Quarter 3 and Quarter 4 however due to the depletion of the IPC Team in November 2019 the audits were undertaken but not analysed or inputted. The DIPC at this time was keen to review all the trust IPC audits undertaken and how we monitor their compliance, this meeting is outstanding.

3.2.3. Criterion 2: Provide and maintain a clean and appropriate environment

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes.

Cleanliness

Cleaning is provided by the Trust's in-house team of cleaners and deep cleaners; the internal team is supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis.

Outcomes for cleaning are monitored through several sources including internal monitoring, internal patient satisfaction surveys, the PLACE assessment and the CQC inpatient survey. Resources are dynamically moved around the Trust so that the best standard is achieved in all areas.

As part of the agenda for change band 1 closure, staff were supported to transition to a new 'Cleanliness Technician' role (band 2). Key changes to the job description emphasised the role these staff play in monitoring of the Trusts environment, and tasked staff with reporting where cleaning could not effectively take place due to damage or areas needing repair. This

has provided the operational estates team with regular updates to prioritise refurbishments including a programme of painting and wall protection.

The initial number of observed environmental issues has generated considerable work for the estates team, but their response has reflected well in the PLACE score.

Cleanliness – Deep Cleaning

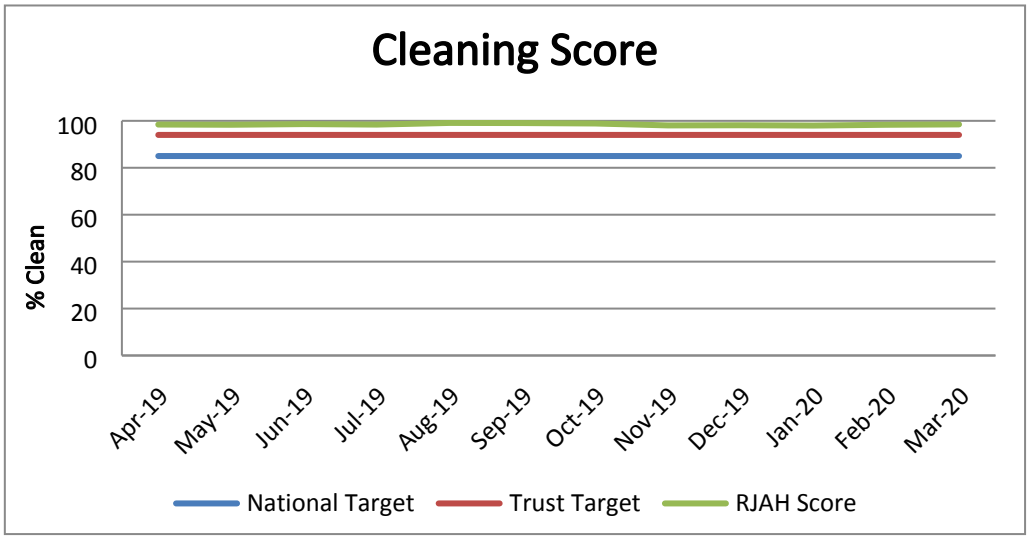
Whilst routine cleaning is completed in all areas on a daily basis, staff in high risk areas are supported with extra staff to complete a deep clean on a weekly basis. In the very high risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service.

In case of an outbreak, the Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment. The Trust now also has a working relationship with Dewpoint Solutions, whose service can be called upon in less than 24 hours. Responses to date have been quick, effective and professional.

15 individual rooms or bays as well as 2 complete wards have undergone HPV fogging treatment in 2019/20; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring and managerial spot checks.



Internal monitoring is carried out every day, visiting all areas on a weekly basis. Very high risk areas are monitored in collaboration with the clinical team to ensure the broadest picture is seen. All required improvements identified by the audits are acted upon by the internal team and the results, along with the patient survey, go to the Infection Prevention & Control Committee on a quarterly basis.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2019/20 the Trust achieved an average score of 98.48%.

Cleanliness – Patient Satisfaction – Internal

Feedback from service users is very important, internal monitoring very much aligns to the feedback PALS (Patient Advice and Liaison Service) receive from the patient. On a monthly basis an internal team speaks to patients one to one and also reviews feedback forms that the patient can fill in privately. The results are fed back to the Estates and Facilities team to act upon.

Further to the categorisation of cleanliness standards through the patient surveys, the department also reviews every comment as part of its 360° review and learns as a team from negative feedback but also highlights the numerous positive comments associated with the hard work of the cleaning team.

Overall comments in 2019/20 comments have been very positive, with no overarching negative themes.

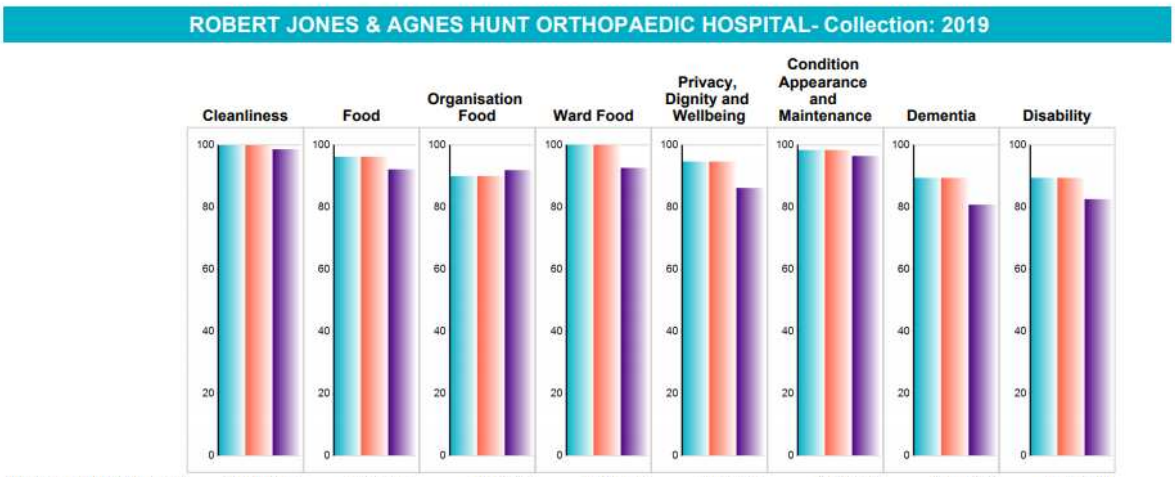
Cleanliness and Environment - Kitchen

The Trust kitchen retained its 5 star food hygiene rating, undergoing an environmental health inspection in February 2020.

Supporting this inspection, the Trust procures a separate external food safety audit which produces a detailed action plan.

PLACE – Patient Led Assessment of the Care Environment

The 2019 PLACE assessment identified many positives for the Trust and also areas to work upon.



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2310.0000	225.0000	81.0000	144.0000	448.6667	816.0000	660.0000	477.0000
Available Score (Actual)	2312.0000	234.0000	90.0000	144.0000	474.0000	830.0000	738.0000	534.0000
Site Score	99.91%	96.15%	90.00%	100.00%	94.66%	98.31%	89.43%	89.33%
Organisation Average	99.91%	96.15%	90.00%	100.00%	94.66%	98.31%	89.43%	89.33%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

In relation to cleanliness and the environment;

- Cleanliness maintained its high standard, consistent with previous years and the internal reporting that goes to the Infection Control Committee quarterly. The two issue identified were mostly related to litter in ward areas and were resolved immediately.
- The condition, appearance and maintenance metric highlights the fact that scoring is based on patient's perception on the day. Whilst estates believe there are multiple areas for improvement in areas such as the poor lighting in Powys ward, patients on the day described Powys as 'inviting and familiar'. Areas that were raised by the

patient assessors focused on flooring giving the perception that the floors weren't clean even though on inspection they were found to be clean due to the floors age. Estates have a programme to replace and improve flooring but this is heavily dependent on access.

- As mentioned, the role of the cleanliness technician in reporting environmental issues saw a high level of minor tasks reported, the resulting work has clearly reflected in the high level of satisfaction the patient assessors had on the day.
- The PLACE collection has been substantially reviewed and refined since publication of the 2018 results. 2019 scores therefore establish a new baseline, and cannot be compared with figures from earlier years; however the Trust can benchmark itself against similar peers to support analysis of areas for improvement.

All PLACE elements are addressed through the quarterly Infection Prevention & Control Committee; these include elements that fall outside of Criterion 2; cleanliness and the environment.

Linen

In 2019/20; quarterly review meetings continued to ensure standards relating to the provision of linen were monitored. The annual audit, undertaken by the multidisciplinary facilities & infection control teams on behalf of the consortium, raised concerns covering cleanliness, health and safety and processing standard procedures of the providing Trust (Mid Cheshire Hopsitals NHS Foundation Trust – MCHT). Through a formal contract review notice, and in line with the associated action plan, a number of isses were addressed. Follow up assessments in the short term noted significant improvements to the compliance of the facilities giving respective boards assurance that previously highlighted risks had been mitigated.

Towards the end of the calender year, MCHT suffered significant mechanical breakdowns and following an options appraisal, MCHT determined that long term provision of the contract was not financially feasible. With the assistance of all Trusts involved, MCHT transitioned the service to one of the leading external providers. For assurance, the Trusts assessed the external provider to ensure the compliance of the service and are satisfied with what was witnessed. Long term, MCHT and the consortium are looking to negotiate an external contract achieveing economies of scale with their collective buying power.

Estates Department Contribution to the Clean and Appropriate Work Environment

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents:-

1. Health Building Note 00-09 (Department of Health, 2013 -which supersedes and replaces all versions of Health Facilities Note 30) and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. Health Technical Memorandum 04 01, The Control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems."

Part A: Design, installation and testing, and

Part B: Operational management. (Department of Health (DOH) 2006). CWP's 'control of Legionella' closely adopts the requirements of the above HTM.

Water

The control of water is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Water safety is managed and controlled by the estates department to guidance HSG274 and HTM 04. The Estates department continues to employ a third party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years, or where required following incidents or significant infrastructure changes. There is a written site specific scheme of control for each inpatient premises. Eurofins provide the Trust an internet based water testing database storage and reporting for statutory test results. There is also a three monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control Working Group.

The Trust have appointed an Authorising Engineer (Water) (AE(W)), on 27/01/2020. The AE will be conducting an audit of the site infrastructure and Estates' management of such, later this year. The AE(W) is a 'critical friend', a requirement of HTM 04-01b and offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

Estates Operational Service continually undertake water tests throughout the Trust estate, this water testing is carried out under legislation and guidance set out by The Health & Safety Executive and the Department of Health. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as leginaellosis; it is a method of using quantitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. During May 19 – April 20 at total of 680 water sample tests were undertaken, this is a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to these tests, thermal disinfection has been undertaken in some areas' domestic water supplies – this process has increased efficacy and reduces costs as the works are now completed by the in house Estates' Mechanical Technicians. Disinfection is often employed to manage domestic water hygiene.

Tender for replacement of main water storage tanks 22/05/2020, currently under tender evaluation. Replacing the 1970s main water storage tanks will bring the trust in line to current regulation and guidance standards.

The last risk assessment highlighted actions to be resolved around the infrastructure in the main service duct. This work has now commenced, being completed by the Estates Mechanical team, to be completed by October 2020.

Decontamination Group

Decontamination covers the theatre and sterile services environment under the guidance of HTM 03-01.

Decontamination is led and monitored by the estates department supported by their third party accredited Authorising Engineer AE(D) .

Accredited third party contractors revalidates theatres on an annual basis, providing an inspection and reverification report. These reports are then reviewed by the AE(D)

The RJAH estates team maintain a local testing regime on a monthly basis to proactively manage any issues with compliance.

Further, there is a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at a sub-committee of the Infection Prevention & Control & Cleanliness Committee.

Annual revalidations continue to be completed by approved contractors, with the AE(D) sighted on reports, and any follow up maintenance.

Due to issues with the resin floor, Theatre 8 floor covering was replaced in June 2020. Theatres 7, 9 and 10 are booked in throughout Q2/3.

Due to the Covid-19 response, extensive face mask fit testing conducted co-ordinated by H&S Officer has been rolled out across the Trust.

COVID19 – Estates & Facilities Response

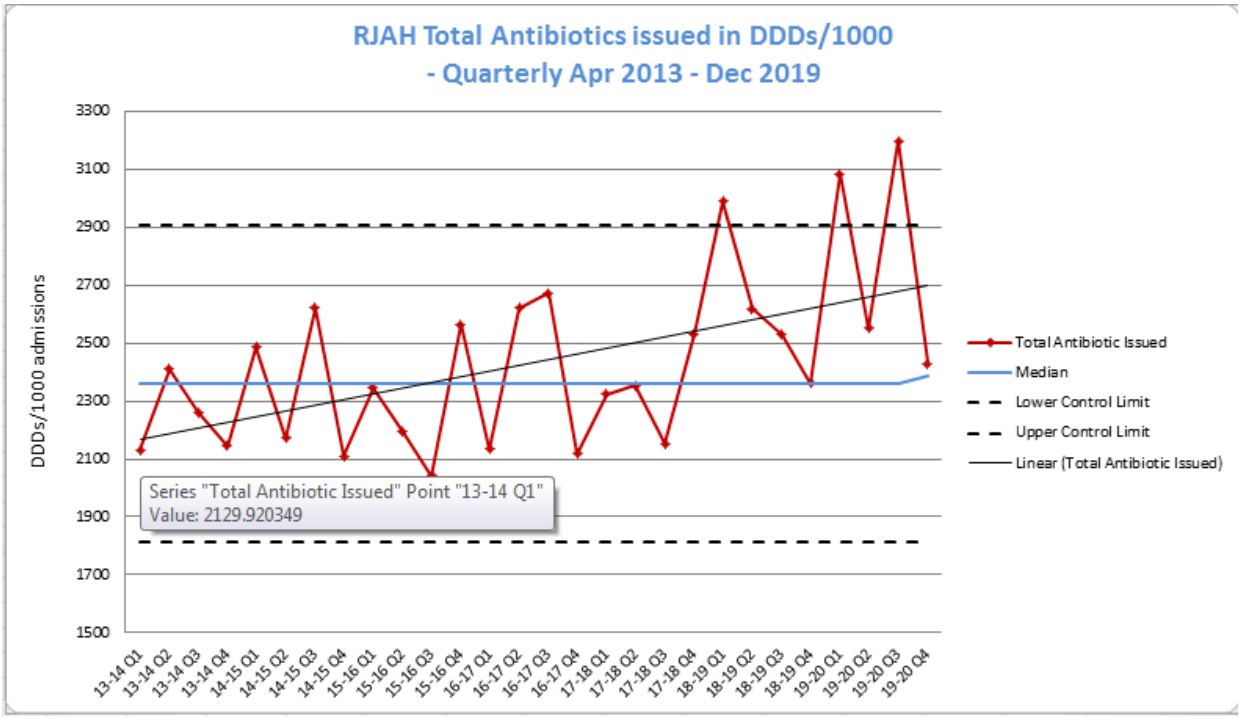
At the very end of quarter 4, the Trust began to implement changes on site in response to the escalating COVID needs, in line with the desktop exercises it had undertaken to test its contingency plans.

E&F took a leadership role in personal protective equipment (PPE), working closely with procurement to ensure the service was always adequately supported with compliant PPE. E&F supported the Trust with operational environmental optimisations, that include air change and pressure regime considerations, enhanced touch point cleaning and access restrictions.

Guidance was received from NHS futures, which proved a good way of centralising all information, allowing discussion forums where Trusts could assist in interpreting how the national guidance affected local needs.

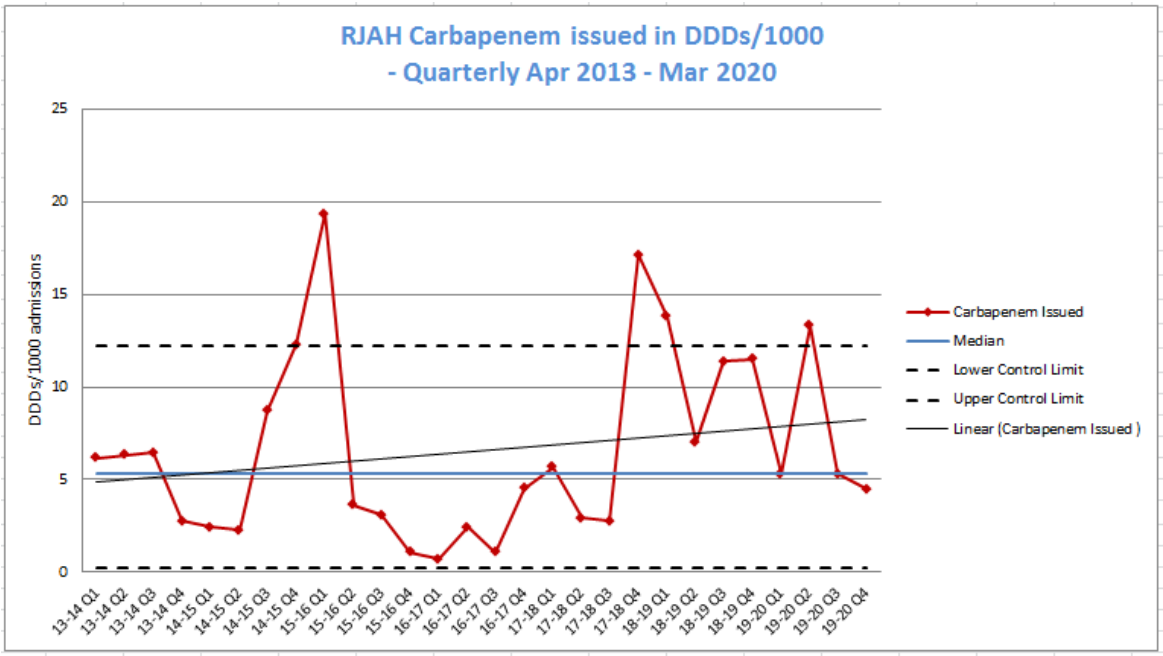
All information was pooled and Estates & Facilities worked collaboratively with infection control on a comprehensive board assurance framework in order to evidence the practices we committed to delivering were achieved.

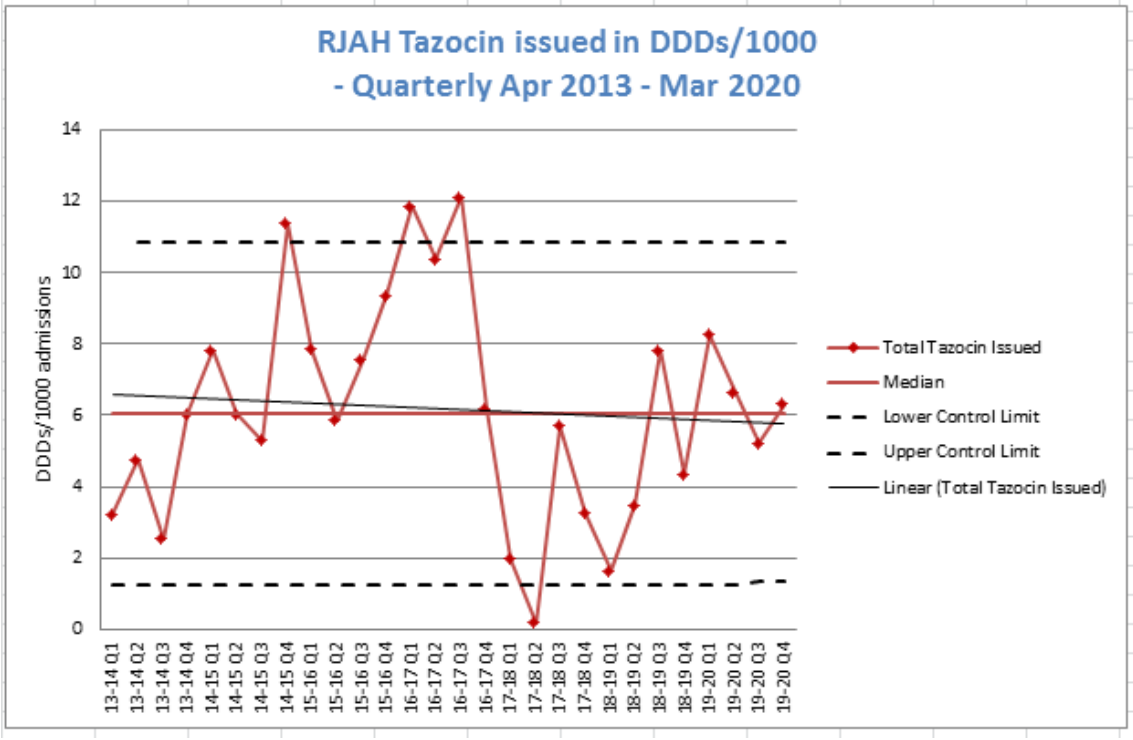
3.2.4. Criterion 3: Ensure appropriate antimicrobial use



Total antimicrobials

The graph above shows the issue of total antibiotics from pharmacy in DDDs per 1000 admissions. This is showing an overall increasing trend since 2013. This trend has been noted in other Trusts and thought it may be due to the impact in the last few years of the sepsis campaigns encouraging prescribers not to delay or withhold initiating antibiotic treatment.





Carbapenems & Piperacillin /Tazobactam (Tazocin)
The graphs above show the issue of carbapenem and piperacillin/tazobactam respectively from pharmacy in DDDs per 1000 admissions.

Carbapenem and Tazocin usage is monitored in the Trust and are only issued per patient. Prudent use of these antibiotics is essential as current evidence clearly demonstrates that the inappropriate use of broad-spectrum antimicrobials is associated with the selection of antimicrobial resistant bacteria.

Tazocin shows a slight downward trend in issue over this time, whereas there is a slight increase in the trend for carbapenems. Neither are issued as stock to the wards and clinical screening for appropriate use takes place by a pharmacist before they are issued. Microbiology approval is sought for all indications not cited in the antibiotic policy. Therefore the issue of these antibiotics is tightly controlled.

Pharmacy

Antimicrobial Stewardship 2019-20

At RJAH

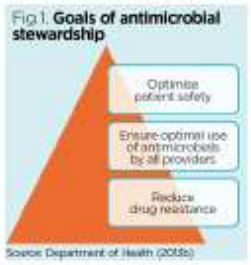
Trust wide use of vancomycin chart, improving vancomycin treatment dosing and patient safety.

Use of a Gentamicin calculator on the RJAH intranet (Applications section), to improve gentamicin prescribing and patient safety.

Continued contribution to the 'Local Health economy infection prevention and control and antimicrobial prescribing group' on a quarterly basis.

Continuation of ongoing programme of audit & feedback. Quarterly Point Prevalence Studies to monitor adherence to 'Start Smart- Then Focus' principles from PHE's Antimicrobial Stewardship toolkit.

Antimicrobial stewardship awareness presentation at LINK nurse meeting.



Antimicrobial Stewardship Pharmacist attendance at Infection MDT.

2 Pharmacists qualified as a non-medical prescriber in specific areas of antibiotic prescribing

Pharmacist attendance at The West Midlands Antimicrobial pharmacist's quarterly meeting. This aims to work collaboratively to improve standards & efficiency of antimicrobial pharmacy practice across the region, sharing best practice and innovation and bench marking regional practice.

Introduction of a box in the Emergency Drug Cupboard (EDC) containing antibiotics required if sepsis diagnosed in a person other than an inpatient e.g. a clinic attender or visitor.

Pilot of new drug card, incorporating specific sections for antibiotic prescribing

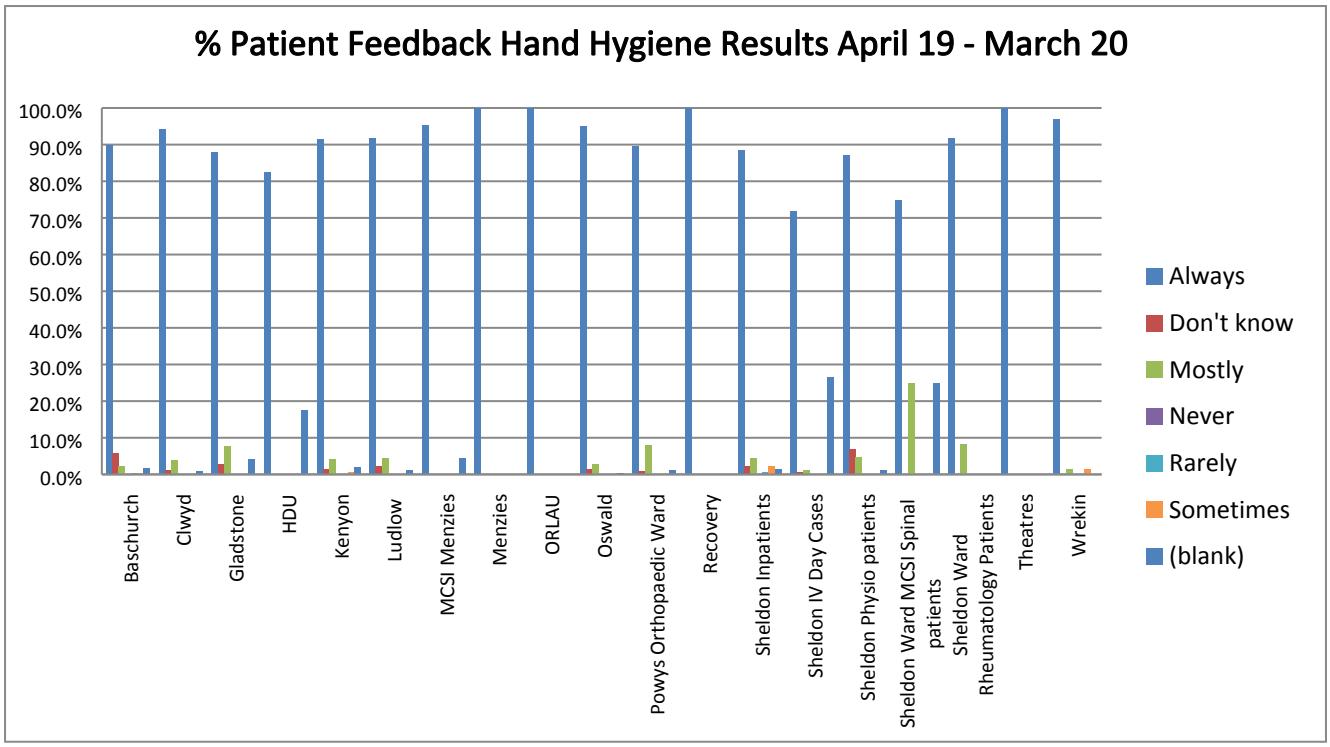
Achievement of Antimicrobial resistance CQUIN 2019/20: Lower urinary tract infection in over 65 year olds completed with a drop in session in December 2019

3.2.5. Criterion 4: Provide suitable accurate information on infections to service users

All patients with alert organisms are seen by the infection control nurse and information leaflets are provided. The microbiologist will also give advice and support to patients and their relatives upon request.

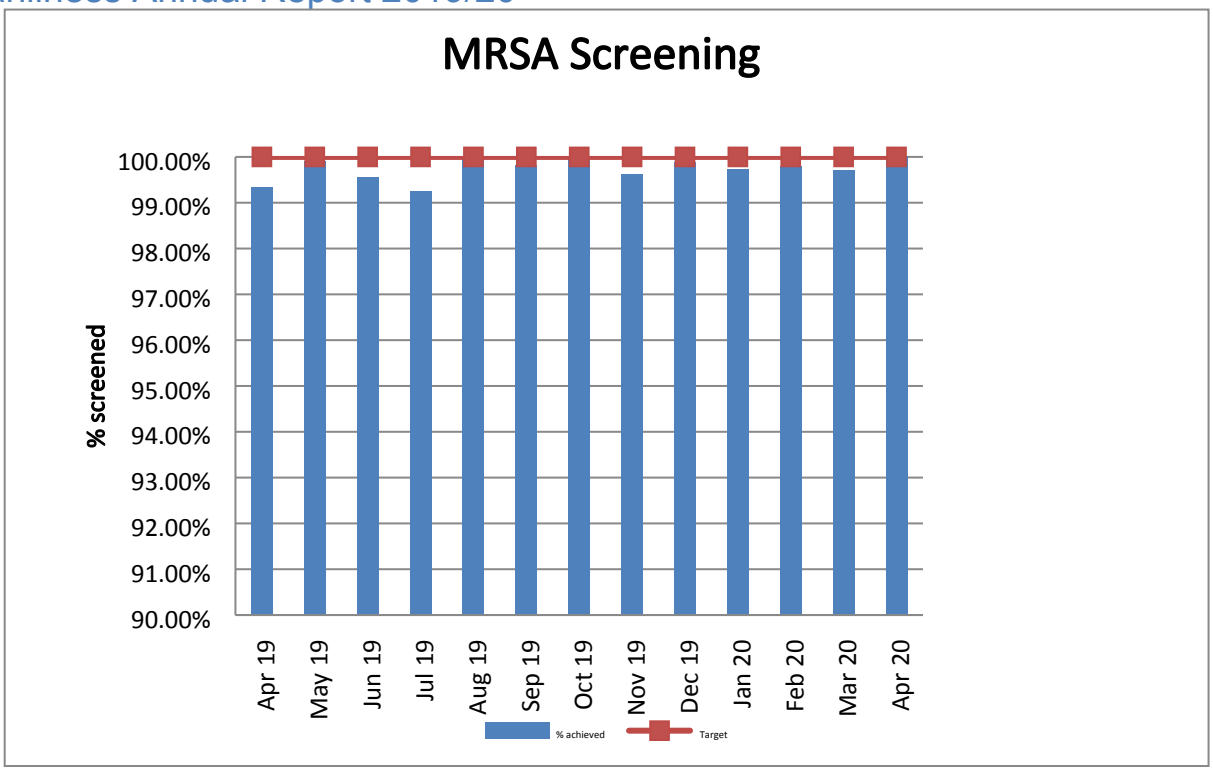
The Trust promotes best practice in infection prevention and control to its patients, relatives and visitors; highlighting the roles they can play in preventing infection through the website, targeted poster campaigns, and promotional events such as hand hygiene day.

The patient comment cards are used as a resource of data – including a specific question asking "Did the staff practice good hand hygiene". The results shown below provide encouraging feedback from a patient's perspective.



3.2.6. Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection

Patients who are at risk or require extra attention – this includes those unable to maintain high levels of hygiene standards, with poor quality skin or at risk of falls. Stakeholders receive an email with patient summaries and suggestions of actions to be in place in readiness for admission & surgery.



	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
Eligible patients	891	973	907	936	939	1043	1106	1024	863	1077	961	662	166
Screened for MRSA	885	972	903	929	939	1041	1106	1020	862	1074	959	660	166
% achieved	99.33%	99.90%	99.56%	99.25%	100.00%	99.81%	100.00%	99.61%	99.88%	99.72%	99.79%	99.70%	100.00%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

The graph and table above demonstrates the MRSA screening compliance which is consistently above 99%, set against a Trust target of 100%.

CPE screening is performed on any patients who have been transferred from inner city hospitals or have been hospitalised abroad as per national guidance.

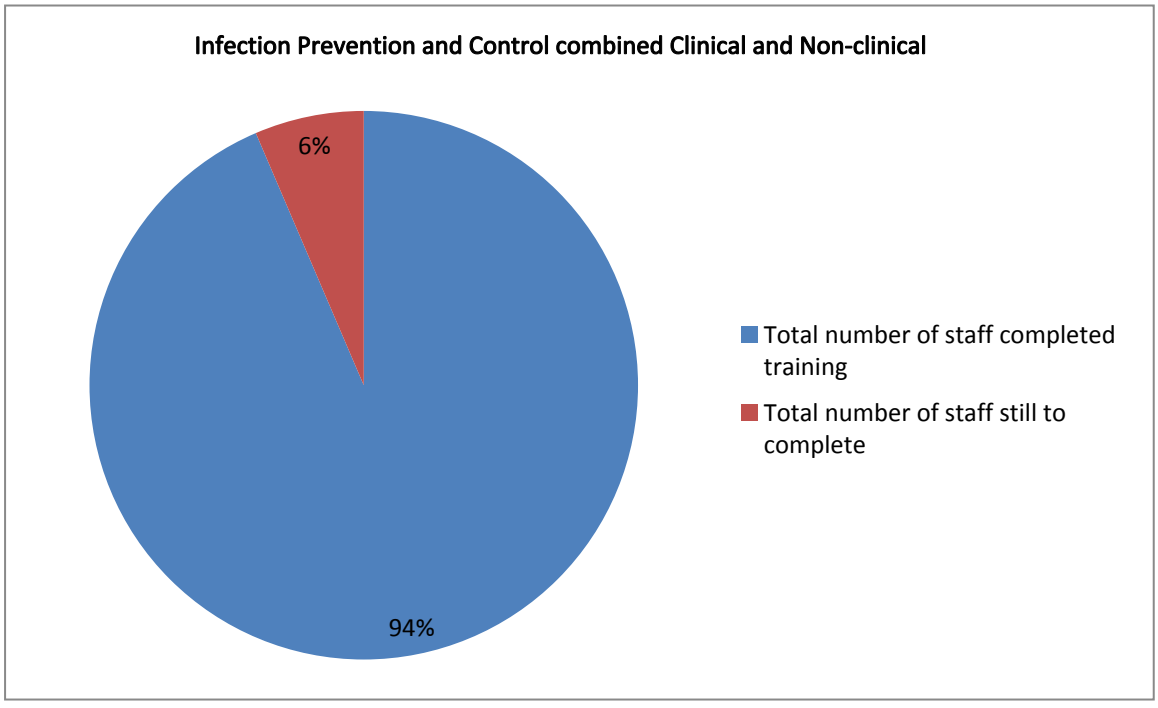
MRSA positive cases and ESBL infections are alerted to the IPCT daily as part of the lab reporting system, which are disseminated to the relevant departments; this ensures that positive cases can be decolonised within a timely framework preventing prolonged postponements of patient surgery.

The Infection Control Nurse/Surgical Site Surveillance Nurse provides advice and support to patients/relatives in the event of acquiring infection.

3.2.7. Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Training Compliance

Core Training Compliance - Infection Prevention & Control - 31 March 2020		Including Bank Staff			
Validity Period	Course Name	Total number of staff required to complete training	Total number of staff completed training	Total number of staff still to complete	Compliance Percentage
Annual	Infection Prevention & Control (Clinical Staff)	901	836	65	92.79%
3 Yearly	Infection Prevention & Control (Non-clinical Staff)	590	559	31	94.75%
Annual/3 Yearly	Infection Prevention & Control combined Clinical and Non-	1491	1395	96	93.56%



Additional training sessions provided by the IPCN include:

- Induction training of 45 minutes for all clinical and non-clinical staff (separate sessions for junior hospital doctors).
- All new/rotational doctors receive a short induction session provided by the IPCN.
- All volunteers receive a short training presentation and hand hygiene education.
- The team is part of the work experience programme run by the Trust on a quarterly basis.

- Provided 'train the trainer' education for link practitioners.
- Engage in the work experience programme based at RJAH
- Engage in the Trust preceptorship programme
- Provided workshop training sessions at ward training days
- Face to face training for groups of staff such as:
  - Catering
  - Porters
  - Domestics
  - Estates Maintenance staff

3.2.8. Criterion 7: Provide or secure adequate isolation facilities

The Trust has always been able to accommodate patient isolation with minimal disruption to the running of the wards. However, due to the increase of patients carrying antibiotic resistant organisms requiring siderooms for isolation, the installation of additional doors to the bays has been implemented on the spinal injuries unit to enable patients with the same carriage to be cohorted together in an isolated bay with the doors acting as a barrier as well as a reminder for staff to implement standard precautions.

3.2.9. Criterion 8: Secure adequate access to laboratory support as appropriate.

The management of prosthetic joint infection is challenging, the microbiology ward round is held once a week with the microbiologist, infection control nurse and the antimicrobial pharmacist. Each patient is reviewed and requires a tailored approach of antimicrobial prescribing due to the microorganisms grown on culture.

The microbiology lab sends a daily list of all positive samples including sensitivities. This enables all patients to receive the appropriate treatment/antibiotic therapy and prompt isolation if required.

3.2.10. Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

Infection Prevention & Control Policies & Standard Operation Procedures (SOP) are reviewed and agreed at the Infection Prevention & Control Committee.
IPC currently operates with 1 Infection Prevention & Control Policy, A framework of Infection Prevention & Control and specific IPC standard operating procedures.

Policies Reviewed Published in 2019- 20
Infection Prevention and Control Policy
Tuberculosis
Influenza Policy & Procedure
Cleaning and Decontamination
Cleaning Policy 2020
LIVE Cleaning Operations 2020

There has been a backlog of policies being reviewed as a result of other priorities, therefore a programme to review is set as a priority for 2020/21

3.2.11. Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Team Prevent Occupational Health and Employee Wellbeing

Team Prevent is committed to the protection of all Trust employees as an essential part of Infection Control. In line with the Health and Social Care Act 2013 and Department of Health Guidelines, Team Prevent have arrangements in place for assessing the immunisation status of all Trust employees as well as regularly reviewing the immunisation status of existing healthcare workers and providing vaccinations as necessary and in accordance with the Green Book to reduce the risk and spread of vaccine-preventable disease.

Blood Bourne Virus Exposure

Blood Borne Virus Exposure incidents or injuries may represent a significant risk to staff working in health care environments.

Under Health and Safety Legislation, Team Prevent work collaboratively with the Trust to ensure their responsibility for the health and safety of staff in relation to preventing, reducing and controlling the risks of healthcare associated infection and management of occupational exposure to blood-borne viruses and post exposure prophylaxis.

Team Prevent are responsible for the assessment and follow up of all Blood Borne Virus exposure incidents occurring during departmental opening hours and for the follow up of those exposure incidents occurring out of hours in Emergency Departments.

2019/20 exposure incidents reported to Team Prevent was 20 which is a reduction since 2018/19 figures. 90% were due to a percutaneous injury, 10% were identified as low risk injuries. The highest number of incidents occurred in theatres.

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Team prevent

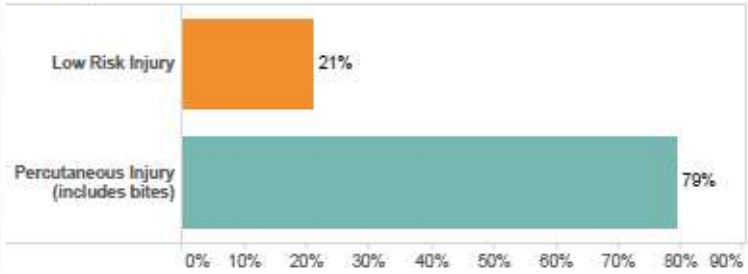
Monthly Dashboard - RJAH
Org Level 1 - RJAH
From 1 April 2019 to 31 March 2020

(months with zero data will not be displayed)

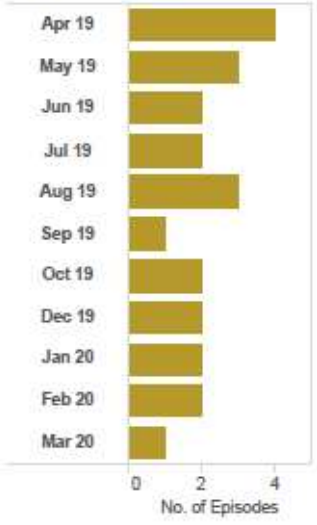
Innoculation/BBV Incidents

		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Dec 19	Jan 20	Feb 20	Mar 20	Total
RJAH	Null		1	1	1	1	1					1	6
	Bank	1											1
	Domestic Services	1											1
	Foot and Ankle							1					1
	High Dependency Unit - HDU		1										1
	Midland Centre For Spinal Injuries		1										1
	Physiotherapy	1											1
	Powys Ward	1			1						1		3
	Rotational Nurse					1							1
	Surgical										1		1
	Theatres			1		1		1	1	2			6
	Theatres - Consultant Surgeons								1				1
	Total	4	3	2	2	3	1	2	2	2	2	1	24
Grand Total		4	3	2	2	3	1	2	2	2	2	1	24

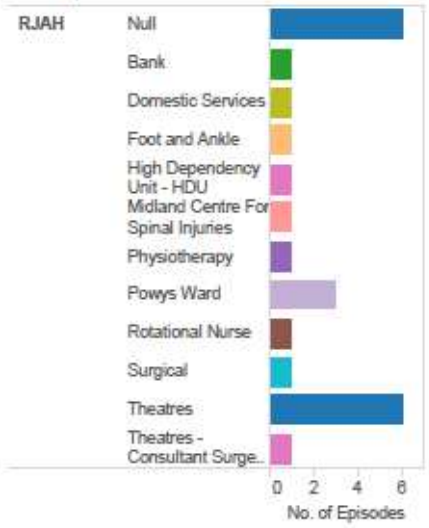
BBV Exposure



BBV Episodes



BBV Episodes



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Needlestick Hospital Attended

Monthly Dashboard - RJAH
Org Level 1 - RJAH
From 1 April 2019 to 31 March 2020

(months with zero data will not be displayed)

		Month of Event Attendance Date											
Question	Quest Answer	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Dec 19	Jan 20	Feb 20	Mar 20	Total
Was the Injury reported out of hours and the individual obtained treatment or assessment from A&E or another source before speaking to Team Prevent?	No	2	5	2	2	1	1	2	2	2	1	1	21
	Yes					1	1				1		3

Needlestick Type of Instrument (Data is only captured as part of the nurse review and not the intitial consultation)

			Month of Event Attendance Date	
Client Directorate	Client Service	Quest Answer	Jan-20	Grand Total
RJAH	Theatres	Blade	1	1

Safer Sharp Regulations

The Health and Safety (Sharp Instruments in Healthcare) Regulations came into effect in May 2013 requiring employers to use safer sharps which incorporate protection mechanisms to prevent or minimise the risk of accidental injury.

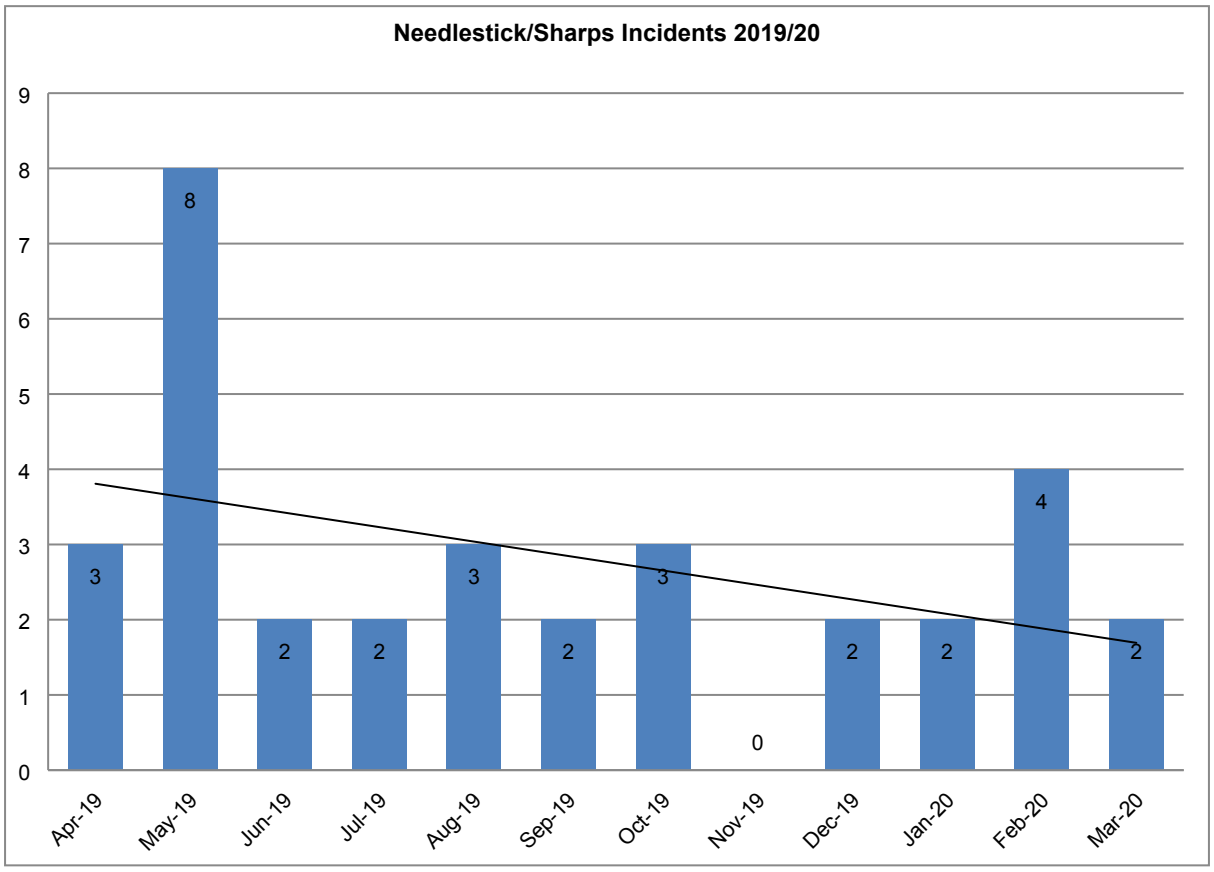
Following a review of safer sharps it was highlighted that the trust is failing to comply with the above regulations.

An audit across all departments within the Trust was undertaken in April 2019 and results were fed back to the Innovation Committee.

A Safer Sharps Working Group was established with a remit to ensure the trust is compliant with the regulations.

A comprehensive risk assessment of the high risk areas including theatres and recovery has been undertaken and safer sharp devices have been trailled throughout the trust. This has led to a declining trend in needlestick injury reported.

The graph below is a breakdown of reported Needlestick / Sharps incidents in the last 12 months:



A Safer Sharps and needlestick awareness campaign was launched through social media and internal staff communications.

3.3. Serious Incidents/ Periods of Increased Incidence

There were no Infection Prevention & Control Serious Incidents reported during 2019/20.

At the very end of quarter 4, the Trust began to implement changes in response to the escalating COVID outbreak.

The IPC Team took a leadership role in screening, isolating and cohorting patients.

Infection and Prevention and Control measures included:

- Early recognition/reporting of cases.
- Early assessment/triaging of cases.
- Maintaining separation in space and/or time between suspected and confirmed COVID-19 patients
- Educating staff and patients about Standard infection control precautions
- Prompt implementation of Transmission Based Precautions (TBPs) including the appropriate use of Personal Protective equipment (PPE) to limit transmission.
- Restricting access of visitors to the trust.
- Participation in the planning and implementation of strategies for surge capacity.

The first COVID-19 positive patient in the Trust was diagnosed on 31st March 2020.

Conclusion

The year 2019/20 was another successful period in meeting the targets set by Public Health England and the Clinical Commissioning Group at RJAH Orthopaedic Hospital.

The Infection prevention and control team have continued to provide an essential service to the Trust encompassing the Infection Prevention and Control service and surgical site surveillance service, microbiology ward rounds, post infection review/root cause analysis meetings and audit.

This annual report needs to be viewed in the context of a severely depleted infection control team during quarter 3 and 4 due to considerable changes within the team. The Infection Prevention and Control (IPC) Sister and part time surveillance nurse were on long term sick leave. The second part time surveillance nurse resigned from post September 2019 and this position remains vacant. The Infection control data analyst/PA also left the trust in November 2019. This post was filled in February 2020. The Infection Control Doctor retired in February 2019 and returned on a 0.4 WTE contract during April 2019.

The Director of Infection Prevention and Control role also saw considerable change in which there have been three appointments in the last 12 months.
The depletion of the IPC team was reported on the trust Datix risk register on 20/12/2019, with a risk rating of 16 & current risk level High.

Christine Morris: Interim Director of Infection Prevention and Control (DIPC)

Sue Sayles: Infection Prevention and Control Sister

June 2020

Key Areas of Focus for 20/21

- Achieving PHE National & CCG Infection targets
- PIR of all patients reported with positive blood cultures
- IT Solution for Infection Prevention & Control
- Improve website and intranet
- Extend Tissue Viability Provision
- Provide a 5 day Wound Clinic service
- Policy Review
- Additional surgical site surveillance for all Orthopaedic Specialities

Appendix 1: Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship Committee
ANTT	Aseptic Not Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DIPC	Director of Infection Prevention & Control
E.Coli	Escherichia coli
EPR	Electronic Patient Record
ESBL	Extended Spectrum Beta Lactamase
GIRFT	Getting It Right First Time
HCAI	Healthcare Associated Infection
HEE	Health Education England
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
IV	Intravenous
JAC	JAC – Electronic Pharmacy System
KPI's	Key Performance Indicators
MDT	Multi Disciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PALS	Patient Advice and Liason Service
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment

Appendix 1: Acronyms Continued:

RCA	Root Cause Analysis
RSH	Royal Shrewsbury Hospital
SATH	Shrewsbury and Telford Hospitals
SCCG	Shropshire Clinical Commissioning Group
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
STAR	Sustaining Through Assessment and Review
TSSU	Theatre Sterile Services Unit
WTE	Whole Time Equivalent

Appendix 2: Glossary

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
C. difficile	or C. diff is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.
E coli	is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.
HCAI	Health Care Associated Infection. An infection acquired as a result of receiving treatment in a health care setting.
MRSA	or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria,Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.
MSSA	or Methicillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

0. Reference Information

Author:	Kirsty Foskett, Head of Clinical Governance & Quality	Paper date:	28th January 2021
Executive Sponsor:	Stacey-Lea Keegan, Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Trust Board are asked to note the contents of the IPC Board Assurance Framework, and outstanding actions required as detailed in the action plan.

2. Executive Summary

2.1. Context

As the understanding of COVID-19 has developed, NHS England, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect learning.

The IPC Board Assurance Framework (BAF) has been developed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. The frameworks offers providers a way of continually review processes and respond in an evidence-based way to maintain the safety of patients, service users and staff.

2.2. Summary

There are ten overarching key lines of enquiry, of which the Trust is in the majority, compliant of the standards required. An action plan has been produced to capture any areas of improvement that is required.

The IPC Committee has reviewed the contents of the IPC BAF and associate action plan, for outstanding action plans to be completed.

2.3. Conclusion

The Trust Board is asked to:

- Note the content of the IPC BAF
- Consider if it is content with the actions being taken to address the identified gaps in controls and assurance

3. The Main Report

3.1. Introduction

As the understanding of COVID-19 has developed, NHS England, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect learning.

The IPC Board Assurance Framework (BAF) has been developed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. The frameworks offers providers a way of continually review processes and respond in an evidence-based way to maintain the safety of patients, service users and staff.

3.2. 10 Key Lines of Enquiry

- Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
- Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide or secure adequate isolation facilities
- Secure adequate access to laboratory support as appropriate
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

3.3. Next Steps

Monitoring of the associated action plan, will take place via the IPC Committee.

3.4. Conclusion

The Trust Board is asked to:

- Note the content of the IPC BAF
- Consider if it is content with the actions being taken to address the identified gaps in controls and assurance

Infection Prevention and Control Board Assurance Framework for COVID-19

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
1.1	Infection risk is assessed at the front door and this is documented in patient notes	Alert signage at the front entrance – Hand washing facilities, hand gel and surgical face mask supplied. At the entrance to site all patients and visitors and contractors are screened. Relatives are requested to stay in the car unless care needs deemed appropriate.	Video https://vimeo.com/439992121/6a4ba69d91 ..\Departmental SOP's\Screening questionnaire for all Out patient attendances flow charts v 1.6.docx		
		COVID-19 questions incorporated into patient passport for transfers of urgent transfers and emergency admissions.	..\Departmental SOP's\Urgent Patient Admission Passport - COVID-19 - Updated May 2020.docx		
		MCSI unit transfer document	..\Departmental SOP's\MCSI Transfer Document.docx		
		Medical Unit transfer document	..\Departmental SOP's\Referral No000168.pdf		
1.2	Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Patients with suspected or confirmed COVID-19 are nursed on Ludlow Ward in the Red Pathway area. Patients whose COVID-19 status is unknown are isolated until they have had 2 negative COVID-19 results, 3 days apart. These patients are managed on the amber pathway.	Hospital Plan July 20 Coronavirus Policy V5.docx		

1.3	Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Screening patients 48hrs prior to discharge to social care environments Request COVID-19 screening from referring trusts within 48 hours of transfer. Patients whose COVID-19 status is unknown are isolated until they have had 2 negative COVD-19 results, 3 days apart. These patients are managed on the amber pathway.	Coronavirus Policy V5.docx	Audit required to ensure swabs are completed 48hrs pre transfer and pre discharge.	
1.4	Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice.	COVID-19 Checklist, PPE Audits and Social Distance Tool kit are now included in the ward/departmental IPC audits. All data is collected and analysed by the IPC team and processed in line with Hand Hygiene, Bare Below Elbow and Environmental audits. Audit results are disseminated monthly to all ward/departmental managers and matrons to highlight areas that require immediate attention/support. Graphical information is provided in the IPC Quarterly reports and presented to the Infection Control & Cleanliness Committee on a quarterly basis.	Hand Hygiene & BBE Audit Template.docx RJAH Social Distance Observational Tool Se COVID-19 Personal Protective Equipment	IPC Audit Response and Escalation SOP required to action non-compliance or non-submission of audit data.	
1.5	Monitoring of compliance with PPE consider implementing the role PPE guardians/safety champions to embed and encourage best practice.	Link nurses for the clinical and non-clinical areas highlights the role SOP of the role Sign off the agreed 'contact'	Environmental Audit.docx COVID-19 Personal Protective Equipment	Update Roles and Responsibilities of the IPC Link Nurse, to include expectations regarding COVID-19	

1.6	Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase.	An absence reporting hotline is available for staff to contact if they or a family member have COVID-19 symptoms. If necessary the people services team can arrange for a PCR test to be taken and get notification of the result. If a member of staff was to test positive then the contact tracing process is undertaken by Occupational Health Team. The Trust have also commenced lateral flow testing, completed twice weekly for clinical, frontline staff.	 Coronavirus Policy V5.docx  Outbreak Management Policy V.		
1.7	Training in IPC standard infection control and transmission based precautions are provided to all staff.	IPC team undertake training with staff on induction to the hospital, which includes all measures pertaining to COVID-19 Infection Control E-learning is available along with a new Cleaning with Confidence, e-learning package. Hand Hygiene competencies are undertaken within departments and renewed yearly. Donning and Doffing training was carried out by the PPE champions, early this year for the areas that required the training. New starters in those areas are taught as part of their local induction process.	 Infection Control Induction Presentatio		
1.8	IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training.	IPC team undertake training with staff on induction to the hospital, which includes all measures pertaining to COVID-19	 Infection Control Induction Presentatio		

1.9	All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintain physical distance both in and out of work	Regular communications are sent out via staff email, Facebook and the COVID-19 portal in regard to PPE and social distancing at work. Departments undertake weekly social distancing audit tools that are submitted to the IPC team on a monthly basis.	RJAH Social Distance Observational Tool Se COVID-19 Personal Protective Equipment		
1.10	All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and contexed per national guidance *(copy link)*	Patients offered face masks if tolerated in OPD and upon transfer up the corridor inter departments Staff have received PPE training in donning and doffing of PHE from PPE champions Traffic light system posters highlighting PHE guidance across the Trust. Staff have access to the portal which maintains the most up to date guidance and opportunity to raise a concern regarding a shortfall which can be anonymised. Patients have the opportunity to raise a concern through PALS or the complaints team. Staff have the opportunity to raise concerns via the Datix system	Video https://vimeo.com/439992121/6a4ba69d91 COVID Incidents Updated infection prevention and contr COVID-19 Personal Protective Equipment		
1.11	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk	Daily updates received from PHE, entered onto compendium of guidance. NHS Futures is regularly reviewed by Estates & Facilities for the up to date guidance to be adopted. COVID-19 portal updated daily by our Communications Team. Coronavirus Noticeboard- daily updates. Screening on admission for MRSA and CPE on admission Patients with alert organisms are isolated in side wards. Individual risk assessment performed for	Guidance Index U:\Group\COVID 19\Covid19 Risk Register MRSA Policy Risk Assessments BAF draft master v1.docx		

	assessment processes and practices are in place for non COVID-19 infections and pathogens • That trust CEOs or the executive responsible for IPC approve and personally signs off all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. • Ensure Trust Board has oversite of ongoing outbreaks and action plans.	ESBL/VRE/MRSA patients on SIU to enable rehabilitation The Trust have also introduced weekly Manager Briefings to update from a national and local perspective, and the focus for the organisation.			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
2.1	Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Ludlow ward - isolation Nursing staff have been trained in caring and treating patients in isolation /cohort areas PPE requirements poster format on all wards and departments	Video https://vimeo.com/439992121/6a4ba69d91 COVID Ludlow Risk Assessment.docx COVID Oswald Risk assessment.docx		

2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All RJAH Cleanliness Technicians are competent in isolation cleaning; following the principles of the cleaning operations manual. (See training records) – backed up by cleaning auditing. Instruction on donning and doffing of PPE was included in these briefings. (See training slides) Staff are allocated to work in singular areas, reducing the likelihood of any risk of spread of infection. (See local rota)	http://edms/doc/Pollib/Cleaning Operations Manual.doc  IPC BAF_Cleaning Audit Scores.xlsx	Signed off completion of donning / doffing technique	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Enhanced cleaning service in cohort/isolation areas is being recorded separately, documented via the NHSE&I SOP published on NHS future. (See local records) Staff use the Trust approved PPE guidance and have been briefed on all amendments as and when they have occurred. (See COVID Portal).	Touch Point sign off sheet COVID Room Clean Checklist Cohort Room Clean Checklist		
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Second cleans have allocated to wards from simple bin changes to spot cleaning, resources have been pulled from offices and reallocated staff from other departments to allow this. (See local sign off sheets) Specific additional duty has been issued to staff to clean public touch points, door pads, hand rails etc. Theatres are getting an additional three hours a day focusing on touch points and staff bases. *Telephones, hand held devices.* Non clinical areas have been provided with adequate cleaning materials to enable them to undertake touch point cleaning of their own work stations. Fixed term 3 month contracts in place until the end of March 2021; Increased cleaning in staff room/ changing rooms/offices	Video https://vimeo.com/439992121/6a4ba69d91		

		Cleaning scores are demonstrating compliance with national standard targets; records held on C4C and physical copy of cleaning record on Housekeeper Manager Office.			
2.5	Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Toilets and bathrooms have their first clean using Tristel all public toilets have increased frequency of cleaning by a dedicated team 7 days a week.	Video https://vimeo.com/439992121/6a4ba69d91		
2.6	Cleaning is carried out with neutral Detergent, a chlorine-based disinfectant in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Cleaning is carried out as per national guidance.	Video https://vimeo.com/439992121/6a4ba69d91		
2.7	Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	As per Cleaning Operations Manual.			

2.8	'Frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	As detailed above Staff provided with cleaning facilities to undertake cleaning of their own work stations this is detailed in the Trust Cleaning Policy. In line with the Trusts cleaning schedules evidenced by signoff sheets available on request.	Video https://vimeo.com/439992121/6a4ba69d91 http://edms/doc/Pollib/Cleaning Policy.docx Increased cleaning in staff room/ changing rooms/offices. Fixed term contracts in place until the end of March 2021, to support the increase in cleaning requirements.		
2.9	Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other *national guidance* and the appropriate precautions are taken	Linen is being managed in line with the SOP produced by NHSE&I, published on NHS futures.	..\..\..\..\..\Group\COVID 19\IPC Board Assurance Framework\Covid_19_Linen_and_Laundry_Policy_Draft.docx –		
2.10	Single use items are used where possible and according to Single Use Policy	Single use mops/BP cuffs/Hats are used in isolation/cohort areas as per cleaning operations manual.			
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	Reusable mops are laundered in line with cleaning operations manual. Reusable patient equipment is decontaminated as per PHE guidance			

2.12	Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	A 'Dump the Junk' effort was recently supported by the Trust to encourage non-clinical areas to dispose of unnecessary items. The benefit of this was to facilitate easier cleaning of the environment and workstations.			
2.13	Ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air.	General ventilation Employers must, by law, ensure an adequate supply of fresh air in the workplace and this has not changed. Good ventilation can help reduce the risk of spreading coronavirus, so focus on improving general ventilation, preferably through fresh air or mechanical systems. Air conditioning The risk of air conditioning spreading coronavirus (COVID-19) in the workplace is extremely low as long as there is an adequate supply of fresh air and ventilation.	Video https://vimeo.com/439992121/6a4ba69d91		
2.14	There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning as opposed to wide spread use of disinfectants.	Trust take a risk managed approach to cleaning with 1000ppm chlorine based cleaner based on the below criteria – in line national guidance: Areas receiving a 1000ppm chlorine based cleaner are: • Amber pathway • Red pathway • Touchpoint cleaning • Plus areas that fall within the Cleaning Operations Manual (e.g. Isolation cleaning etc.)			
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**

3.1	Arrangements around antimicrobial stewardship are maintained	Evidence-based local antimicrobial guidelines are in place and are reviewed on an annual basis. Adherence to the local guidelines is monitored using quarterly Point Prevalence studies. Weekly microbiology ward round attended by consultant microbiologist, Antimicrobial Stewardship Pharmacist & IPC nurse, covers all wards in the hospital to review all current antibiotic prescribing. Pharmacists clinically check antibiotic prescribing daily during their ward visits. Quarterly monitoring of antibiotic issue in the Trust. Ongoing programme of audit. Education and training for doctors at induction, nurses at link meetings and pharmacists at department meetings	IPC Annual Report		
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Report the retrospective antibiotic consumption data (declared as amount 'issued' as electronic prescribing not available) highlighting the use of broad-spectrum antibiotics i.e. piperacillin-tazobactam and the carbapenems.	Minutes of Antimicrobial Meeting 14th July Meeting Structure		.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
4.1	Implementation of national guidance on visiting patients in a care setting	Patient visiting has been limited to end of life patients, parent of a paediatric patient and affected patient main carer. Trust visiting protocol updated SOP for visitors	..\Departmental SOP's\Standard Operating Procedure EOL visiting .docx Ward Visitor Schedule & COVID Screen		

4.2	Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Isolation areas on Ludlow ward are clearly marked as isolation areas have adequate signage and are restricted areas	 TrafficLight_Main (RJAH).pdf		
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	COVID-19 information is available on the Trust Intranet and COVID-19 portal.	https://rjah.interactgo.com/login?returnUrl=%2FInteract%2FPages%2FContent%2FDocument.aspx%3Fid%3D2172		
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Infection status is communicated to departments prior to patient transfer, porters x-ray and other wards/departments. Patients being transferred to other care environments are screened 48-72 hours prior to transfer and isolated on admission to the Organisation. These patients would be isolated on Ludlow Ward until further screening had been completed, with the exception of patients being admitted to MCSI.	Healthcare associated COVID-19 Infections  Coronavirus Policy V5.docx		
4.5	There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice.	Hands, face and space posters are located in all entrances; Floor signage is used to demonstrate appropriate space; Various posters used around site to support the message.	U:\Clinical Governance\Group\Infection Control\Coronavirus\IPC Board Assurance Framework\Photo Evidence		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**

5.1	Screening and triaging of all patients as per IPC and *NICE* guidance within all Health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	All visitors and patients are screened on entrance to the hospital. For patients undergoing elective surgery, they are required to isolate for a minimum of 72hrs prior to admission and have a negative PCR screen before admission. Some patients may be advised to isolate for longer, prior to their admission date, and this is based on an individual patient risk assessment.	..\Departmental SOP's\Screening questionnaire for all Out patient attendances flow charts v 1.6.docx  Pre-op process SOP 121120 v4.docx		
5.2	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per *national guidance*	SOP for appropriate triaging in place for symptomatic patients	 Screening questionnaire_Main E Video https://vimeo.com/439992121/6a4ba69d91		
5.3	Staff are aware of agreed template for triage questions to ask.		..\Departmental SOP's\Screening questionnaire for all Out patient attendances flow charts v 1.6.docx		
5.4	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible face coverings are used by all outpatients and visitors.	The front door screening of patients and visitors at the main entrance of the hospital is undertaken by our Volunteer staff, which have had training to be able to undertake this task. For elective admissions into organisation, isolation guidance is provided by the Pre-op Service. Any urgent / emergency transfers are requested via the Clinical Site Manager, who has oversight on the correct patient placement within the Organisation.	..\Departmental SOP's\Screening questionnaire for all Out patient attendances flow charts v 1.6.docx ..\Departmental SOP's\Urgent Patient Admission Passport - COVID-19 - Updated May 2020.docx		
5.5	Face masks are available for patients with respiratory symptoms.	Ward stock of masks is monitored and refreshed regularly by dedicated PPE top up team . Stock levels are monitored daily and any shortages in supply is via a Daily Sitrep. The Sitrep is provided to the senior nursing and management team in the organisation to highlight any issues, regarding stock levels of PPE	 COVID-19 Dashboard Summary.		

		PPE usage and stock is recorded on NHS Foundry which facilitates the push of stock as required to those sites that are in need.			
5.6	Provide clear advice to patients on use of face masks to encourage use of surgical face masks by all inpatients in Amber and red pathways if this can be tolerated and does not compromise their clinical care.	Signage to mandate the wearing of facemasks for all site users at all site entrances. There is guidance on appropriate mask use at every mask station. Signage relating to medium and high risk pathways includes advocating use of surgical masks for inpatients where tolerated.	Poster -How to wear a face mask safely Poster – How to wear a surgical mask correctly Poster next to mask dispenser Infection Prevention and Control New Guic		
5.7	Ideally segregation should be with separate spaces but there is potential to use screens e.g. to protect reception staff.	All screens are in place for Outpatient settings. The majority of screens are now in place in ward areas, with the exception of 3. There is a plan to place screens within these areas.			
5.8	For patients with new onset symptoms isolation, testing and instigation of contact tracing is achieved until proven negative	SOP for transfer of patients to isolation areas, with instruction for areas to commence contact tracing.	Patient Transfers to Ludlow.docx Coronavirus Policy V5.docx		
5.9	Patients that test negative but display or go onto develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly.	Symptomatic patients are transferred to isolation area on Ludlow Ward and screened for COVID-19 Patients that have tested negative and develop symptoms are transferred to the isolation areas and re swabbed.	Patient Transfers to Ludlow.docx Coronavirus Policy V5.docx		
5.10	Patients that attend for routine appointments who display symptoms of COVID-19 are managed	Symptomatic patients that attend appointments are taken to the charity hub area and seen by the consultant who assesses if patient urgently requires the planned procedure	..\Departmental SOP's\Outpatients Protocol COVID-19 (updated).docx		

	appropriately				
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
6.1	Separation of patient pathways and staff flow to minimise contact between pathways. For example this would include provision of separate entrances or exits (if available) or use of one way entrance/exit systems, clear signage and restricted access to communal areas.	To ensure separation of Amber and Green pathways, a new entrance through Baschurch has been designated for patients attending for elective surgery; Green pathway patients.			
6.2	All staff (clinical and non-clinical) have appropriate training, in line with latest *national guidance* and other guidance, to ensure their personal safety and working environment is safe	PHE PPE equipment table posters displayed on all wards and departments and COVID-19 portal PPE audit toolkit implemented	..\Departmental SOP's\PPE Audit May 2020.docx Video https://vimeo.com/439992121/6a4ba69d91 COVID-19 Personal Protective Equipment		
6.3	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to *don and doff it* safely	PPE Champions have provided face to face training workshops on :- Hand hygiene PPE/FFP3 Fit Testing Donning/Doffing PPE PHE videos demonstrating donning and doffing on the intranet and COVID-19 portal Anaesthetist has provided donning and doffing training to	..\Departmental SOP's\STAFF PPE COVID19.xlsx HH, BBE & PPE Audit Template Ward HH, BBE & PPE Audit Template Theatre Fit Test Register available via the		

		theatre staff IPCN provided training on isolation ward. All staff job descriptions include IPC responsibilities.	COVID Portal Job Description		
6.4	A record of staff training is maintained	Staff training records held Ward/Departmental Managers			
6.5	Appropriate arrangements are in place that any reuse of PPE in line with the *MHRA CAS alert* is properly monitored and managed	No reuse of PPE has been required by the trust.	This is evidenced via satisfactory stock levels and no reported incidents in regard to the need of re-using PPE.		
6.6	Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Any incidents will be reported on Datix which is monitored daily, however the trust is not required to reuse PPE.	Monitoring of Incident reports.		
6.7	Adherence to PHE national guidance on the use of PPE is regularly audited	Ward and Department areas are required to Audit PPE adherence on a weekly basis, with audit results sent to the IPC team at the end of each month.	COVID-19 Personal Protective Equipment RJAH Social Distance Observational Tool Se		
6.8	Any incidents relating to use of PPE are monitored and the appropriate action taken	All incidents relating to PPE are reported on Datix and appropriate action is taken in accordance with the Trust Policy.		To ensure all of the IPC team are on the distribution list for all IPC related incidents.	
6.9	Hygiene facilities (IPC Measures) and messaging are available for all patients/individuals staff and visitors to minimise COVID-19	Please see video attached, which demonstrates the measures being taken to minimised COVID-19 transmission.	Video https://vimeo.com/439992121/6a4ba69d91		

	transmission such as; • Hand hygiene facilities including instructional posters • Good respirator hygiene measures • Maintaining physical distancing of 2 meters when possible unless wearing PPE as part of direct care. • Frequent decontamination of equipment and environment in clinical and non-clinical areas. • Clear advice on the use of face masks by patients/individuals, visitors and by staff in non-patient facing areas.				
6.10	Staff regularly undertake hand hygiene and observe standard infection control precautions	Weekly hand hygiene audits are undertaken and reported via ICC committee Annual hand hygiene competencies are undertaken and held locally with ward/departmental managers. Adapted the Hand Hygiene/BBE audit tool to incorporate appropriate usage of PPE.	IPC Annual Report  Hand Hygiene & BBE Audit Template.docx  COVID-19 Personal Protective Equipment		
6.11	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposal paper towels from a dispenser which is located close to the sink but beyond the	Hand dryers disconnected in public toilets and paper towel dispensers as and where required.	Video https://vimeo.com/439992121/6a4ba69d91		

	risk of splash decontamination as per *national guidance*				
6.12	guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Posters displaying the correct technique of Hand Hygiene procedure in all toilets.	Video https://vimeo.com/439992121/6a4ba69d91		
6.13	Staff understand the requirements for uniform laundering where this is not provided for on site	Staff laundry is available for all scrubs Guidelines issued by PHE for laundering of staff uniforms on intranet. Laundering of uniforms SOP in place	..\..\..\..\..\Group\COVID 19\IPC Board Assurance Framework\Laundering of Uniform SOP V1.docx		
6.14	All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other *national guidance* if they or a member of their household display any of the symptoms.	Signs and symptoms and actions to be taken are on Trust Intranet and COVID-19 portal. There is also the staff reporting absence helpline available and a proportion of frontline clinical staff, are undertaking twice weekly lateral flow tests.	Video https://vimeo.com/439992121/6a4ba69d91		
6.15	A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	A daily Sitrep is distributed to the senior nursing and management teams, to update on the position of the Organisation and neighbouring hospital.	COVID-19 Dashboard Summary.		

6.16	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	The process is identified within the Trusts Coronavirus Policy,	Coronavirus Policy V5.docx		
6.17	Robust policies and procedures are in place for the identification of and management of outbreaks of infection.	Please see attached policy, and tools available for identification and management of Outbreaks	Outbreak Management Policy V. Checklist and Monitoring Tool for th Coronavirus Policy V5.docx		
7. Provide or secure adequate isolation facilities					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
7.1	Restricted access between pathways if possible, (depending on size of facility, prevalence/incidents rate low/high) by other patients/individuals, visitors or staff	Red, Amber and Green Pathways are in place in the hospital. The Red Pathway is restricted to one designated isolation area within the hospital.	TrafficLight_Main (RJAH).pdf		
7.2	Areas and wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the risk areas	Signage is in place identifying which areas are applied to which pathway.	TrafficLight_GREEN (RJAH).pdf TrafficLight_AMBER (RJAH).pdf		

			TrafficLight_GREEN (RJAH).pdf		
7.3	Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Ludlow ward is the designated isolation area.	Patient Transfers to Ludlow.docx	.	
7.4	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE *national guidance*	Ludlow Ward is the designated isolation area for patients with suspected or confirmed cases of COVID-19.	COVID Ludlow Risk Assessment.docx		
7.5	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients with alert organisms are nursed in single side rooms MRSA, CPE,ESBL,VRE ESBL patients are cohorted in bays on Spinal Injuries Unit	Isolation Policy.docx		
8. Secure adequate access to laboratory support as appropriate					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
8.1	Ensure screens taken on admission given priority and reported within 24 hours.	Testing is performed by the Microbiology lab service provided by Shrewsbury and Telford Hospitals.	No incidents reported via Datix.		
8.2	Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Testing is performed by the Microbiology lab service provided by Shrewsbury and Telford Hospitals. Information has been requested.		Assurance of Audit compliance requested from SATH.	

8.3	Testing is undertaken by competent and trained individuals	Testing is performed by the Microbiology lab service provided by Shrewsbury and Telford Hospitals. Lab staff are trained and competent in processes. Patient testing of staff is taken in areas, where the staff are familiar and competent to undertake the procedure. These areas are designated as Ludlow Ward and Pre-op. Guidance is also available for staff, on how to undertake a deep throat swab.	 RSH How to take a swab (deep).pdf		
8.4	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other *national guidance*	Swabs are sent to the microbiology lab during the hours of 8am-2:45pm via hospital transport Out of hours specimens are sent via Blood bikes/ Trust taxi. Reports are received within 24/48hrs	..\Departmental SOP's\Internal Transport of Samples from Suspected.docx		
8.5	Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Testing is performed by the Microbiology lab service provided by Shrewsbury and Telford Hospitals. Information has been requested.		Assurance of Audit compliance requested from SATH.	
8.6	Screening for other potential infections takes place	MRSA screening for all admissions. ESBL screening on admission to Spinal Injuries Unit. CPE screening for patients from high risk areas from abroad, London, Manchester & Liverpool and documented in patient pathway.			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC policies are in place. Link Nurse champions take responsibility in clinical areas, alongside Ward/Departmental Managers and the IPC team.	 Coronavirus Policy V5.docx		
9.2	Any changes to the PHE *national guidance* on PPE are quickly identified and effectively communicated to staff	Changes to national guidance is communicated via the intranet/ COVID-19 portal and daily Coronavirus noticeboard Compendium of evidence updated. NHS Futures regularly reviewed for updates.	Comms example		
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and	National Guidance aligns to the Trusts standard practice for handling of infectious waste –ward environments have been considered infectious environment and therefore all waste is now described in line with standard European	 C0611-covid-19-waste-management-guid		

	managed in accordance with current *national guidance*	Waste Codes.	Ward Waste Audit		
9.4	PPE stock is appropriately stored and accessible to staff who require it	PPE is stored and topped up at ward level by redeployed staff; further stock is easily accessible via one central point (Switchboard) – staffed 24/7. Contingency stock is securely stored and can be accessed via facilities approval.	COVID-19 Dashboard Summary.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Key lines of enquiry		**Evidence**	**Document Link**	**Gaps in Assurance**	**RAG**
10.1	Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	We have had a risk assessment process in place, which is informed by our Occupational Health Provider and our wider STP. The risk assessment process is revised as the pandemic develops (eg BAME)	Example of Staff health & wellbeing CL0015 Demographic Responsive Staff Risk		
10.2	The risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Oversight for risk assessment completion is held by the People Services Team, and ward / departmental managers. Monitoring of compliance is the via the People Committee.	CL0015 Demographic Responsive Staff Risk		
10.3	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE *national guidance* and a record of this training is maintained	The trust does not use FFP reusable respirators to date.			

10.4	Staff who carry out fit testing training are trained and competent to do so	A cohort of staff are trained to fit test in accordance with Health & Safety Executive Guidance.	Fit testing Appendix 2.7.2020 Fit testing Appendix 3.7.2020 Fit Testing Group Cert 2.7.2020 Fit testing Group Cert 3.7.2020 Fit testing Ind Cert - Workshop & Assessment 2.7.2020 Fit testing Ind Cert - Workshop & Assessment 3.7.2020	New FFP3 fit testing is being carried out by an external company. This is due to stock of FFP3 due to expire in March 2021.	
10.5	All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	All staff required to wear an FFP respirator are tested for the make and model that they are required to use. In the event supply issues staff are retested onto current available model. A live version of the fit testing register can be found on the RJAH Coronavirus portal.	Coronavirus Portal- Live Fit test register		
10.6	A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Staff have open access to the fit testing register via the Coronavirus portal so that staff are fully aware of the make and model they have been fitted to.	Coronavirus Portal- Live Fit test register Coronavirus Noticeboard – Communicate		
10.7	For those who fail a fit test, there's a record given to and held by trainees and centrally within the organisation of repeat testing on alternative respirators and hoods	All staff who fail fit testing are verbally notified but to minimise risk of cross infection paper records are not given to staff members but are filed centrally. Fit testing register is updated and fully accessible to staff via the Coronavirus Portal.	Coronavirus Noticeboard – Communicate		
10.8	For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate	No documented process for ensuring but verbal discussion is had with the area manager.		SOP needs to be developed for staff who fail to be adequately fit tested and the options that are then available to the individual, through discussions with People Services and	

	with the staff members skills and experience and in line with nationally agreed algorithm			Occupational Health.	
10.9	A documented record of this discussion should be available to staff member and held centrally within the organisation, as part of employment record including Occupational Health	SOP needs to be developed for staff who fail to be adequately fit tested and the options that are then available to the individual, through discussions with People Services and Occupational Health.			
10.10	Following consideration of reasonable adjustments e.g respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational Health service record.	SOP needs to be developed for staff who fail to be adequately fit tested and the options that are then available to the individual, through discussions with People Services and Occupational Health.			
10.11	Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	Infection Control Committee is chaired by a member of the board. Health & Safety Advisor is now a member of the Infection Control & Cleanliness Committee and will provide an assurance report at future meetings.	(Minutes of the committee Quartly infection control report Quarter 2		

10.12	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per *national guidance*	Movement of staff between the green and red pathways are restricted and monitored on a daily basis and staff have dedicated allocations Discussed and reviewed in State of Play daily meetings Areas are identified by various signage. Dedicated clinical areas / theatres for amber and green pathways	Video https://vimeo.com/439992121/6a4ba69d91		
10.13	All staff adhere to *national guidance* on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Risk assessments have been carried out in all clinical and non- clinical areas across the trust. To confirm we have complied with the Governments guidance on managing the risk of COVID-19 5 steps to safer working together posters are displayed in every clinical and non- clinical area Various social distancing signage are displayed throughout the Trust. PPE audits are also undertaken to ensure adherence to the guidance. Staff are encouraged to challenge when social distancing is not adhered.	Video https://vimeo.com/439992121/6a4ba69d91 COVID-19 Personal Protective Equipment RJAH Social Distance Observational Tool Se		
10.14	Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	Ward/departmental Managers coordinate team breaks and encourage to stagger to reduce crowding and maintain social distancing. Additional rest areas have been designated for staff in Denbighs and meeting room areas in the main conference facility.			
10.15	Staff are aware of the need to wear a facemask when moving through COVID-19 secure areas, unless in an office on their own	Communicated via Managers and Trust communications. Compliance is monitored via walkabouts, and audit.	COVID-19 Personal Protective Equipment		

10.16	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff absences both through self-isolation, clinically extremely vulnerable or other high risk reason are monitored daily; we have put in place an central absence reporting line to ensure that any member of staff with covid-19 (or similarly a household member) can immediately be referred to our testing service	Example of Staff health & wellbeing Wellbeing report		
10.17	Staff that test positive have adequate information and support to aid their recovery and return to work.	People business partners are liaising with the line manager of any staff testing positive for covid-19 to ensure their ongoing welfare	 Outbreak Swabbing FAQs.docx		

Action Plan

Action Number	Action	Name of Person Responsible	Progress (include dates)	Date Action Completed	Status
1.3	Audit required to ensure swabs are completed 48hrs pre transfer and pre discharge.	To be completed by Ward Managers, Matrons to arrange.		31.01.2021	
1.4	IPC Audit Response and Escalation SOP required to action non-compliance or non-submission of audit data.	IPC Team	SOP in progress	26.01.2021	
1.5	Update Roles and Responsibilities of the IPC Link Nurse, to include expectations regarding COVD-19	IPC Team	In progress	31.01.2021	
2.5	Toilets and bathrooms have their first clean using Tristel all public toilets have increased frequency of cleaning by a dedicated team 7 days a week.	Estates and Facilities	Trust has 7 day a week cleaning in place, supported by temporary contracts – 3 months; Will have to re-apply for contract extension as required.	31.01.2021	
5.7	Segregation of Reception areas in ward areas	Estates and Facilities		31.01.2021	
6.8	To ensure all of the IPC team are on the distribution list for all IPC related incidents.	IPC Team / Governance		17.01.2021	
8.2	Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	IPC Team	Information requested, awaiting feedback	31.01.2021	
8.5	Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	IPC Team	Information requested, awaiting feedback	31.01.2021	
10.4	New FFP3 fit testing is being carried out by an external company. This is due to stock of FFP3 due to expire in March 2021.	Health & Safety	In progress	31.03.2021	

10.8, 10.9, 10.10	SOP needs to be developed for staff who fail to be adequately fit tested and the options that are then available to the individual, through discussions with People Services and Occupational Health.	Health & Safety	Requested from Ian Gingell	31.01.2021	

Key

	Complete
	On track
	Behind Plan
	Overdue
	Not started

Board of Directors
People Committee Chair Report – 16/12/2020

0. People Committee Chair Report

Author:	Sarah Sheppard	Paper date:	28th January 2021
Executive Sponsor:	Sarah Sheppard – Chief of People	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	The Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the People Committee Briefing Meeting held on 16th December 2020 and is provided for assurance purposes. This meeting was a briefing to update the Board of assurances within the Trust due to current pressures.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's workforce agenda 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 points to highlight from the meeting
- There was good progress of actions from the previous meeting with all actions completed or updated
- The work plan was reviewed and agreed
- Good progress was reported on the corporate risk register
- To ensure the Trust is meeting it statutory and regulatory requirements in relation to workforce management
- To oversee the development and implementation of the People Plan and any related workforce plans
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'

- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising HR issues of significance

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 16th December 2020. The meeting was attended by the Chief of People and the Non-Executive Lead, due to current pressures to offer assurance to the board and enable other committee members to focus on urgent tasks.

Attendance:
Attendance: **Paul Kingston – Non-Executive Director** **Sarah Sheppard – Chief of People**

3.2 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Vaccine Hub		
Work is currently on-going with setting up a vaccine hub within the Maternity Unit at The Robert Jones and Agnes Hunt Orthopaedic Hospital. The plan is for the hub to be open from 4th January 2021, to accept staff from the Trust alongside those within the vulnerable category within the community. It is estimated that the hub will be in place until March 2021, and regular updates on progress and vaccinations administered will be brought to the People Committee monthly.	Y	
2. Flu Campaign		
The Chair was informed that the Flu campaign has progressed, although there is still a push from managers for further staff to have the vaccination. Managing Directors of each Unit have now been supplied with the names of individuals who have not received there vaccination to have further	Y	

discussions on the reasons for this. Updated figures will be brought to the next full committee in 2021.		
3. People Plan Update		
Progress is being made with the People Plan, along with the local action plan that is in place. Actions are being completed within the timeline and progress is being made, despite the on-going pressures.	Y	
4. Recruitment		
People services have currently been recruiting for the Vaccination Hub, requesting staff to offer help where they can. Communications have been sent across social media and internally to reach all staff, to encourage support within the hub. Further progress is being made with recruiting to Radiology, with pastoral support underway for the newly recruited Radiologists.	Y	
5. Absence		
Absence has begun to increase due to Covid, with more people needing to self-isolate. It is expected for this number to rise, and mitigations are being put in place to support each Unit with low staff levels. Data will be submitted to the next full committee on the increase in absence. Although, it was noted that non-covid related absence continues to be low compared to previous years.	Y	

3.3 Risks to be Escalated

In the course of its business the Committee identified the following risks to be escalated:

No risks were escalated to the committee this month.

3.4 Conclusion

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

Safe Working Hours: Doctors in Training Q4 2016-17

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	28/01/2021
Executive Sponsor:	Medical Director	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the Feb 2020 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

Work scheduling – junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work,

the working pattern, the service commitments and the training opportunities available during the post or placement.

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

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period Jan 2021 – *International training fellows not included*

Orthopaedics	Training posts	16
	Of which Doctors in training on 2016 contract	9
Rehabilitation/ Spinal Injuries	Training posts	1
	Of which Doctors in training on 2016 contract	1

3.2.2 Exception reports (with regard to working hours)

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

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

Currently there have been no exceptions reported to the Trust.

The demands of the COVID pandemic have been significant throughout the NHS and our Trust is no exception. The ongoing and worsening case numbers will no doubt impact on our working practices and the ability to train the junior doctors. They will require our ongoing support during this difficult time.

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

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

3.2.3 Work schedule reviews

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

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Please see Appendix 1

Trauma and Orthopaedics

Number of Vacancies

July - 2 (Fellows)

Aug - 1

Sep - 1

Oct - 0

Nov - 0

Dec - 1

Vacant shifts

Safe Working Hours: Doctors in Training Q4 2016-17

July - 64
Aug - 40
Sept - 5
Oct - 4
Nov - 5
Dec - 6

Total cost - £82568

Medicine

Number of Vacancies

Juyl - None
Aug - None
Sep - None
Oct - None
Nov - None
Dec - None

Vacant shifts

July - 2
Aug - 5
Sept - 0
Oct - 1
Nov - 6
Dec - 11

Total cost - £21600

MCSI **-Data included from outstanding months**

Number of Vacancies

Feb - 2

Mar - 1
Apr - 1
May - 1
Jun - 1
Jul - 1
Aug - 1
Sept - 1
Oct - 2

Vacant Shifts

Feb - 11
Mar - 16
Apr - 19
May - 12
Jun - 18
Jul - 18
Aug - 9
Sept - 1
Oct - 4
Total cost - £23960.70

Long Term Vacant Shifts

MCSI is consistently running with vacancies of 1-2

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction was attended in August and is due in February2021. During the pandemic Junior Doctor Forum has not occurred. Attempts have been made to reinstate this virtually.

3.3.2 Software System

Engagement with Allocate is still awaited.

Associated Risk

Whilst outside the specific remit of the Guardian role, the impact of COVID remains significant. With the new variant, an increase in case numbers will be reflected in the workforce with the need for self-isolation and subsequent rota gaps. The trust has implemented strategies to help with this, and the role out of the vaccination will, hopefully, also help.

Next Steps

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

3.4. Conclusion

The Trust continues to see no exception reports or fines.

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

Christopher Marquis

Guardian of Safe Working

Safe Working Hours: Doctors in Training Q4 2016-17

Appendix 1: Junior Doctor Agency and Locum usage and Rota Vacancy Report

Redacted for Information Governance Purposes

Chair's Assurance Report
Audit Committee – 11th January 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	28 January 2020
Executive Sponsor:	David Gilburt, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Audit Committee Meeting held on Monday 11th January 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the Audit Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It is responsible for seeking assurance regarding the Trust's internal and external audit programme, the local counter fraud service and compliance with the law and regulations governing the Trust's activities. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended
- There was good progress of actions from the previous meeting with all actions completed or updated
- Updates were received from the Internal and External Auditors as well as the Local Counter Fraud Specialist
- Updates were received on topical areas of work such as Consultant Job Planning, Data Quality and the National PTL
- The effectiveness of both Internal and External Audit was considered
- The work plan was reviewed and agreed

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Audit Committee which met on 11th January 2021. The meeting was quorate with three Non-Executive Directors present. A full list of the attendance is outlined below:

Chair/ Attendance:		
Present:	David Gilburt	Non-Executive Director (Chair)
	Paul Kingston	Non-Executive Director
	Harry Turner	Non-Executive Director
Attendance:		
	Shelley Ramtuhul	Trust Secretary
	Harry Turner	Non-Executive Director
	Craig Macbeth	Chief Finance Officer
	Diana Owen	Head of Financial Accounting
	James Shortall	Counter Fraud Specialist
	Greg Rubins	Internal Audit Representative
	Gurpreet Dulay	Internal Audit Representative
	Yasmin Ahmed	Internal Audit Representative
	Mo Ramzan	External Audit Representative
	Simon Adams	Director of Digital
	Mark Salisbury	Operational Director of Finance
	Laura Peill	Managing Director - SSU
Apologies:		
	Stacey Keegan	Chief Nurse / Patient Safety Officer

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

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

Chair's Assurance Report
Audit Committee – 11th January 2021

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
None		
2. RJAH Consultant Job Plan Final Report		
The Committee received the report which provided a refreshed action plan and an up to date summary of the current position. The Committee noted that of the five recommendations contained in the report, two had been completed in relation to the governance around the cancellation of lists and private patients. There were three recommendations with work ongoing as there is further reporting to be carried out before being fully complete. These recommendations were in relation to the following: **Clinical Hours worked against Job Plans** It was noted that electronic job planning had been rolled out with 96% of consultants using it. A bespoke solution is being looked at to monitor sessions worked against job plan. Work on the reporting is continuing with aim to complete this by the end of February. It was noted the time for completion had been extended due to Covid pressures on the Access Team. **Study Leave / Annual Leave Recording** The Committee was advised that work on the software to allow the electronic recording of annual leave and study leave was in the very early stages of implementation but should be fully rolled out by the end of December 2021. Again the timescales were longer than hoped for due to Covid. **Out of Job plan worked in In Job Plan Time** It was noted that the reporting is still being worked on around this but that the Chief of People, Chief Medical Officer and Clinical Chairs were reviewing the use of flexible SPAs. The Committee was assured regarding the enhancements in monitoring but discussed the change needed in the culture around job plans and agreed that the increased visibility of the data would support this work. The timelines for completion of the work were considered in the context of Covid pressures but the Committee felt consideration should be given to the impact this may have on restoration and the Trust's	Partial	The Committee was assured regarding the actions taken to date but full assurance could not be given until the recommendations had been completed.

risk appetite and tolerance. The Committee was advised that the risk was well recognised and that resources are being ring-fenced to keep the work going. The Committee considered that closer oversight of the work was needed for assurance purposes and given that the Committee only met quarterly would seek advice as to which other Committee could oversee this. The Committee noted the update.		
3. Assurance of Data Quality Audits		
The Committee received an update on the progress of Data Quality Audits and noted the capacity issues with completing these due to pressures within the information team. The internal auditors are going to provide some support with this and an updated plan is due to be presented at the next Information Governance Committee with onward reporting of any issues to this Committee.	Partial	The Committee noted that additional resource was being put in place to complete the audits and provide full assurance.
4. Finance Governance Pack		
The Committee was presented with the Finance Governance Pack which highlighted the following: • Performance against plan after adjustments shows £925k surplus compared to planned £227k deficit • Aged debt has started to increase as expected as activity increases with three older debts over £5k • Losses have increased in line with activity increasing with theatre losses impacted by surgery being delayed due to Covid. In addition there were two employer's liability claims. • There was one SFI waiver in relation to the x-ray rooms which amounted to £171k • Cash flow was above plan but not as much as in previous months and a revised cash plan has been submitted to NHSI as part of revised financial plans. • Cash balances were healthy as the Trust continues to be paid one month in advance for the majority of income which it is assumed will continue until March.	Y	

• Performance for prompt payment of invoices remains good. The Committee queried the absence of a forecast for the end of the year enquired if the Trust is still planning breakeven at the end of the year and was advised that this is reported via the Finance Planning and Digital Committee but that there are no specific new risks emerging at the current time to place the break-even position in jeopardy. The Committee noted the report.		
5. Register of Interests & Hospitality Register		
The Committee noted that compliance is down slightly owing to the time of year but that overall the position continues to be good year by year and declarations continue to be chased. The Committee noted the report.	Y	
6. Board Assurance Framework		
The Committee noted that the Board Assurance Framework had been realigned to the new objectives to the end of the financial year and went to the Board in November. Based on the Board comments and further review with the executive team and then the usual cycle of reporting will be resumed. The Committee noted the update.	Y	
7. Counter Fraud		
The Committee was joined by the Trust's Local Counter Fraud Specialist who presented the report and highlighted the following: • Three fraud prevention notices were issued in the week leading up to the Christmas break and these would be circulated. • The Counter-fraud Authority have revised local procedures and there is a revised timesheet for overtime claims for areas of the Trust that may be reliant on hard copies of timesheets. • Awareness of mandate fraud has been raised with the Trust's financial team and will continue to be raised during awareness training in Q4. • Guidance regarding use of corporate credit	Y	

cards has been issued • PPE scams seen during the spring / summer months of 2020 are now being replaced by vaccination and treatment scams which tie into the prevalence of using SMS text messaging. There are messages being generated, supposedly from the NHS inviting, someone to a vaccination appointment and requiring the clicking of a link or the input of personal data to prove who they are. • Procurement risks relating to direct awards being made for procurement. The LCFS has started a piece of work looking at high risk contracts, unusual leases entered into, and those needed at pace and as a matter of urgency to provide the Committee with some post-event assurance across the Covid procurement budget. • A governmental cyber fraud brief detailing cybercrimes and frauds that have emerged during the Covid pandemic. This work is linking with the Trust's IT Department. The Committee noted the helpful summary and commented on the timesheet notice as the Trust has mostly virtual timesheets but that the Estates Department would is an area where manual timesheets still exist and it would be helpful to share this with them. The Committee noted that the Trust's credit card usage is overseen by the Head of Financial Services but that it would be helpful for the LCFS to link into this. The Committee noted there was one fraud investigation currently ongoing in relation to a civil case and the LCFS confirmed he was fully briefed on the case. The Committee noted the report.		
8. Review of Internal Audit Progress Report		
The Committee received an update from the Trust's Internal Auditors which highlighted the following: • **Non Referral to Treatment Activity**. The referral to Treatment in terms of 18 weeks for England and 26 weeks for Wales is regulated and there is national guidance around this. This audit	Y	

focussed on waiting times which do not fall under the regulation. It received a moderate opinion for system design and system effectiveness. There were three recommendations, one high risk, one medium risk and one low risk. The trust has agreed to implement all recommendations by 30th June 2021 and there will be a follow up check to ensure these completed. • **Main Financial Systems**. The controls are still operating as expected with several minor points to improve on but nothing significant. • **Changes to the Plan** It was noted that Covid had impacted on the plan and it is hoped the Research Audit will start at the end of January. The Data Quality report will result in the Equality, Diversity and Inclusion Review being deferred to next year's plan. The Committee queried the January 2021 start date for the Research Audit given that NIH Research recently undertaken. There was consensus that it would make sense to delay this for 6 months to allow the recommendations to be enacted. The internal auditors agreed to look at the scope of the external review to see if there is overlap and if so discuss a deferrment. • **Pressure Ulcers**. The Audit is planned to go ahead and will be reported to the 10th May Audit Committee. • **Temporary Staffing.** This audit was due to commence on Monday 18th January 2021 but there are pressures within People Service and the People Committee has been temporarily suspended and therefore there are questions around whether this audit will be able to progress. • **Sickness and Absence**. The Committee was advised that this audit has commenced but again there has been a slowdown in the progress. The Committee noted the communication arrangements in place between the Trust and the internal auditors to ensure appropriate progress of the audits. The Committee considered the impact of any deferred		

audits on the Head of Internal Audit opinion required at the year end and was advised that a reasonable level of audit needs to be achieved to be able to give an opinion i.e. 6/7 audits. If this is not achieved an opinion would still be given however the scope would be limited – some caveat around coverage and what has been completed. It was agreed the Trust would look at this with the internal audit team. The Committee concluded by noting the progress to date has been accepted and it is recognised that the Covid surge is changing the workload significantly,		
9. Annual Review of Effectiveness of Internal Audit		
The Committee noted the survey sent out to members of the Audit Committee, members of Trust Management and directors that are involved in internal audits. Responses were received from 11 / 17 people and a variable level of satisfaction with the service provided but the scores are higher than last year. The strong areas were overall planning and planning for each audit. The weakest areas were communication, resources and timetabling which are the same strong and weak areas as last year. The review concluded that overall it has been a difficult year but the recommendation would be that the Committee approves the conclusion that the Trust has an adequate internal audit service. The internal auditors noted the feedback and confirmed this would be picked up with the Chief Finance Officer. The Committee approved the recommendation.	Y	
10. External Audit Progress Report and Audit Plan		
The external auditors advised the Committee that work on the 20/21 Financial Statements is on track with early planning work undertaken during December and the interim and timing audits will progress in due course. Some of the national timings are now being indicated with a mid-June deadline which is slightly earlier than last year but later than historically when it used to be the end of May deadline. The following was highlighted:- • **Charitable funds for 19/20** It was agreed with the Trust to be finalised pre-Christmas. The majority of the work is complete there was a delay in terms of the final reviews on Deloitte's side but	Y	

it will be finalised by the end of the week. • **Quality Accounts** There is uncertainty whether this will still be required and the Committee will be kept updated. • **Value for Money** This is a new requirement and the work will be carried out before the year end process and the scope has been shared with the Trust • **Climate related risks** Tis is coming up the agenda across corporate organisations with the NHS following suit The Committee noted the summary and there was comment, in relation to climate change that the Trust has recently installed solar panels and is focussed on the climate change issues and trying to be a responsible organisation (an interest free loan was taken out from a Government agency that is repaid over 10 years out of the energy savings from the solar panels). The Committee noted the update.		
11. Annual Review of Effectiveness of External Audit Review		
The Committee noted the survey that had been issued and was advised that the scores are not as high as the previous year yet they continue to indicate a high level of satisfaction with the service provided. There were positive comments around communication, a good understanding of the Trust issues and a pleasant attitude of audit staff. Areas for improvement included availability of staff which affected the timing of audits (e.g. charitable funds) however it was again acknowledged it has been a difficult year for all. It was recommended the Audit Committee approved the conclusion that Trust has an effective external audit service. The Committee approved the recommendation	Y	
12. External audit Contract Extension		
The Committee was informed that given the Covid situation it has been decided that the best course of action is to extend the external audit contract with Deloitte for a further year for continuity. The Council of Governors have agreed to this extension. The external auditors were thanked for their work to date and the Committee looked forward to continuing work together for another year.	N/A	

13. Agreement of Final Accounts Timetable and Plans		
The Committee was advised that NHSI have not released a timetable yet but this is anticipated within the next week or so and will be circulated to committee members. The Committee noted that it is custom for an informal committee meeting to talk through the highlights of the accounts before they are given to the external auditors and it was agreed that suggested dates for this would be looked at. The Chair advised that NHSEI have circulated invitations to Audit Chairs to attend a meeting at the beginning of February 2021 and any information from this will be shared with the Committee. The Committee agreed the plans in principle noting that the final timetable was awaited.	N/A	
14. Review of Accounting Policies		
The Committee reviewed and approved the following changes:- • Small percentage change in the RTA provision for impairments • IFRS 16 deferral • Revenue from NHS contract section – awaiting official wording from NHSI • Key sources of estimation uncertainty – this cannot be completed until the accounts are finalised.	N/A	
15. Review of Audit Committee Workplan		
The work plan was reviewed and agreed in principle noting that the dates may change when the timetable is released. The Committee noted there is a joint Audit and Risk Committee meeting on 7th April which all members confirmed they are able to attend.		
16. Review of Audit Committee Terms of Reference		
The Committee approved the Terms of Reference with an amendment to the Medical Director job title which has become Chief Medical Officer.		

17. Policy Tracker		
The Committee noted the policies that the Policy Committee has reviewed and the tracker provides an update of the changes and tracks dates for review. The Chair has requested that this appears regularly on the Audit Committee agenda to give assurance that policies are up to date and flag those becoming out of date. Going forward the monitoring schedule will include which Board Committee is responsible for oversight of individual policies (People Committee, Risk Committee, Quality and Safety Committee etc.) The Committee noted the tracker.		
18. National PTL Diagnostic Programme		
The Committee was advised that the audit was undertaken and fed back to the national team, highlighting the following points:- The audit looked at outcomes, duplicates in the system, missing RTT statuses, automatic uploads of PTL data, validation resource. 20 files were sampled There were recommendations made relating to the mapping of source of referrals data which is being pursued with the data quality lead which will be reported to data quality assurance group. It has been decided that daily files are no longer needed and weekly files have been commenced. There was overall satisfaction with the Trust's engagement and robust internal processes. The Committee asked what processes are in place to audit the waiting list and validate that the people on the list still need the operation. The Committee was advised that there is a national project where elective patients are being contacted and prioritised according to the information they provide. This is not currently applicable to diagnostic patients. It was noted that the next submission on this will be February 2021. Internally this will be engrained in the Trust's business as usual practice with the priority status recorded against all elective patients as they are being added to the list.	Y	

The Committee noted the report		
19. Top Risks		
The Committee identified the following top risks during the course of the meeting:- **An escalated risk on the restoration and delivery of services** and the impact this will have on the management of waiting lists. **Staff absence** was noted to have mitigating actions in place but is likely to increase and impact on the delivery of services and the wellbeing of employees. **Vaccination programme** was noted to be a sizeable piece of work with many staff being redeployed to support the programme very quickly. This coupled with the increased impact of Covid locally will put increasing pressure on a limited cohort of staff		

3.4 Approvals

Approval Sought	Outcome
Audit Committee Terms of Reference	Approved
Account Policies	Approved

3.6 Risks to be Escalated

In the course of its business the Committee identified the risks outlined at section 19 in the above table to be escalated.

3.5 Conclusion

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

Chair's Assurance Report

Finance Planning and Digital Committee – 24th November 2020

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	28th January 2021
Executive Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Governance and Quality
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Finance Planning and Digital Committee Meeting which was held on 24th November 2020 and is provided for assurance purposes.

NOTE: the meeting was held as a briefing for members only

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 on that the Trust is operating within its financial constraints and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was attended by member only
- There was good progress of actions from the previous meeting with all actions completed and no issues raised.
- Consideration was given to the indicative Trust's financial position and performance
- A briefing was presented on the Headley Court Agreement and Digital Agenda.

2.3. Conclusion

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

Chair's Assurance Report

Finance Planning and Digital Committee – 24th November 2020

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Finance Planning and Digtal Committee which met on 24th November 2020. The meeting was quorate with two Non-Executive Director and two Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:
Members
Rachel Hopwood, Non-Executive Director (Chair)
David Gilburt, Non-Executive Director
Kerry Robinson, Chief Performance, Improvement and OD Officer
Craig Macbeth, Chief Finance and Planning Officer
In Attendance
Mark Salisbury, Deputy Director of Finance
Simon Adams, Associate Director of IM&T
Shelley Ramtuhul, Trust Secretary

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and receive an update on the progress of each. All actions were noted to be completed or an updated was presented.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declaration of Interest		
There were no announcements regarding declarations of interest.	N/A	
Performance Report Month 7		
The Committee received the report and noted that the KPIs have been updated to remove duplication and that a report would be presented to the Board to outlining the changes that have been made across the performance framework. The Committee ***noted*** the update.	Y	
Update from Restoration Committee		
The Committee members noted that the October performance and the forward look for November had been reviewed and that a full update was expected at the next meeting. It was noted that the forecast received the week before was based on data at the time and that since this time a national major incident had been declared which may impact on this. It was confirmed the Non-Executive Directors had been briefed on the incident and were aware of the material impact this may have. The committee ***noted*** the update.	Y	

Chair's Assurance Report

Finance Planning and Digital Committee – 24th November 2020

Finance Report Month 7		
The Committee were provided with the following update: • Favourable financial position of £672k to plan • Reduced activity against plan • Private income above plan The Committee discussed the risks relating to income in relation to the elective incentive scheme and Welsh funding. These are subject to national discussion and the Trust is awaiting further clarification. It was explained that the forecast and actual data reported is the same and based on assumptions which have not changed and the variances the Trust is working with were noted. It was noted there are no major risks to delivery of the breakeven position but this will continue to be monitored and reported accordingly. In relation to the month on month projections, the Trust confirmed this element is more difficult as it is linked to the activity. The income is largely fixed under the block contract, with some variables around private income which may take the Trust above plan. The cost base is likely to be under plan due to reduced activity. Support has been received from the system and this will be kept under review. The Committee requested some quantification against each of the risks to the forecast. The Trust's position with regard to the Capital Programme. Developments to support restoration include: • Orders placed for the digital x-ray rooms • Further commitment made from contingency funding to support social distancing measures • Bed solution- this is in the design stage so this scheme will take some time to mobilise but an allowance has been made in the programme for this • An emergency capital bid has been submitted but it is anticipated that we won't hear back regarding this for around 4 weeks. The committee ***noted*** the update.	Y	
Headley Court Agreement		
The Committee was advised that the agreement is being finalised following a couple of minor points outstanding. The Committee were satisfied with this, provided the agreement is signed before any commitment on the part of the Trust with contractors. The Trust provided further assurance regarding the arrangements for the draw down of funds which minimised any risk. The Committee *noted* the update.	Y	
Digital Agenda		
The Committee was informed that NHS Digital has confirmed there will be some penetration testing this month. The Committee *noted* the update.	Y	

3.4 Approvals

The Committee did not approve any documents during the meeting.

Chair's Assurance Report
Finance Planning and Digital Committee – 24th November 2020

3.5 Risks to be Escalated

In the course of its business the Committee identified no risks for escalation.

3.6 Conclusion

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

Month 9 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	28/01/2021
Executive Sponsor:	Kerry Robinson	Paper Category:	Performance
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 Board of Directors and what input is required?

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

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

This paper is for information summarising the key performance indicators, highlighting areas of high or low performance for operational and financial metrics.

The committee is asked to note the overall performance as presented in the month 9 (December) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

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

It should be noted that from week commencing 11th January the Trust began to cancel some of its elective work as part of the covid-19 system response. Changes to our services will impact on some of our standard KPIs. Trajectories and forecasts that are included in the IPR are based on activities before the system response was known.

2.2. Summary

In line with the Trust's Performance Framework, Board-level Key Performance Indicators (KPIs) which are considered to drive the overall performance of the Trust.

Areas of performance to highlight this month are as follows;

Caring for Staff;

- Sickness absence remains above target at 4.42% for December.
- Slight increase in voluntary staff turnover but below 8% target at 6.98%.

Caring for Patients;

- One serious incident reported in December due to a RJAH acquired grade 3 pressure ulcer.

- Four complaints in December and back within tolerance level, although response rate remains red rated for the second consecutive month.
- No RJAH acquired infections throughout December.
- Five out of six cancer waits standards met; two breaches reported against the 62 day standard
- 18 weeks RTT open pathways performance remains consistent with previous month; 55.66% for December. Reduction in list size from 11,017 to 10,937.
- The number of patients waiting 52 weeks and over continues to grow now at 1,350.
- Both diagnostics standards remain below target with English reported at 83.37% and Welsh at 85.82%.

Caring for Finances;

- Total Elective activity was 779 in December; 215 behind 19/20 levels but 51 ahead of phase 3 plan submission.
- Total Outpatient activity was 10,1087; 2553 behind 19/20 levels but 75 attendances above phase 3 plan submission.
- Income as expected from above activity remain below plan, with cost base aligned.

2.3. Conclusion

The Board is asked to ***note*** the report and where insufficient assurance is received seek additional assurance.

Integrated Performance Report
December 2020 – Month 9

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

Aspiring to deliver world class patient care

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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Integrated Performance Report
December – Month 9

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Thirteen-month heatmap view

Caring for Staff

	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	4.87%	4.75%	4.83%	4.37%	4.06%	3.98%	2.82%	2.77%	2.61%	2.79%	3.6%	4.45%	4.42%	3.6%	3.6%	3.49%	R	Feb-20
Voluntary Staff Turnover - Headcount	6.73%	7.46%	7.51%	7.32%	8.41%	7.96%	7.99%	8.14%	8.24%	8.34%	8.07%	8.2%	8.33%	8%	8%	8.33%	R	Sep-19

Caring for Patients

	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	0	1	0	0	0	1	0	2	0	0	0	1	1	0	0	5	R	Apr-18
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Number of Complaints	5	7	13	7	2	7	5	3	2	4	8	10	4	8	72	45	G	May-18
RJAH Acquired C.Difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	G	Apr-18
RJAH Acquired E. Coli Bacteraemia	1	1	0	0	0	0	0	1	2	1	2	0	0	0	0	6	R	Jun-19
RJAH Acquired MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Unexpected Deaths	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	R	Apr-18
31 Days First Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			96%	100%	G	Nov-19
Cancer Plan 62 Days Standard (Tumour)*	100%	100%	100%	100%	85.71%	50%	100%	100%	100%	50%	100%	0%			85%	79.41%	G	
18 Weeks RTT Open Pathways	88.3%	88.15%	87.08%	85.27%	78.77%	67.3%	50.6%	40.82%	42.93%	49.13%	52.01%	55.21%	55.66%	92%	92%	53.91%	R	
Patients Waiting Over 52 Weeks – English	0	0	0	0	12	33	68	123	198	306	418	540	687	0			R	Nov-19
Patients Waiting Over 52 Weeks – Welsh	0	0	1	3	15	40	77	135	199	299	385	453	528	0			R	Nov-19
6 Week Wait for Diagnostics - English Patients	98.09%	98.8%	98.6%	90.2%	22.38%	20.24%	26.36%	28.66%	39.56%	72.35%	86.92%	88.7%	83.37%	99%	99%	50.79%	R	
8 Week Wait for Diagnostics - Welsh Patients	99.32%	99.75%	99.52%	90.57%	41.65%	21.04%	21.2%	20.66%	36.73%	74.93%	92.18%	87.99%	85.82%	100%	100%	48.18%	R	

Integrated Performance Report
December – Month 9

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Finances

	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Total Elective Activity					35	35	81	132	153	491	605	693	779	994			NO FORE-CAST	
Bed Occupancy – All Wards – 2pm	88.31%	85.88%	89.53%	80.53%	74.31%	70.96%	71.57%	74.43%	72.33%	72.86%	78.17%	75.14%	75.84%	87%	87%	74.06%	R	Sep-19
Total Outpatient Activity					6,382	5,152	6,508	7,222	6,593	9,528	10,845	11,218	10,187	12,740			NO FORE-CAST	
Financial Control Total	-457	794	560	1,107	0	0	0	0	0	0	462	463	138	124	1,025	1,063	G	
Income	8,595	10,415	9,792	10,633	8,783	8,756	8,716	8,962	8,656	9,306	9,387	10,058	9,138	9,626	82,086	81,762	G	
Expenditure	9,095	9,670	9,275	9,564	8,827	8,799	8,761	9,006	8,701	9,350	8,967	9,640	9,045	9,547	81,462	81,096	G	
Efficiencies Delivery	301	230	356	303	46	57	61	155	152	200	88	79	137	95	273	303	G	
Cash Balance	5,822	5,467	6,781	8,250	15,380	17,150	17,270	18,140	18,880	18,850	18,740	19,100	19,510	15,800	15,800	19,510	G	
Capital Expenditure	158	836	234	2,451	72	167	267	308	183	770	694	935	307	919	5,506	3,703	G	
Use of Resources (UOR)	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	G	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Sickness Absence

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

4.42% against **3.6%** target

Breaching target red rated

Exec Lead:
Director of People

Integrated Performance Report

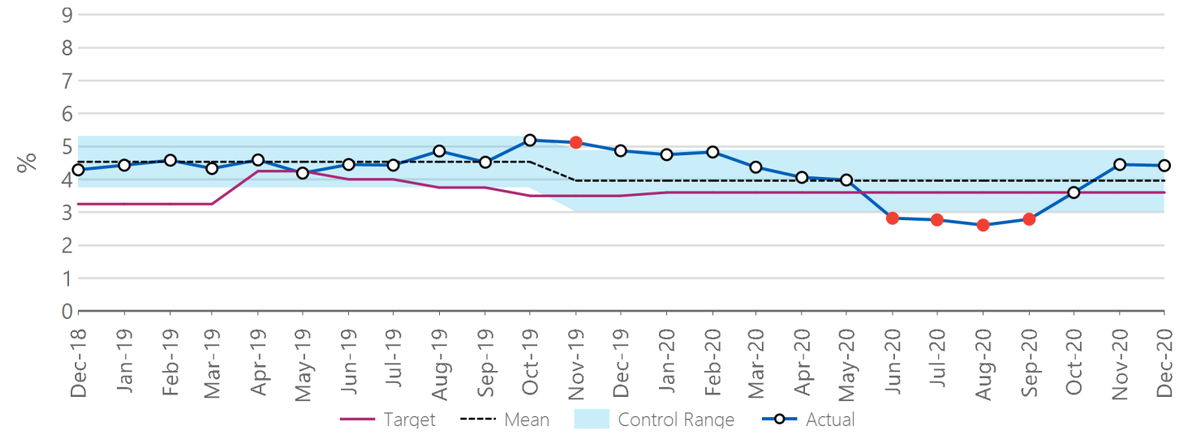
Narrative

The sickness rate for December is reported at 4.42%, very similar to the levels in November at 4.45%. Trust-wide there was a reduction in short term absence at 1.84% whilst long term absence increased to 2.58%. A unit breakdown is:
- MSK Unit 5.88% overall with 2.33% short term and 3.55% long term
- Specialist Unit 4.27% overall with 2.21% short term and 2.07% long term
- Clinical Services Unit 3.52% overall with 1.82% short term and 1.70% long term
- Support Services Unit 3.47% overall with 1.12% short term and 2.36% long term
- Assurance and Standards Team 3.54% overall with 0.19% short term and 3.35% long term

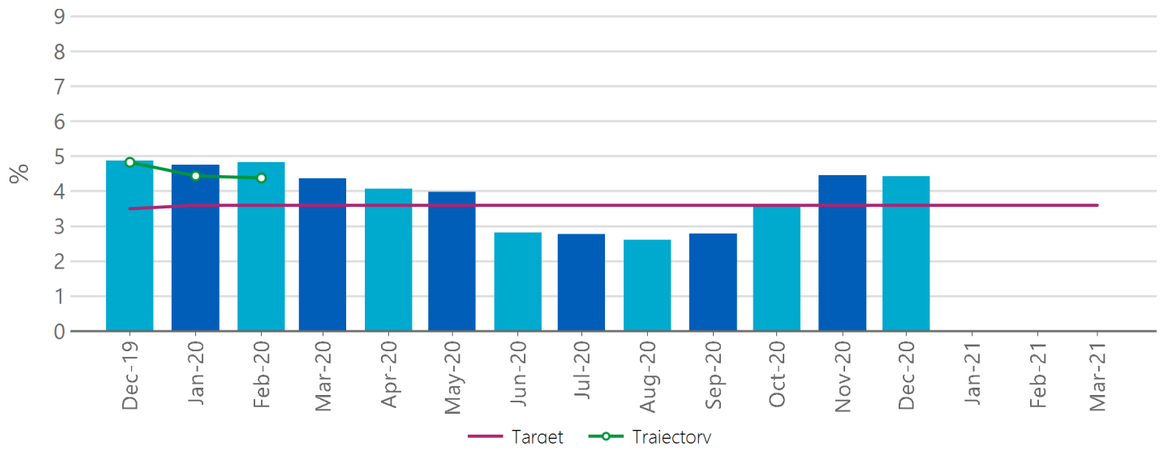
We anticipate increased sickness levels of approximately 8-10%, in line with what other Trusts have seen nationally.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: Continue to ensure that sources of psychological support are promoted.

Every member of staff to have had a wellbeing conversation by 31/3/21.

Theatres are looking at sickness as part of the work being undertaken on Theatres Objectives. A small group of managers are taking forward work on this in order to take recommendations to the Theatres Objectives Meetings. This work will include incorporating wellness considerations into appraisals. Sickness is discussed at the monthly Theatres Senior Managers' Meeting and at managers' one to ones. Actions undertaken to improve working lives on the surgical wards include: planning of meal breaks in conjunction with Denbighs; provision of equipment; provision of an outside rest area.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
4.29%	4.43%	4.58%	4.33%	4.59%	4.19%	4.45%	4.43%	4.86%	4.52%	5.19%	5.12%	4.87%	4.75%	4.83%	4.37%	4.06%	3.98%	2.82%	2.77%	2.61%	2.79%	3.6%	4.45%	4.42%	3.49%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Director of People

Integrated Performance Report

Voluntary Staff Turnover - Headcount

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

8.33% against **8%** target

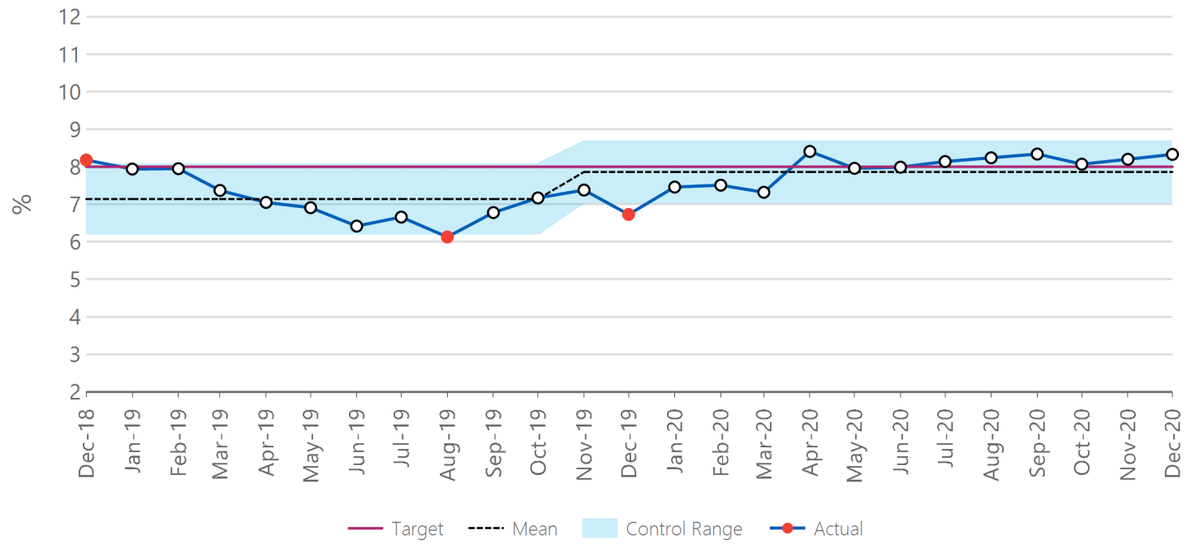
Breaching target red rated

Narrative

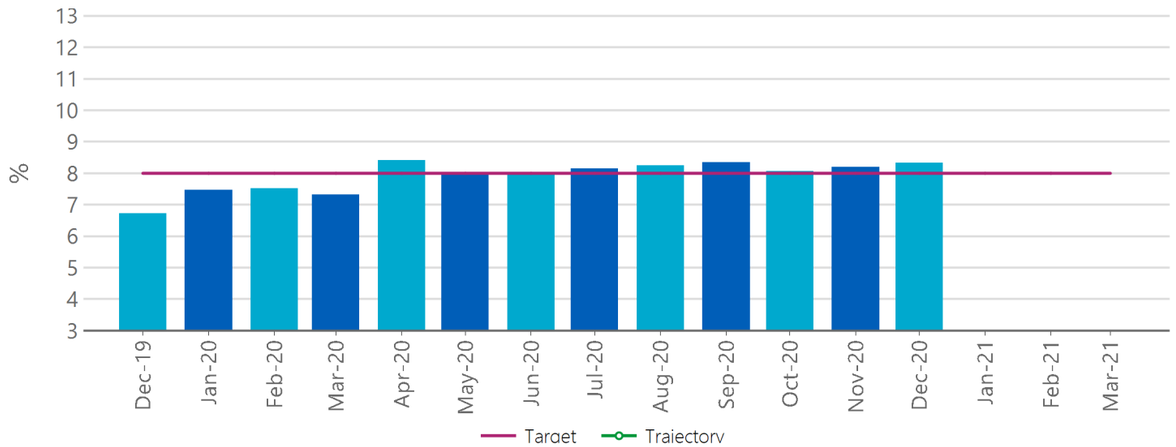
The voluntary staff turnover rate is reported above tolerance at 8.33%. A breakdown by unit is:
- MSK Unit - 10.55%
- Specialist Unit - 7.29%
- Clinical Services Unit - 9.32%
- Support Services Unit - 4.96%
- Assurance and Standards Team - 8.62%

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: Operationalising local actions in accordance with our "We are the NHS" People Plan:
- Design roles which make the greatest use of each person's skill and experience and fits with their needs and preferences
- Ensure that staff who are mid-career have a conversation with their line manager, HR, OH

Active focus on learning and actions from exit process for nursing and AHPs

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
8.18%	7.94%	7.95%	7.37%	7.05%	6.91%	6.42%	6.66%	6.13%	6.78%	7.17%	7.38%	6.73%	7.46%	7.51%	7.32%	8.41%	7.96%	7.99%	8.14%	8.24%	8.34%	8.07%	8.2%	8.33%	8.33%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Director of Nursing

Integrated Performance Report

Serious Incidents

Number of Serious Incidents reported in month

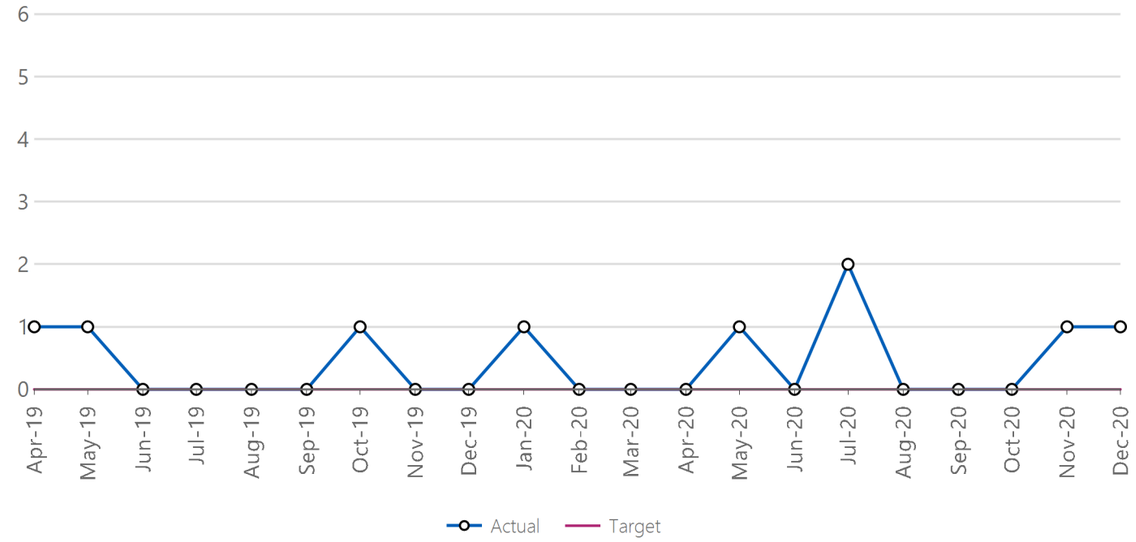
1 against 0 target

Breaching target red rated

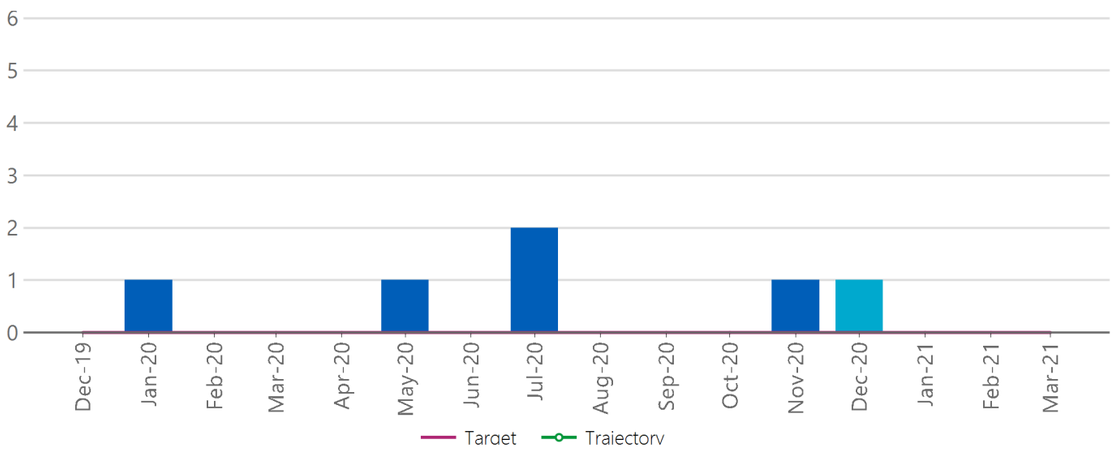
Narrative

There was one serious incident reported in December in relation to a patient that acquired a grade 3 pressure ulcer.

Performance over 24 months –



Trajectory



Actions

Action to Improve: Please see the grade 3 pressure ulcers indicator for relevant actions in relation to this serious incident.

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
1	1	0	0	0	0	1	0	0	1	0	0	0	1	0	2	0	0	0	1	1	5

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Director of Nursing

Integrated Performance Report

Never Events

Number of Never Events Reported in Month

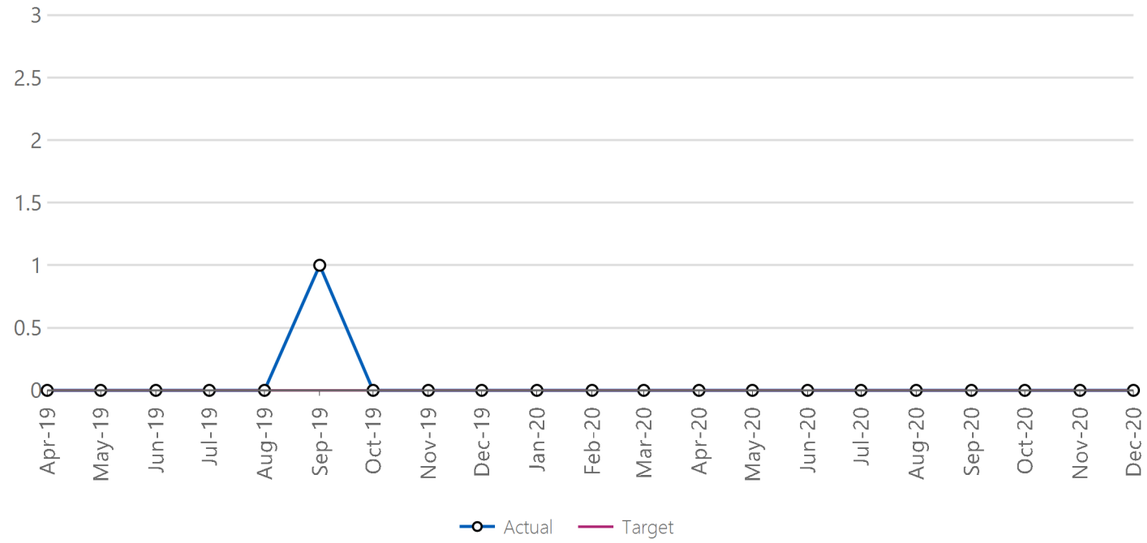
0 against 0 target

On target green rated

Narrative

There were no never events reported in December.

Performance over 24 months –



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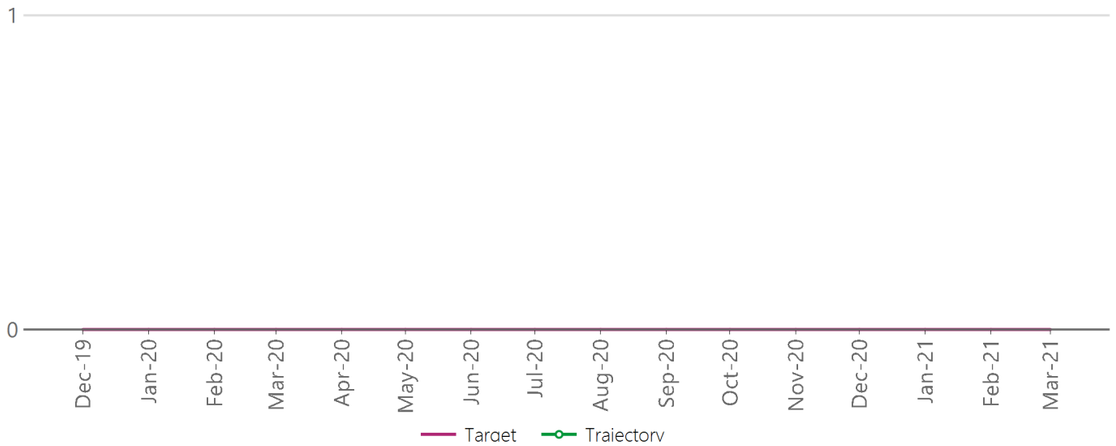


Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Number of Complaints

Number of complaints received in month

4 against 8 target

Within target green rated

Exec Lead:
Director of Nursing

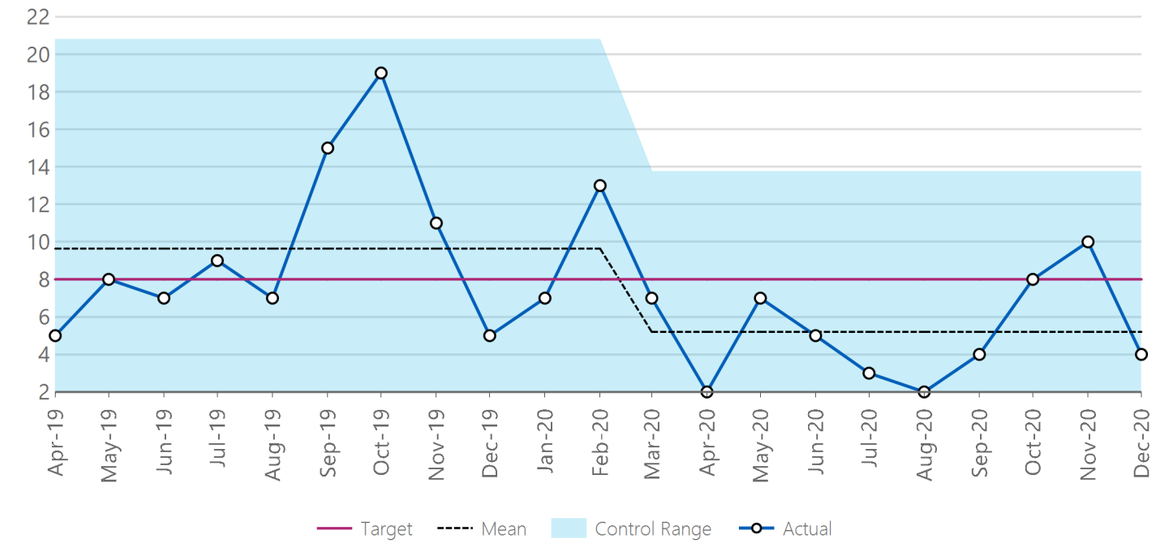
Integrated Performance Report

Narrative

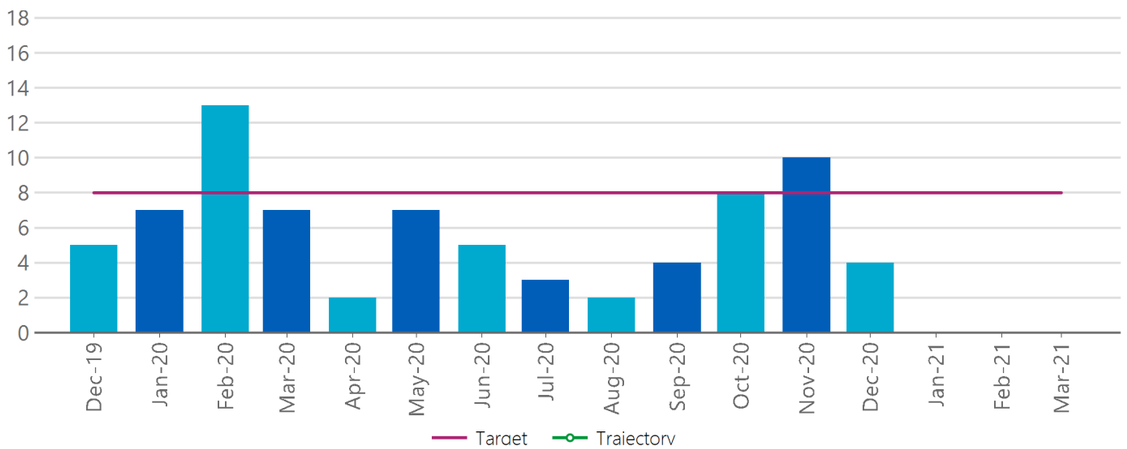
There were four complaints received in December; all relating to operational issues with. The reasons associated with the complaints were difficulties getting appointments with SOOS (2), waiting times (1) and appointment letters (1).

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
5	8	7	9	7	15	19	11	5	7	13	7	2	7	5	3	2	4	8	10	4	45

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month

0 against 0 target

On target green rated

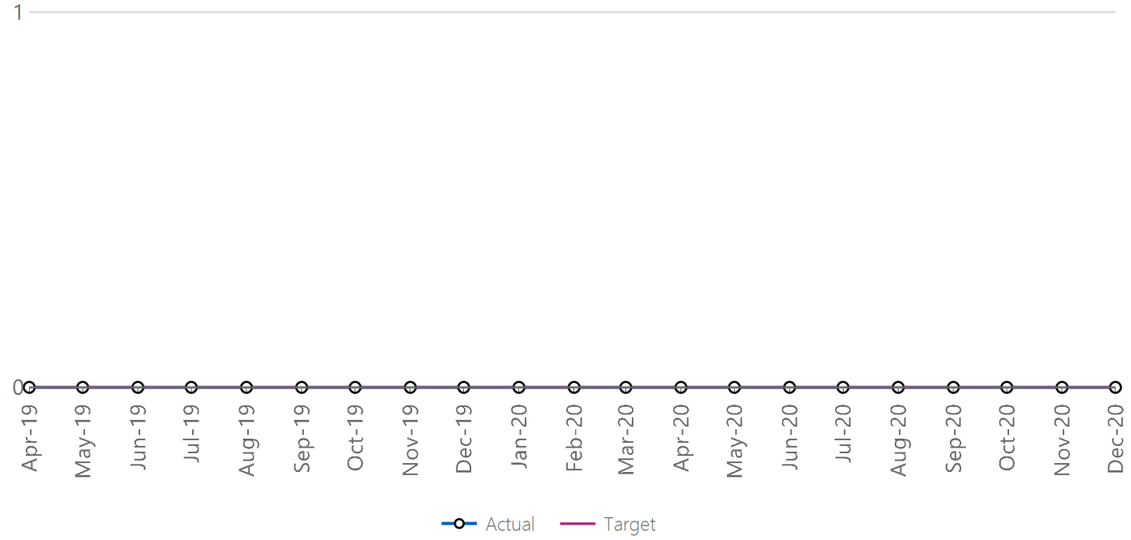
Exec Lead:
Director of Nursing

Integrated Performance Report

Narrative

There were no incidents reported in December.

Performance over 24 months –



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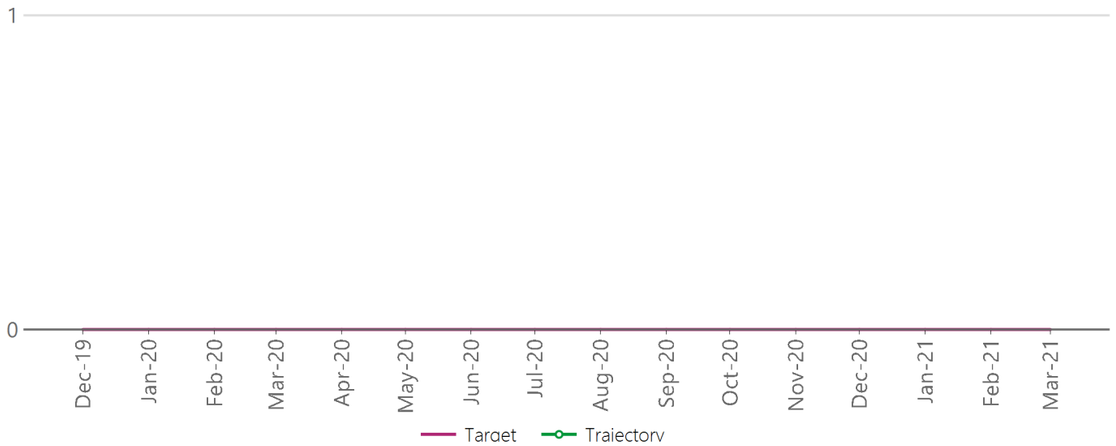


Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired E. Coli Bacteraemia

Number of cases of E. Coli Bacteraemia in Month.

0 against 0 target

On target green rated

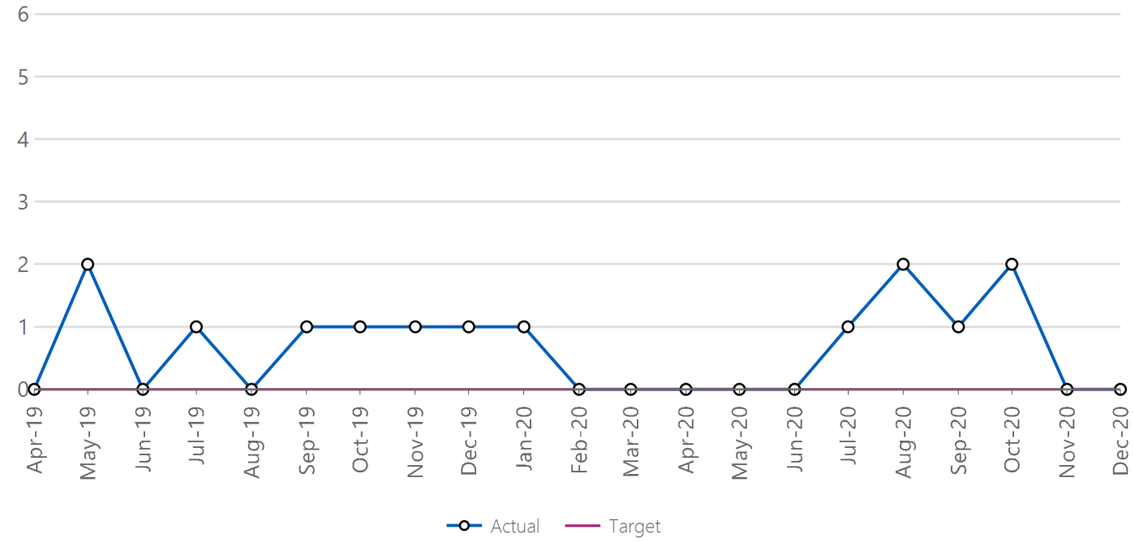
Exec Lead:
Director of Nursing

Integrated Performance Report

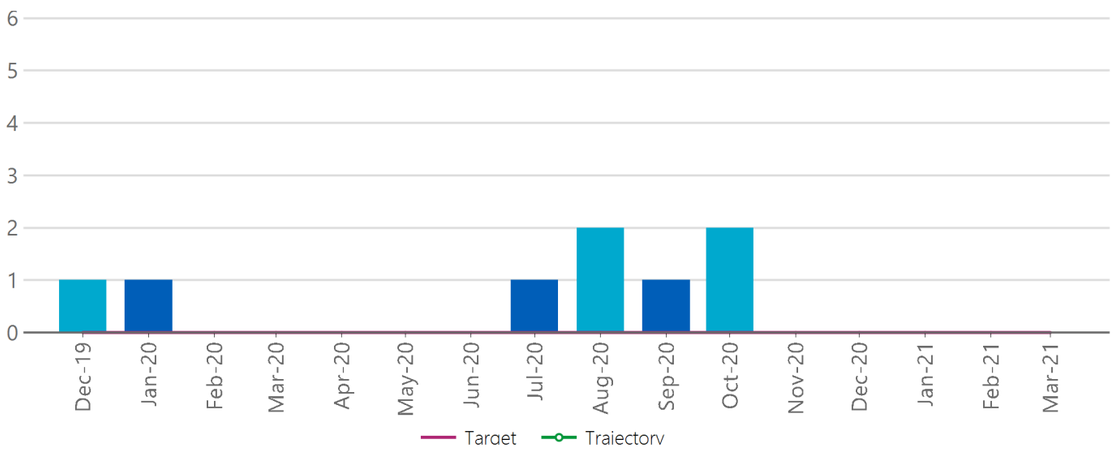
Narrative

There were no incidents of E.Coli Bacteraemia reported in December.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
0	2	0	1	0	1	1	1	1	1	0	0	0	0	0	1	2	1	2	0	0	6

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Director of Nursing

Integrated Performance Report

RJAH Acquired MRSA Bacteraemia

Number of cases of MRSA bacteraemia in month

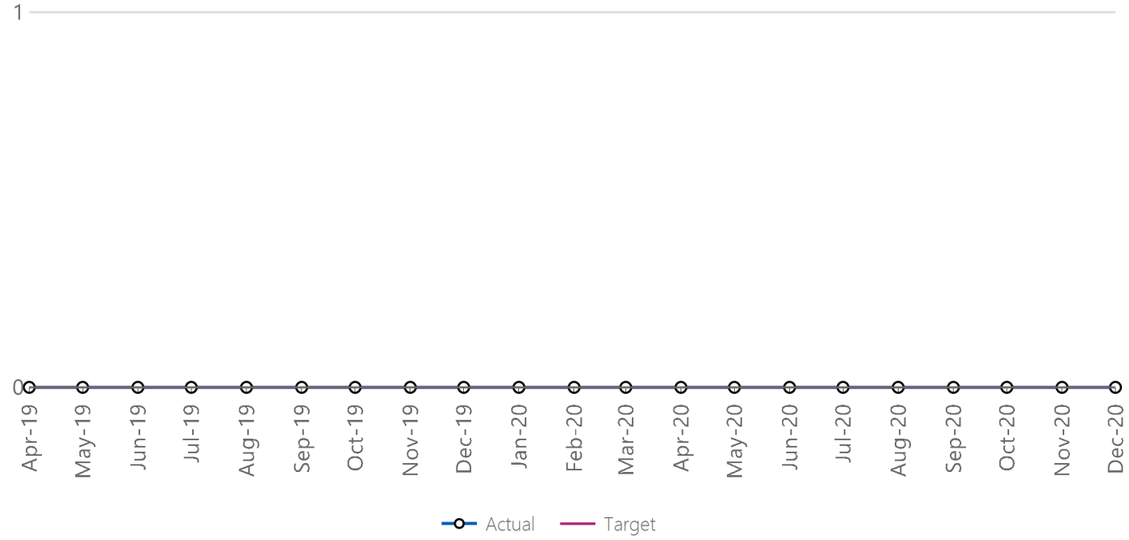
0 against 0 target

On target green rated

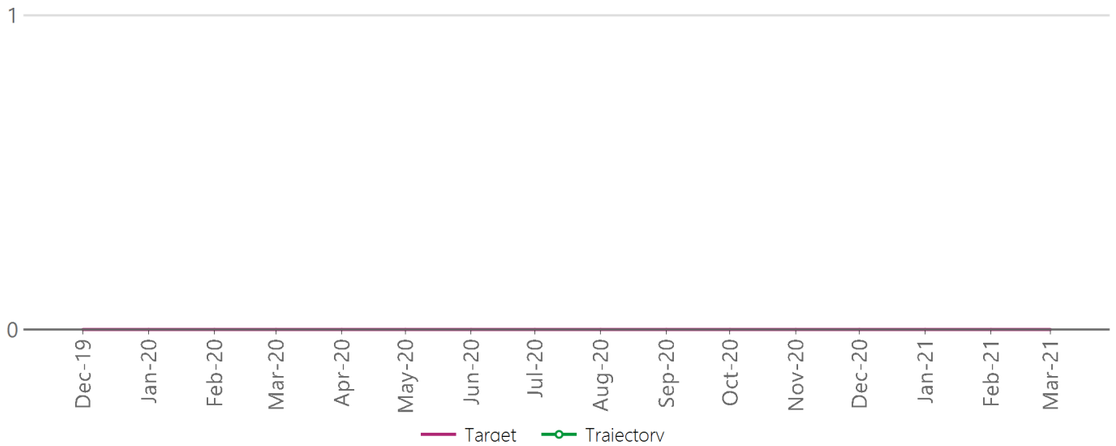
Narrative

There were no incidents reported in December.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Unexpected Deaths

Number of Unexpected Deaths in Month

0 against 0 target

On target green rated

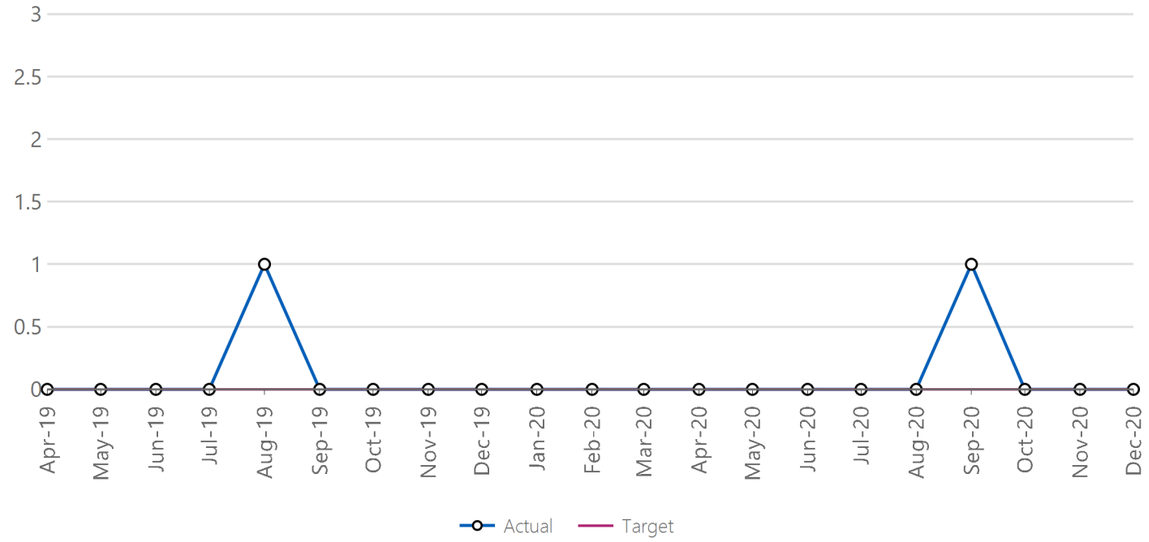
Exec Lead:
Medical Director

Integrated Performance Report

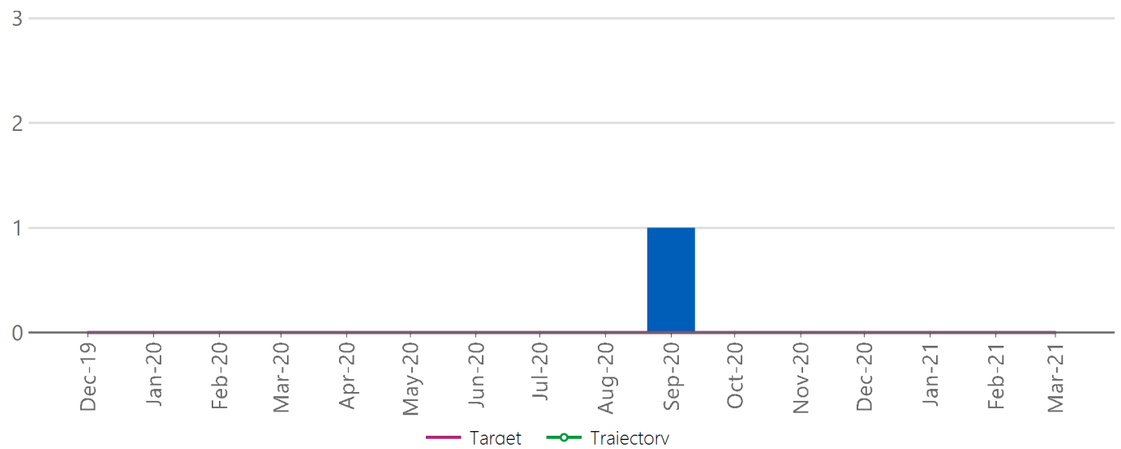
Narrative

There were no deaths within the Trust in December.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Specialist Services Unit

Integrated Performance Report

31 Days First Treatment (Tumour)*

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

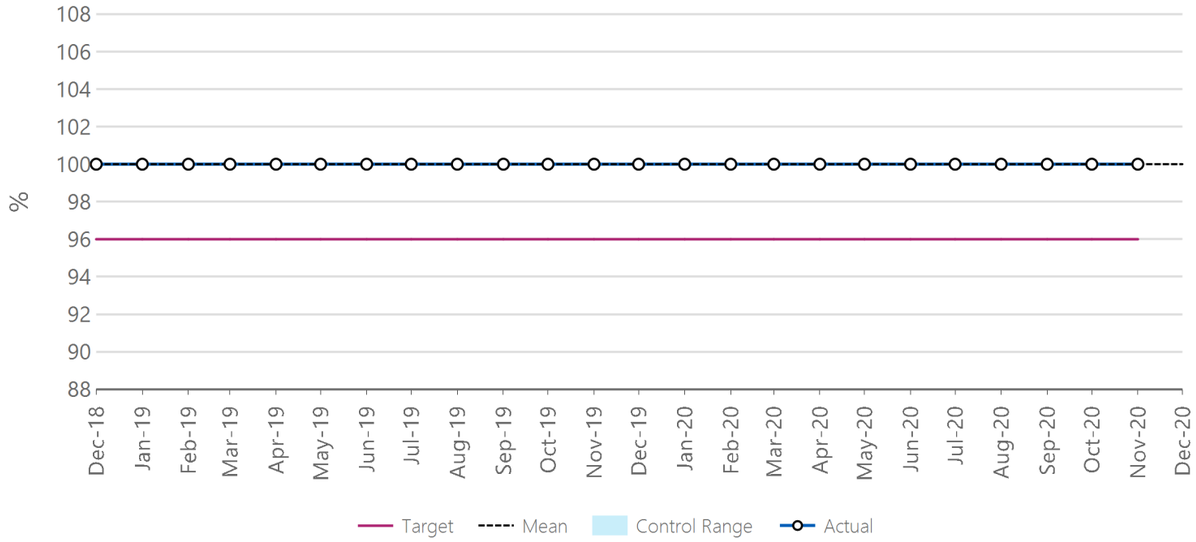
100% against 96% target

green rated

Narrative

The Cancer 31 day first treatment standard was achieved in November. Indicative data for December shows achievement of the standard will not be met next month due to one known breach.

Performance over 24 months – SPC



Trajectory

Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Specialist Services Unit

Integrated Performance Report

Cancer Plan 62 Days Standard (Tumour)*

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

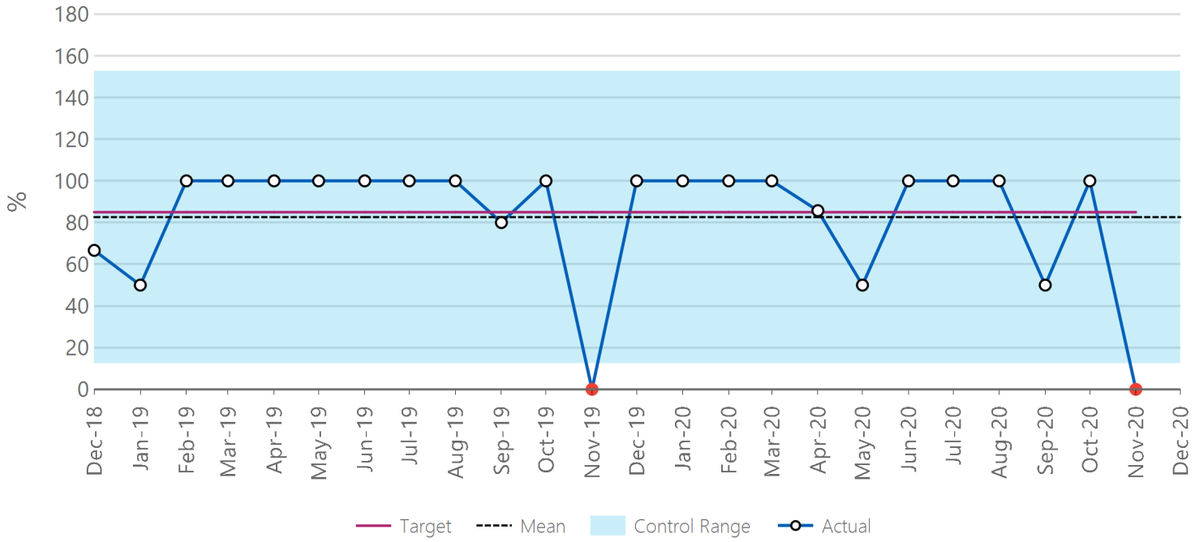
0% against 85% target

red rated

Narrative

The Cancer 62 day standard was not achieved in November and is reported at 0%. Two patients are reported against this standard in November, both shared pathways with other Trusts where RJAH have been reported as partly accountable for the breaches however we are querying this with NHS Digital as from our perspective these patients were referred out in a timely manner; one patient on day 27 and the second patient on day 22..

Performance over 24 months – SPC



Trajectory

Actions

Action to Improve: As part of the review of these pathways and the query with NHS Digital we will improve our understanding and learning with regards to the reporting of this data.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
66.67%	50%	100%	100%	100%	100%	100%	100%	100%	80%	100%	0%	100%	100%	100%	100%	85.71%	50%	100%	100%	100%	50%	100%	0%		79.41%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

18 Weeks RTT Open Pathways

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

55.66% against 92% target

Below target red rated

Exec Lead:
Support Services Unit

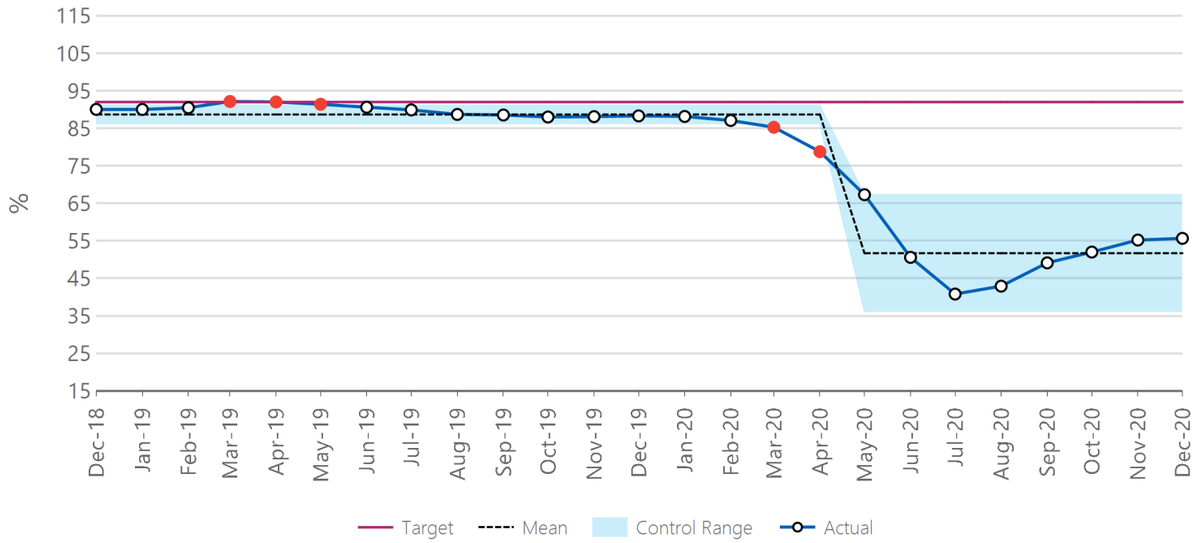
Integrated Performance Report

Narrative

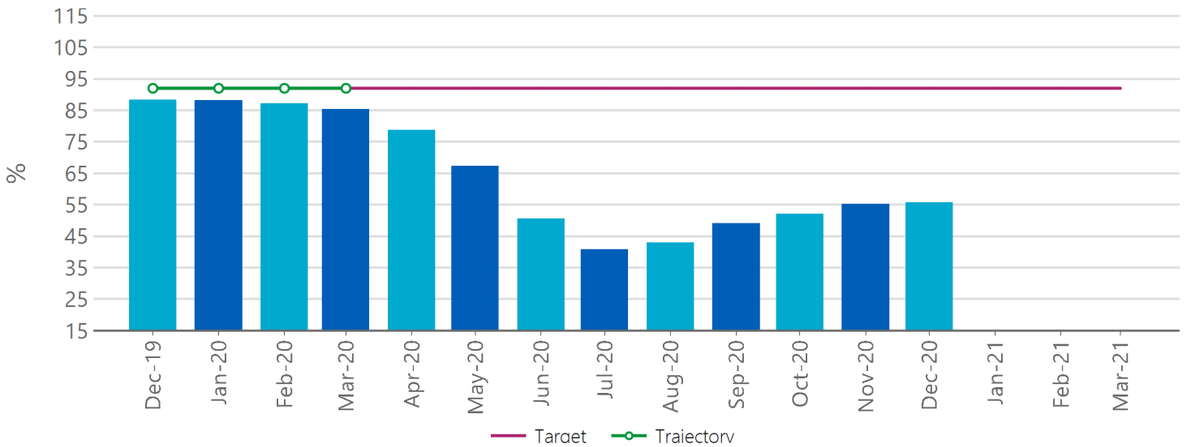
Our December performance was 55.66% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The total number of breaches has reduced by 86, reducing from 4935 at the end of November to 4849 at the end of December. The performance breakdown by milestone is as follows: MS1 - 6872 patients waiting of which 2189 are breaches, MS2 - 1062 patients waiting of which 659 are breaches, MS3 - 3003 patients waiting of which 2001 are breaches.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: Due to the Trust's covid-19 system support, we anticipate the open pathways performance to deteriorate as we will only be treated priority 2 patients where it is deemed clinically essential in January.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
90.04%	90.02%	90.47%	92.14%	92.01%	91.4%	90.61%	89.9%	88.69%	88.54%	88.01%	88.1%	88.3%	88.15%	87.08%	85.27%	78.77%	67.3%	50.6%	40.82%	42.93%	49.13%	52.01%	55.21%	55.66%	53.91%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Specialist Services Unit

Integrated Performance Report

Patients Waiting Over 52 Weeks – English

Number of English RTT patients currently waiting 52 weeks or more

687 against 0 target

Breaching target red rated

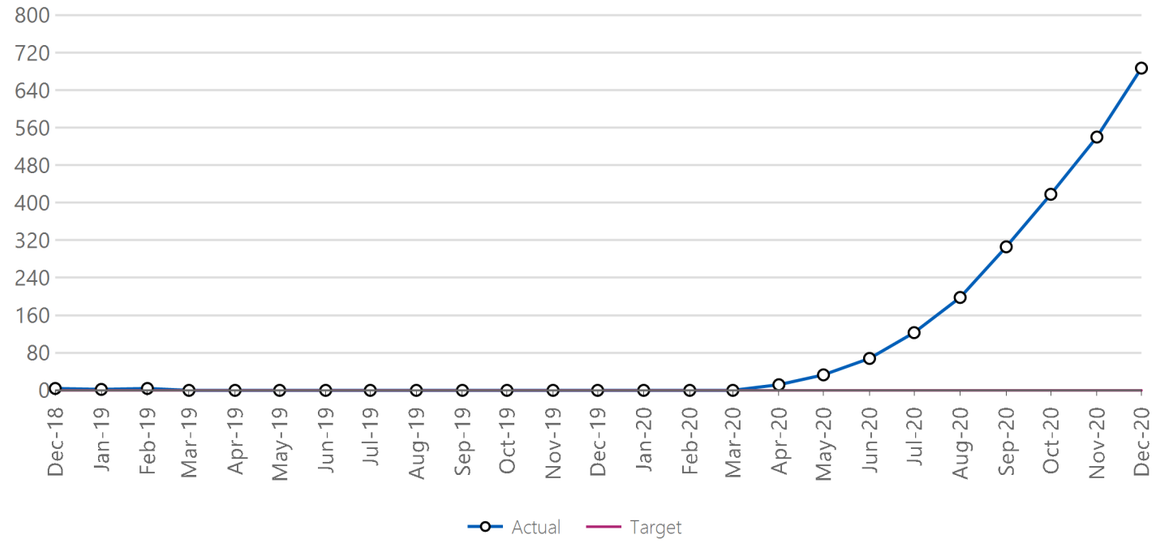
Narrative

At the end of December there were 687 English patients waiting over 52 weeks. This is above our trajectory figure of 550.

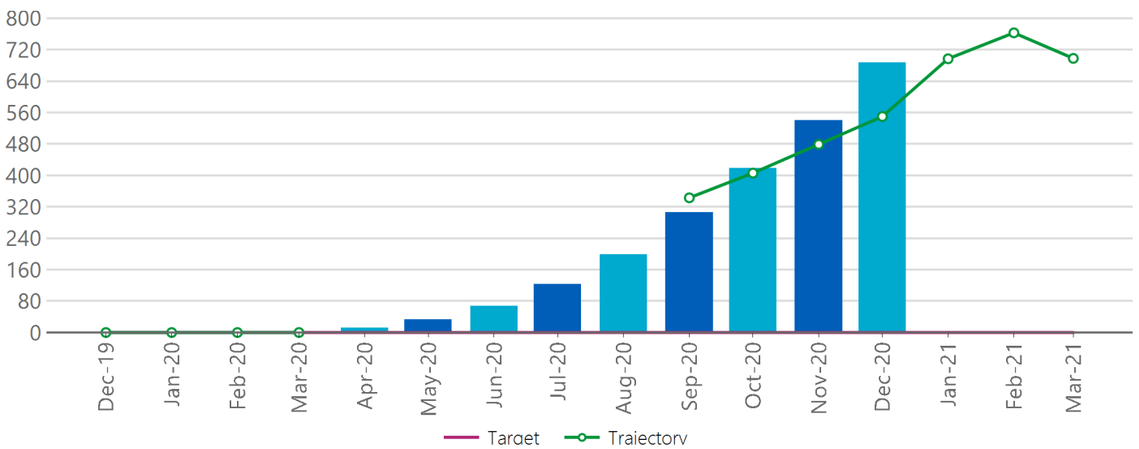
The patients are under the care of the following sub-specialities; Arthroplasty (228), Spinal Disorders (203), Knee & Sports Injuries (119), Upper Limb (71), Foot & Ankle (35), Paediatric Orthopaedics (14), Spinal Injuries (5), Tumour (5), Neurology (2), SOOS GPSI (2), Metabolic Medicine (2) and Rheumatology (1).

The number of patients waiting, by weeks brackets is:
- 52 to 60 weeks - 370 patients
- 61 to 70 weeks - 213 patients
- 71 weeks to 80 weeks - 79 patients
- 80+ weeks - 25 patients

Performance over 24 months –



Trajectory



Actions

Action to Improve: Due to the Trust's covid-19 system support, we anticipate the number of patients waiting over 52 weeks to deteriorate as we will only be treated priority 2 patients where it is deemed clinically essential in January.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
4	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	12	33	68	123	198	306	418	540	687

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Exec Lead:
Specialist Services Unit

Integrated Performance Report

Patients Waiting Over 52 Weeks – Welsh

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

528 against 0 target

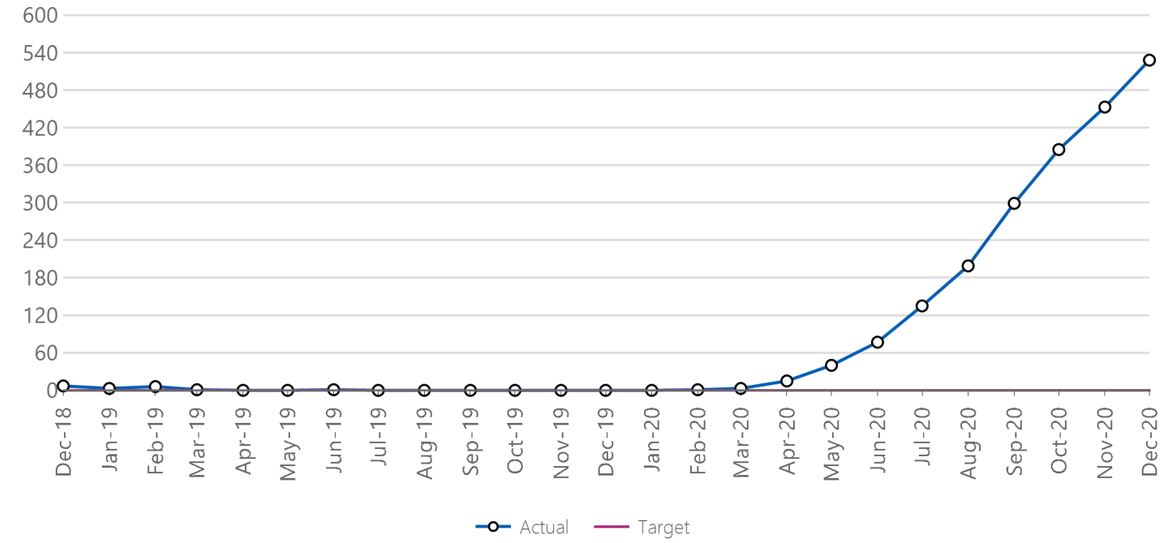
Breaching target red rated

Narrative

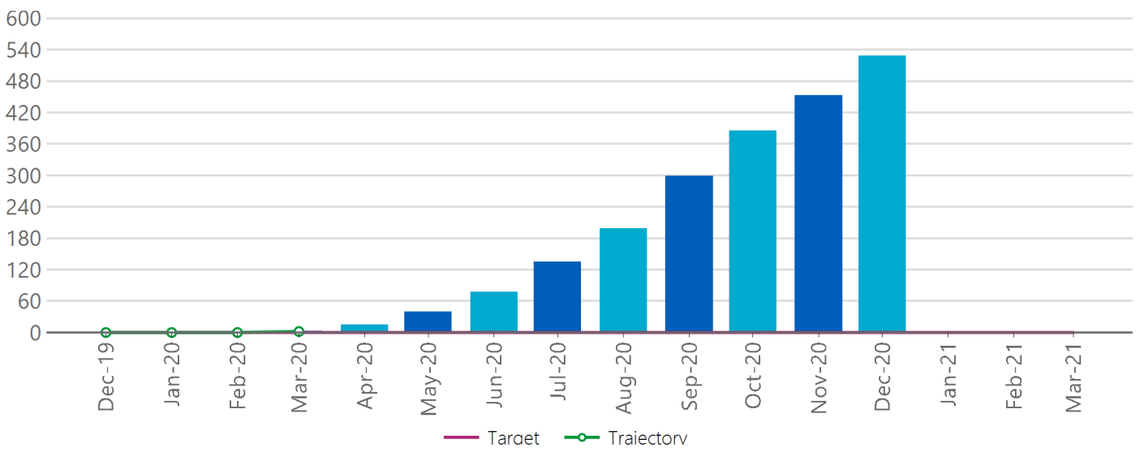
At the end of December there were 528 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (229), Arthroplasty (144), Knee & Sports Injuries (66), Foot & Ankle (33), Upper Limb (31), Paediatric Orthopaedics (17), Tumour (3), Neurology (3), Spinal Injuries (1) and Occupational Therapy (1). The patients are under the care of the following commissioners; BCU (288), Powys (228), Hywel Dda (10) and Aneurin Bevan (2).

The number of patients waiting, by weeks brackets is:
- 52 to 60 weeks - 226 patients
- 61 to 70 weeks - 196 patients
- 71 to 80 weeks - 69 patients
- 80+ weeks - 37 patients

Performance over 24 months –



Trajectory



Actions

Action to Improve: Due to the Trust's covid-19 system support, we anticipate the number of patients waiting over 52 weeks to deteriorate as we will only be treated priority 2 patients where it is deemed clinically essential in January.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
7	3	6	1	0	0	1	0	0	0	0	0	0	0	1	3	15	40	77	135	199	299	385	453	528

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

6 Week Wait for Diagnostics - English Patients

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

83.37% against **99%** target

Below target red rated

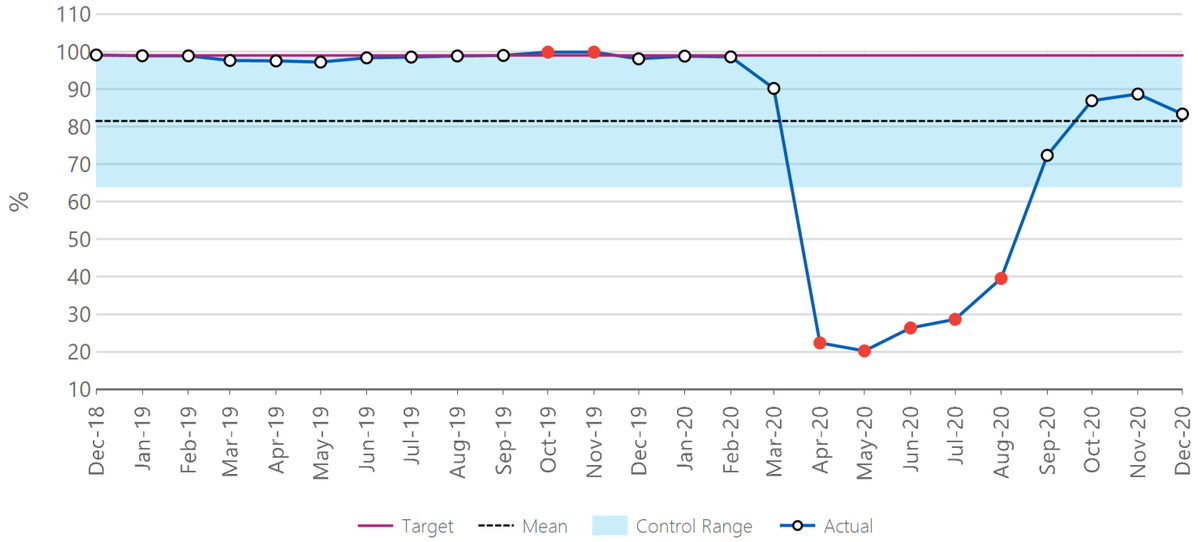
Exec Lead:
Clinical Services Unit

Integrated Performance Report

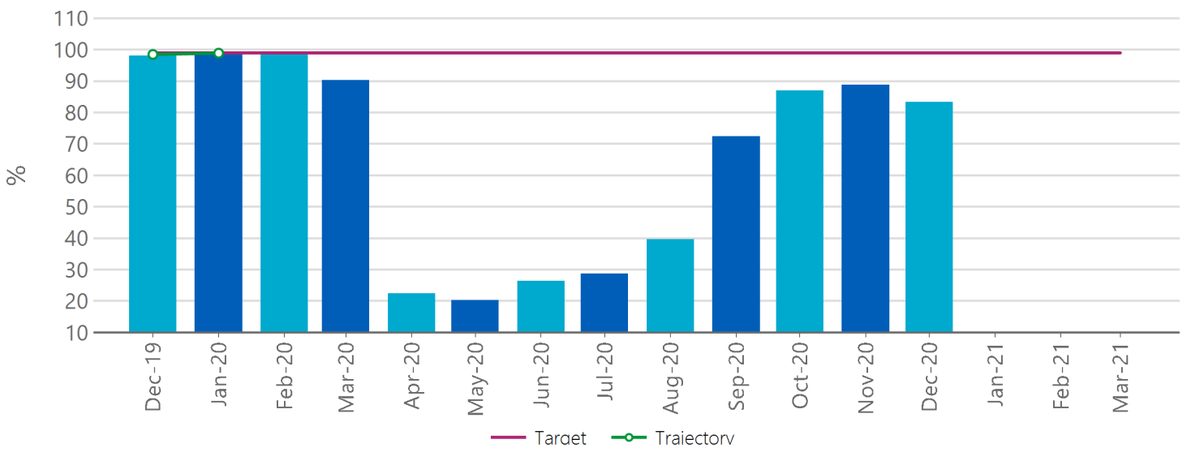
Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 83.37%. This equates to 140 patients who waited beyond 6 weeks, a 38 increase on the figure reported at the end of November.
The breaches occurred in the following modalities;
- MRI (125 - with 69 dated)
- Ultrasound (1 undated)
- CT (7 - with 5 dated)
- DEXA (7 - with 5 dated)

Performance over 24 months – SPC



Trajectory



Actions

Action to Improve: • Following a deep dive into the efficiency of CT, extended working hours and weekend working remain in place.
• Recruitment of additional radiographers, to include agency radiographers. The international recruitment process contract has now been signed and commenced. Appointed radiographers to commence employment throughout quarter one.
• Ongoing review of workforce/skill mix, recruitment of support positions to release radiographer capacity that will improve activity levels delivered.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
99.1%	98.91%	98.88%	97.64%	97.53%	97.21%	98.35%	98.55%	98.85%	98.99%	99.87%	99.87%	98.09%	98.8%	98.6%	90.2%	22.38%	20.24%	26.36%	28.66%	39.56%	72.35%	86.92%	88.7%	83.37%	50.79%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

8 Week Wait for Diagnostics - Welsh Patients

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

85.82% against 100% target

Below target red rated

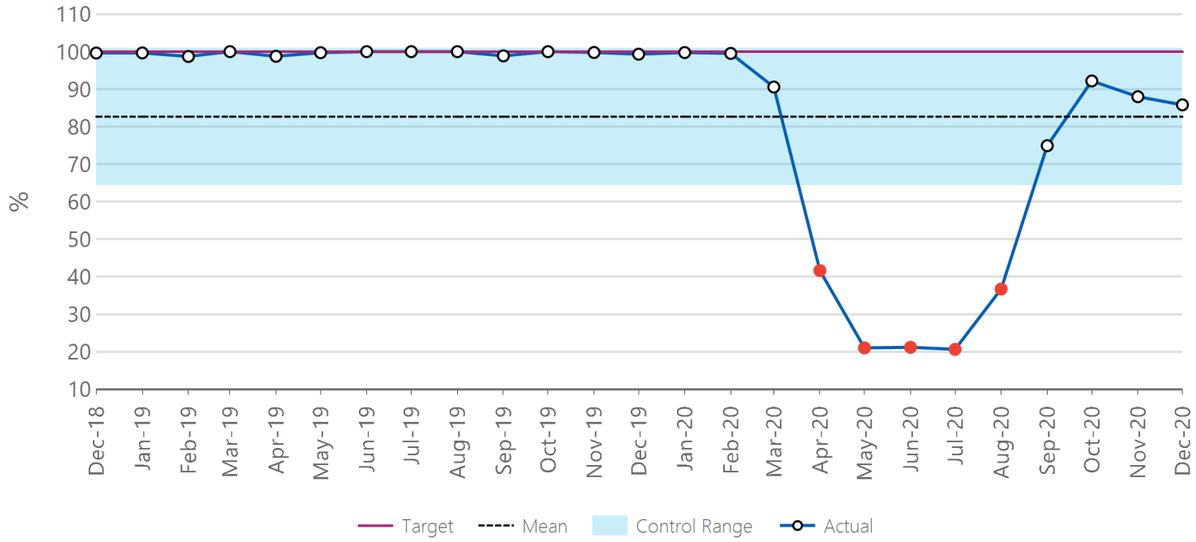
Exec Lead:
Clinical Services Unit

Integrated Performance Report

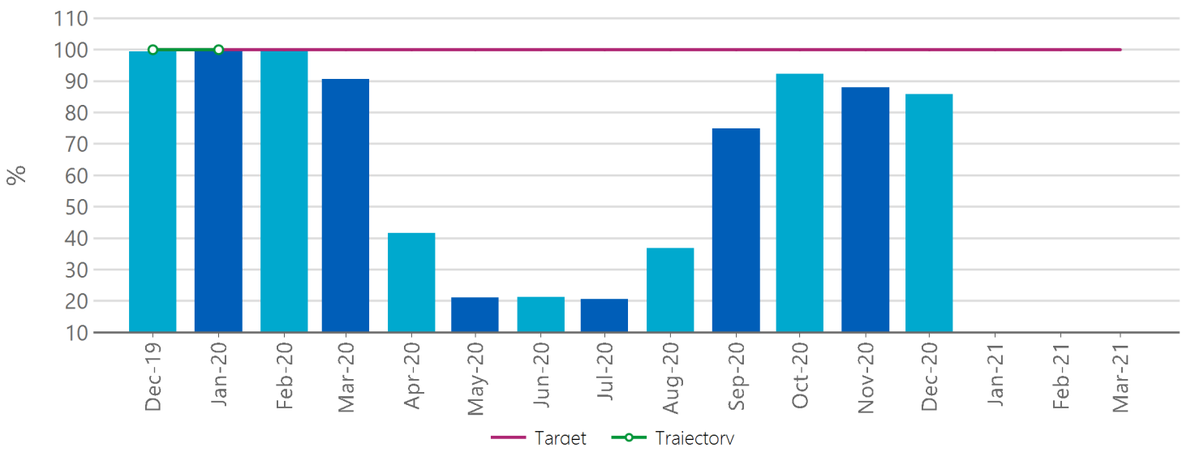
Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 85.82%. This equates to 57 patients who waited beyond 8 weeks; an increase of 14 from volume reported at the end of November. The breaches occurred in the following modalities;
- MRI (52 - with 30 dated)
- CT (4 - with 1 dated)
- DEXA (1 dated)

Performance over 24 months – SPC



Trajectory



Actions

Action to Improve: • Following a deep dive into the efficiency of CT, extended working hours and weekend working remain in place.
• Recruitment of additional radiographers, to include agency radiographers. The international recruitment process contract has now been signed and commenced. Appointed radiographers to commence employment throughout quarter one.
• Ongoing review of workforce/skill mix, recruitment of support positions to release radiographer capacity that will improve activity levels delivered.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
99.64%	99.66%	98.72%	100%	98.76%	99.72%	100%	100%	100%	98.87%	100%	99.78%	99.32%	99.75%	99.52%	90.57%	41.65%	21.04%	21.2%	20.66%	36.73%	74.93%	92.18%	87.99%	85.82%	48.18%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Elective Activity

.

779 against 994 target

Within target red rated

Exec Lead:
MSK Unit

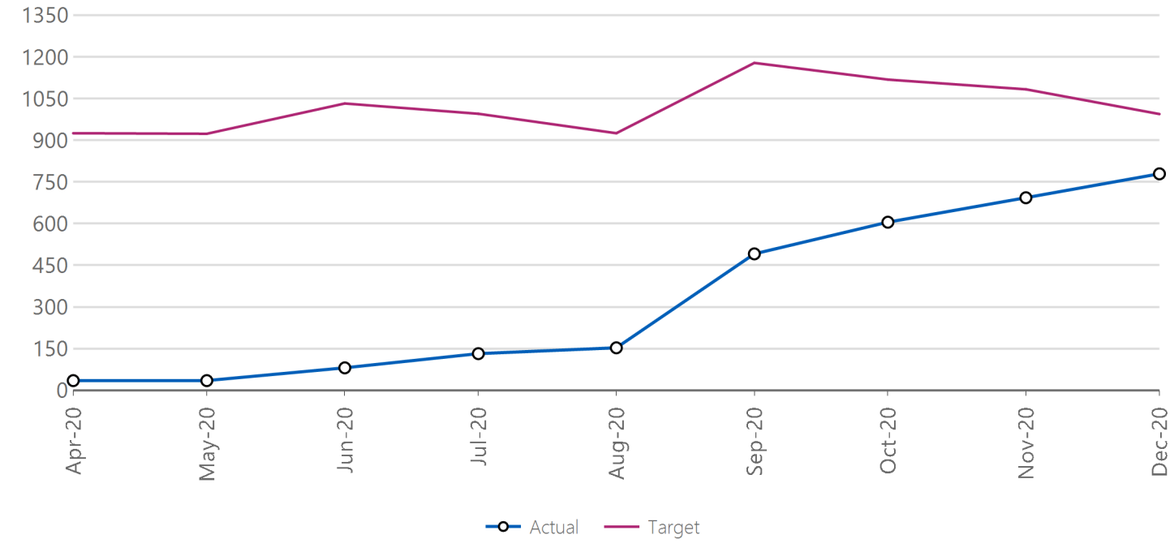
Integrated Performance Report

Narrative

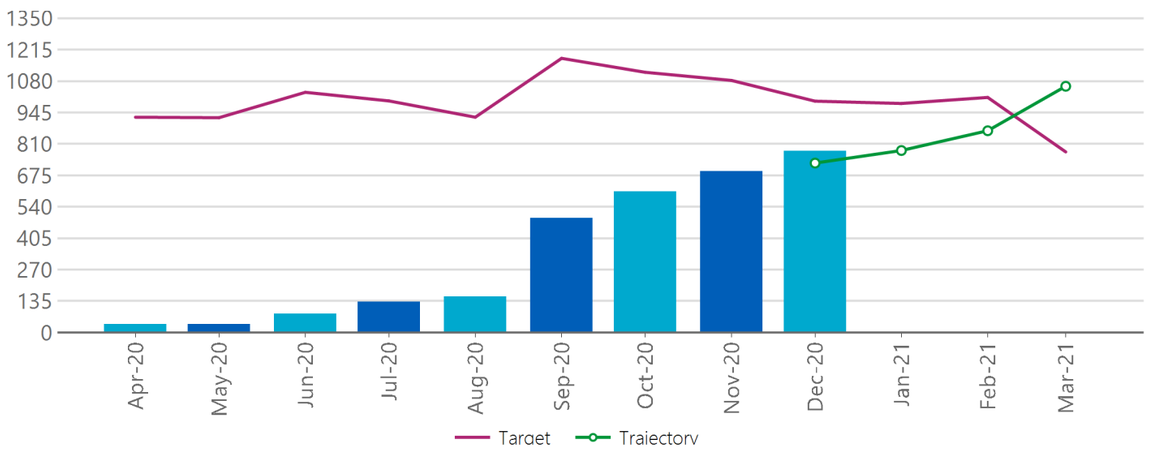
Nationally, Trusts are being monitored against activity levels delivered in 19/20, therefore the 20/21 plans have been updated to monitor against these figures. In November the Trust revised the submitted phase 3 planning figures with revised plans for the months of December to March. These figures are represented as a trajectory in the trajectory graph.

In December the total elective activity undertaken in the Trust was 779; this was 51 spells ahead of the plan of 728. As at 8th January, the forecast for total elective spells against the refreshed January plan is 687; this is 95 behind the plan of 782 for January. This forecast was taken before the Trust's covid-19 system response.

Performance over 24 months –



Trajectory



Actions

Action to Improve: The Trust will continue to review our actions alongside the impact of the covid-19 system response.

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
35	35	81	132	153	491	605	693	779

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

75.84% against **87%** target

Within target red rated

Exec Lead:
MSK Unit

Integrated Performance Report

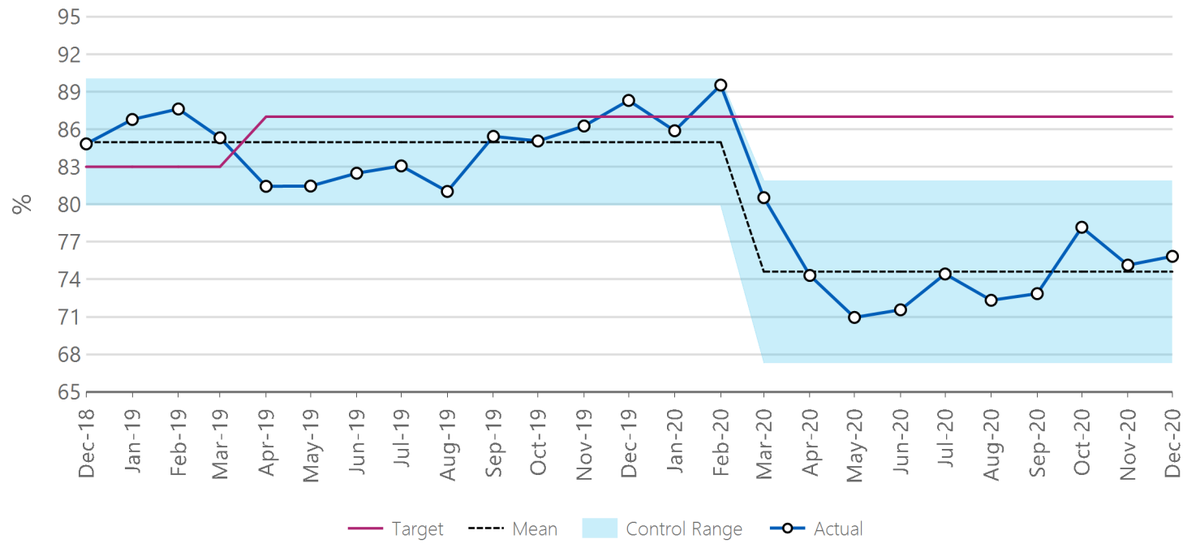
Narrative

The occupancy rate for all wards is red rated this month at 75.84%. The breakdown below gives the December occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:
MSK Unit:
- Clwyd - 82.78% - usually 28 beds; open to 18/20 beds for majority of the month
- Powys - 80.56% - usually 28 beds; open to 18/20 beds, then closed from 24th
- Kenyon - 83.69% - open to usual 16 beds, then closed from 19th
- Ludlow - 42.09% - usually 16 beds; open to 14 beds for majority of the month - used for suspected/confirmed covid patients

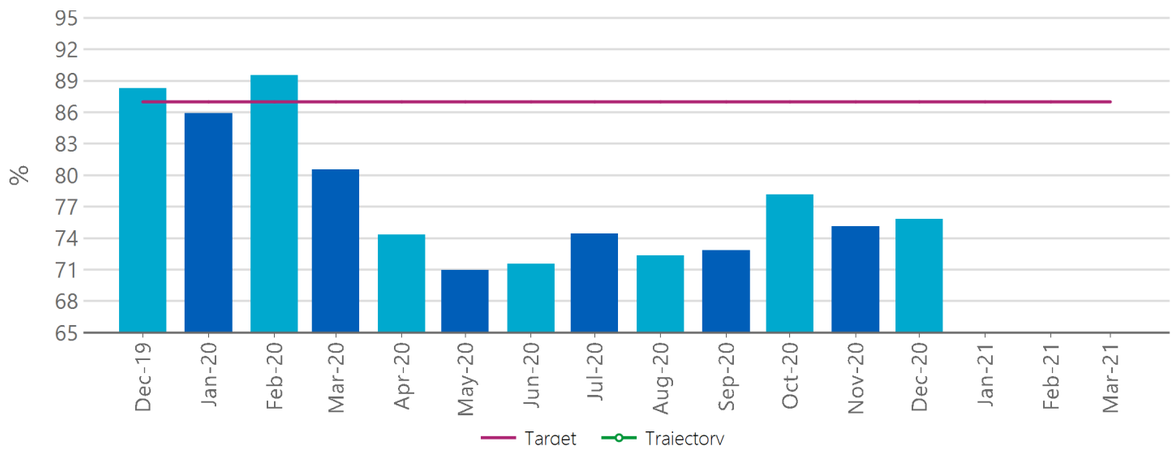
Specialist Unit:
- Alice - 23.33% - open to usual 16 beds, then closed from 23rd
- Oswald - 74.34% - open to usual 10 beds
- Gladstone - 88.99% - open to usual 29 beds
- Wrekin - 96.34% - open to usual 15 beds
- Sheldon - 74.36% - usually 23 beds; open to between 15 and 19 beds throughout month

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: As part of the Trust's covid-19 system response we will need to continually review our availability and utilisation of beds.

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
84.83%	86.78%	87.62%	85.32%	81.44%	81.46%	82.49%	83.07%	81.03%	85.43%	85.06%	86.26%	88.31%	85.88%	89.53%	80.53%	74.31%	70.96%	71.57%	74.43%	72.33%	72.86%	78.17%	75.14%	75.84%	74.06%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (Phase 3), Catchment Based)

10,187 against 12,740 target

Within target red rated

Exec Lead:
Clinical Services Unit

Integrated Performance Report

Narrative

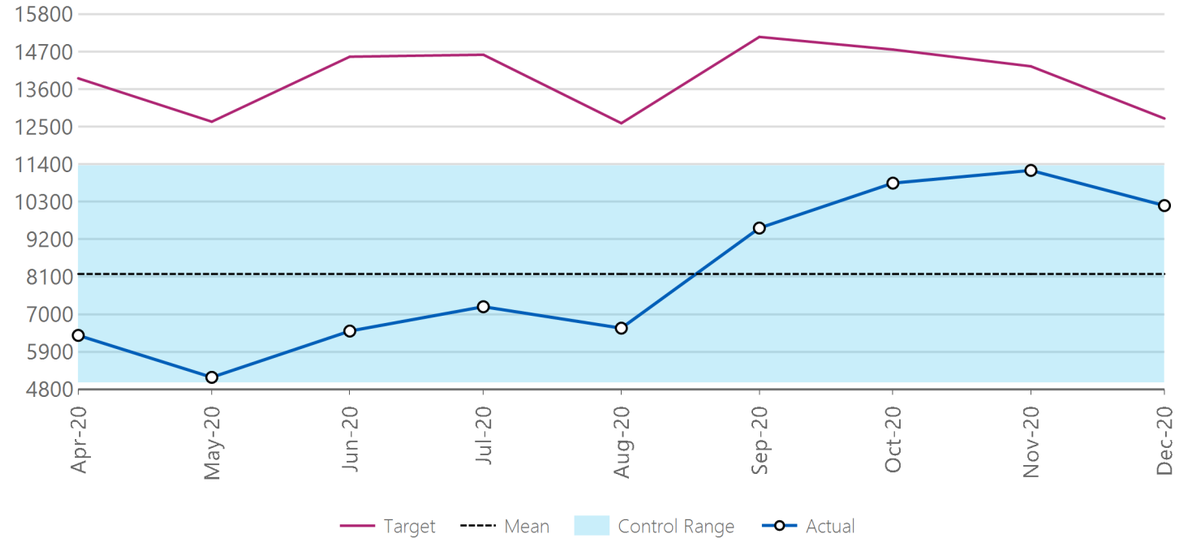
Historically we have reported our Outpatient activity metric from a commissioning perspective whereas it is now appropriate to look at the Total Outpatient Activity that is carried out and that which has been submitted in our phase 3 plans, with the months of December to March representing those figures from our planning refresh in November. This now aligns with the NHS E/I inclusions and exclusions for restoration monitoring, effectively monitoring consultant-led activity. The target for this measure is the 19/20 activity that was delivered with the phase 3 plans included as a trajectory in the trajectory graph.

In December the total Outpatient activity undertaken in the Trust was 10187, 75 cases above our phase 3 plan. As at 8th January (5th working day) there were 392 missing outcomes so once administrative actions are taken with these data entries, the December position will alter and updated figures will be included in the IPR next month. Taking into account the missing outcomes, this would mean that the Outpatient activity for December was 10579, 467 above our phase 3 plan of 10112.

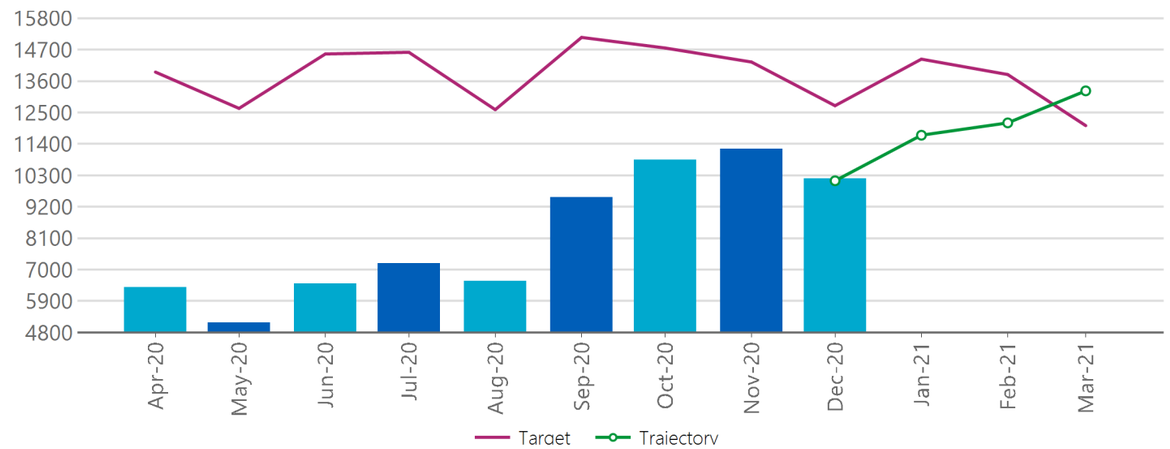
Last month November was reported as 11087, 330 cases behind our phase 3 plan, now with latest data available, as at 8th January, November now reported at 11218, 199 cases behind our phase 3 plan.

As at 8th January, the forecast for January is 9189 against the plan of 11707. This forecast was taken before the Trust's covid-19

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
6,382	5,152	6,508	7,222	6,593	9,528	10,845	11,218	10,187

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Financial Control Total

Surplus/deficit adjusted for donations and excluding STF funding

138 against **124** target

Above target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

Narrative

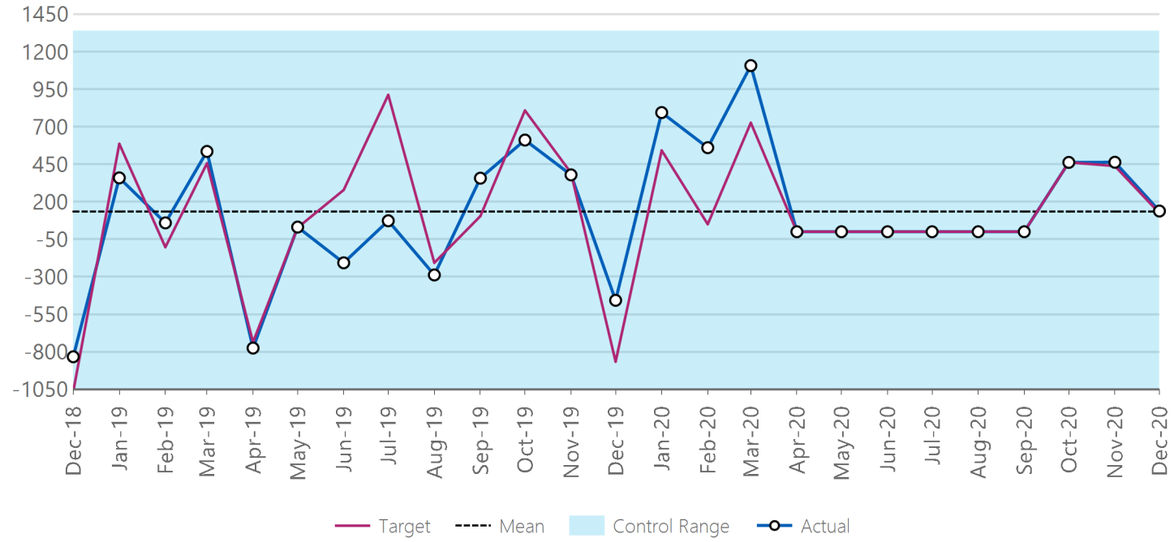
Overall £138k surplus in month, £13k favourable to the revised plan.

YTD £1,060k surplus, £38k favourable to revised plan.

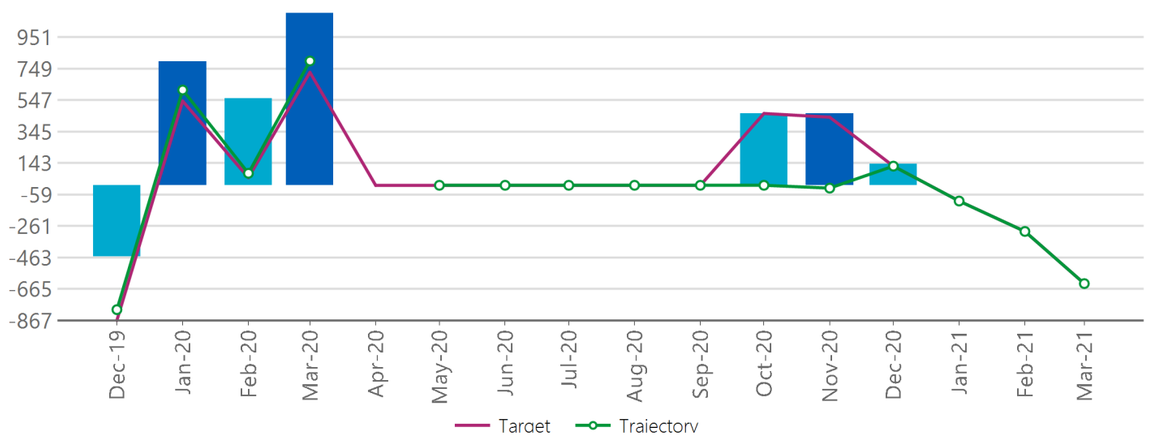
Activity Penalties - separate financial schemes exist for England and Wales tracking delivery of activity against 2019/20 baseline.

- Welsh income risk recognised linked to suspension of elective activity to support local surge response.
- Elective Incentive Scheme (EIS) income risk continues to be excluded as per the latest national guidance (potential cumulative £0.7m impact).

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
-833	359	59	535	-775	31	-207	73	-288	357	611	379	-457	794	560	1,107	0	0	0	0	0	0	462	463	138	1,063

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Income

All Trust Income, Clinical and non clinical

9,138 against **9,626** target

Below target red rated

Exec Lead:
Director of Finance

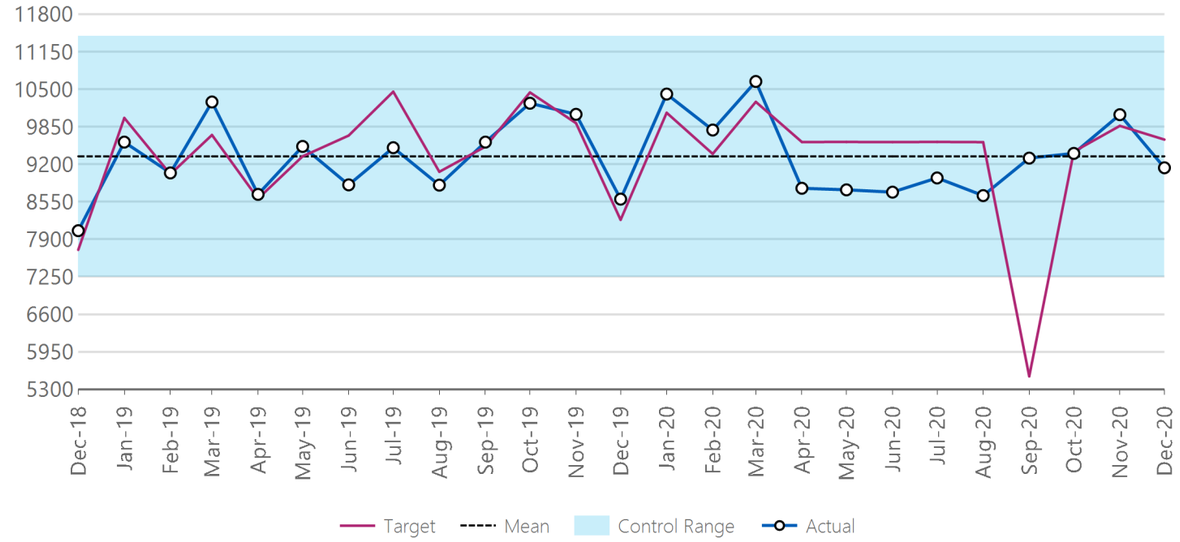
Integrated Performance Report

Narrative

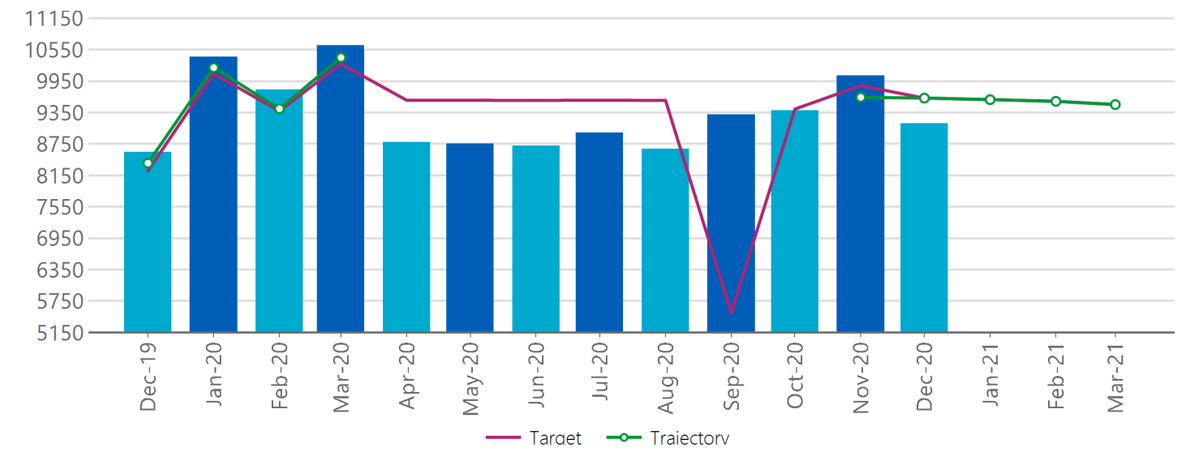
Income £487k adverse in month

- Clinical income adverse due to recognition Welsh income risk linked to suspension of elective activity.
- Private patients favourable

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
8,048	9,583	9,049	10,278	8,677	9,508	8,842	9,486	8,837	9,583	10,256	10,064	8,595	10,415	9,792	10,633	8,783	8,756	8,716	8,962	8,656	9,306	9,387	10,058	9,138	81,762

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Expenditure

All Trust expenditure including Finance Costs

9,045 against **9,547** target

Within target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

Narrative

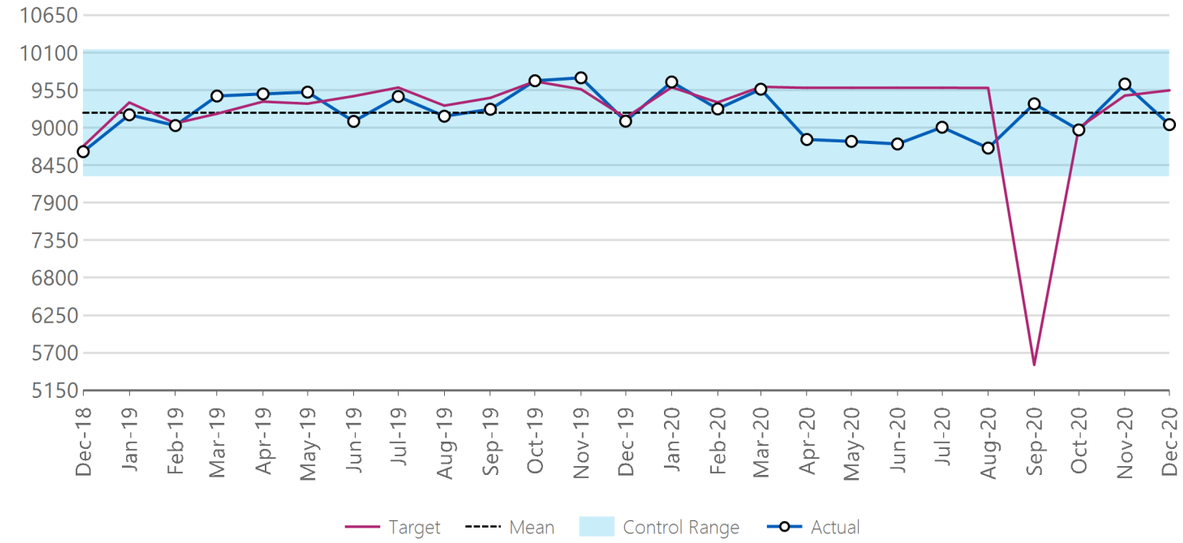
Overall expenditure £502k favourable

Pay £207k favourable:
- Flexible staffing spend reduced and vacancies against establishment

- Non pay £295k favourable
- Casemix favourable
- Covid direct expenditure favourable

Note: expenditure includes £27k Vaccination costs recharged to Shrewsbury and Telford Hospitals

Performance over 24 months – SPC



Trajectory

Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
8,648	9,189	9,031	9,464	9,495	9,521	9,092	9,457	9,168	9,270	9,688	9,731	9,095	9,670	9,275	9,564	8,827	8,799	8,761	9,006	8,701	9,350	8,967	9,640	9,045	81,096

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Efficiencies Delivery

Cost Improvement Programme requirement

137 against 95 target

Above target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

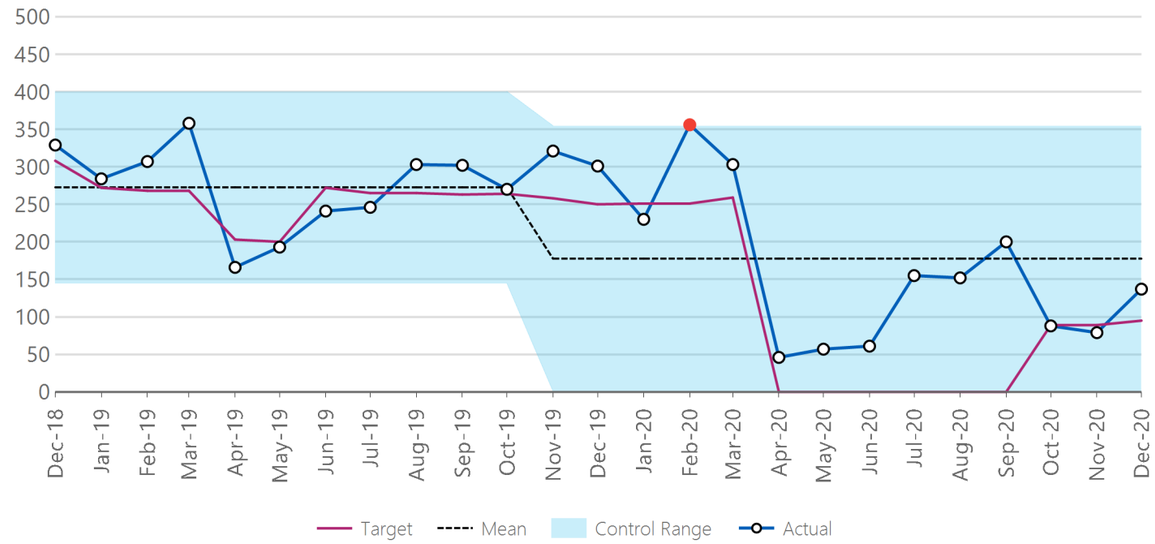
Narrative

Revised phase 3 planning requirements include a 1.4% efficiency expectation (increase from 1% to align with national average).

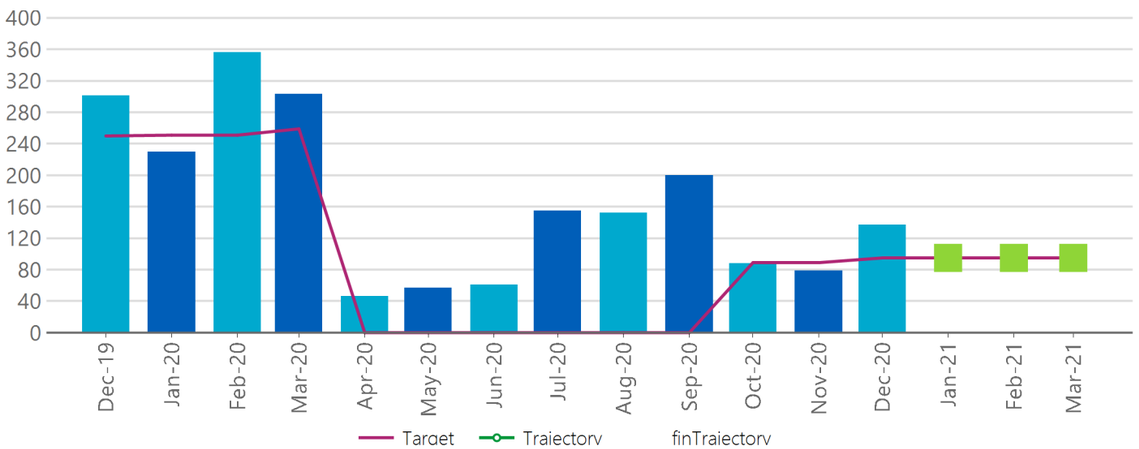
£42k favourable to new target in month.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
329	284	307	358	166	193	241	246	303	302	270	321	301	230	356	303	46	57	61	155	152	200	88	79	137	303

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cash Balance

Cash in bank

19,510 against **15,800** target

Above target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

Narrative

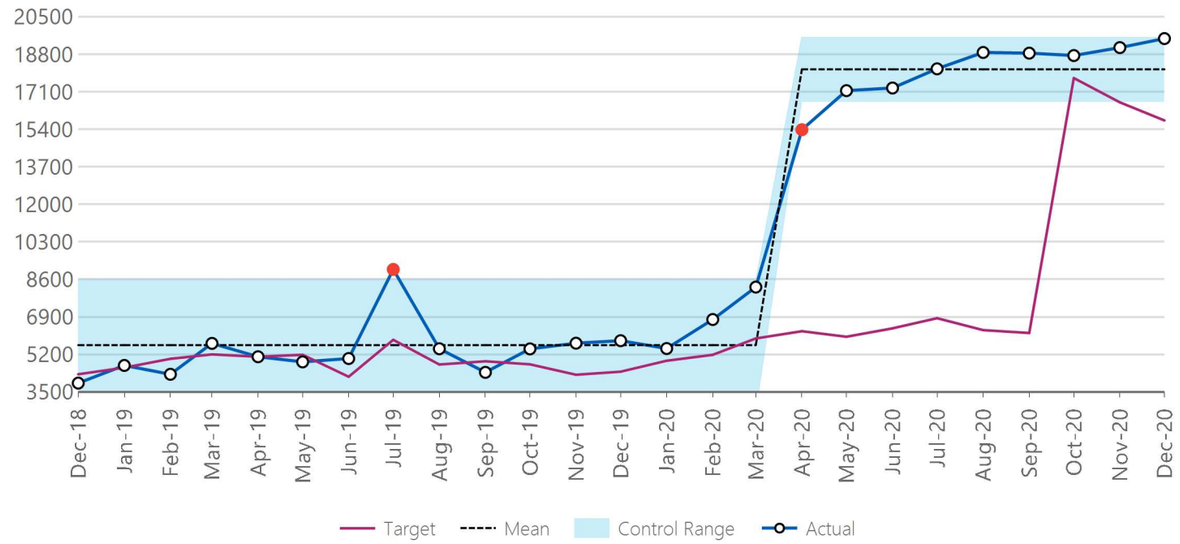
Cash balance of £19.5m, which includes the following payments in advance:

- £5.8m English block income
- £1.1m of Covid top up funding

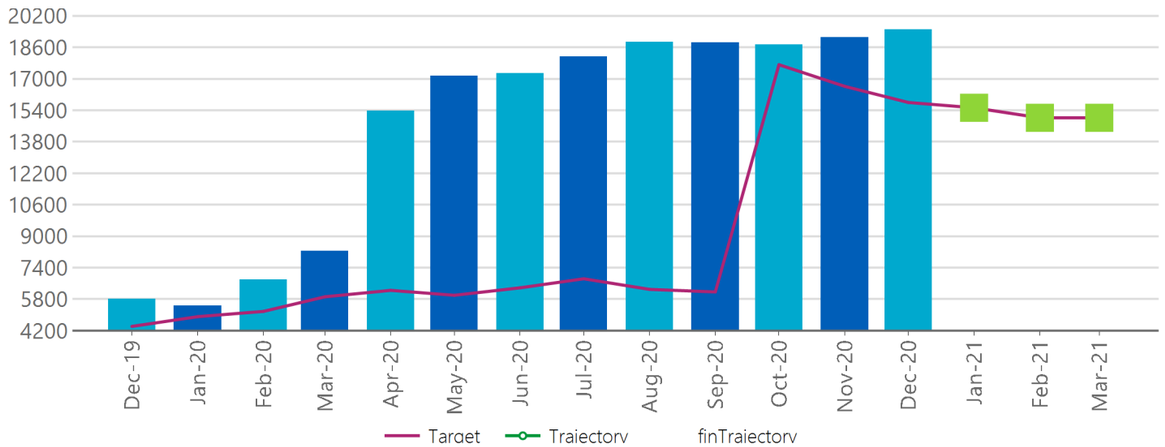
Underlying cash balance £12.6m

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
3,900	4,700	4,300	5,700	5,094	4,861	5,013	9,051	5,457	4,387	5,450	5,708	5,822	5,467	6,781	8,250	15,380	17,150	17,270	18,140	18,880	18,850	18,740	19,100	19,510	19,510

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Capital Expenditure

Expenditure against Trust capital programme

307 against 919 target

Within target green rated

Exec Lead:
Director of Finance

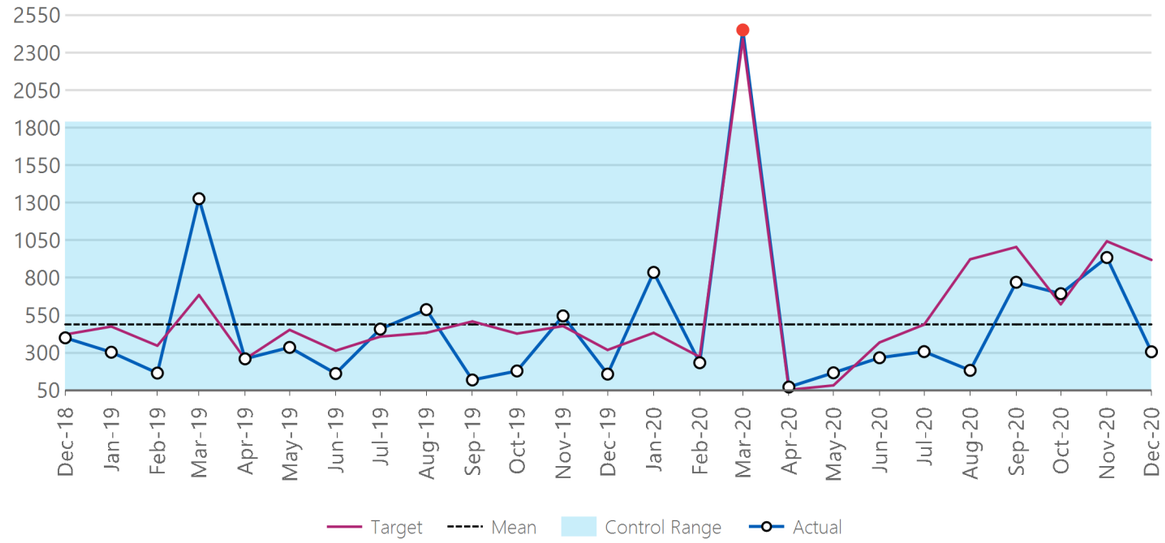
Integrated Performance Report

Narrative

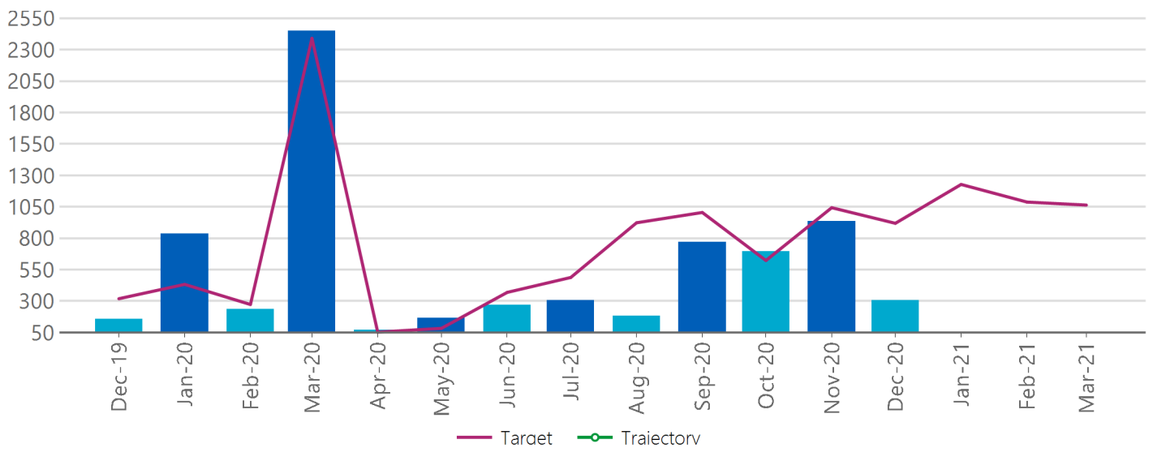
In month £612k favourable to plan.

Year to date £1,803k favourable to plan made up of £538k NHS and £1,264k donated.
- Slippage on NHS schemes forecast at c£1m by 31st March 2021 - largest scheme replacement X-ray rooms to be carried over to 2021/22.
- Slippage on donated linked to Veteran's project which will be carried forward to 21/22.

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
400	304	165	1,327	260	336	162	458	588	119	179	546	158	836	234	2,451	72	167	267	308	183	770	694	935	307	3,703

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Use of Resources (UOR)

Overall Use of Resources indicator

1 against 1 target

On target green rated

Exec Lead:
Director of Finance

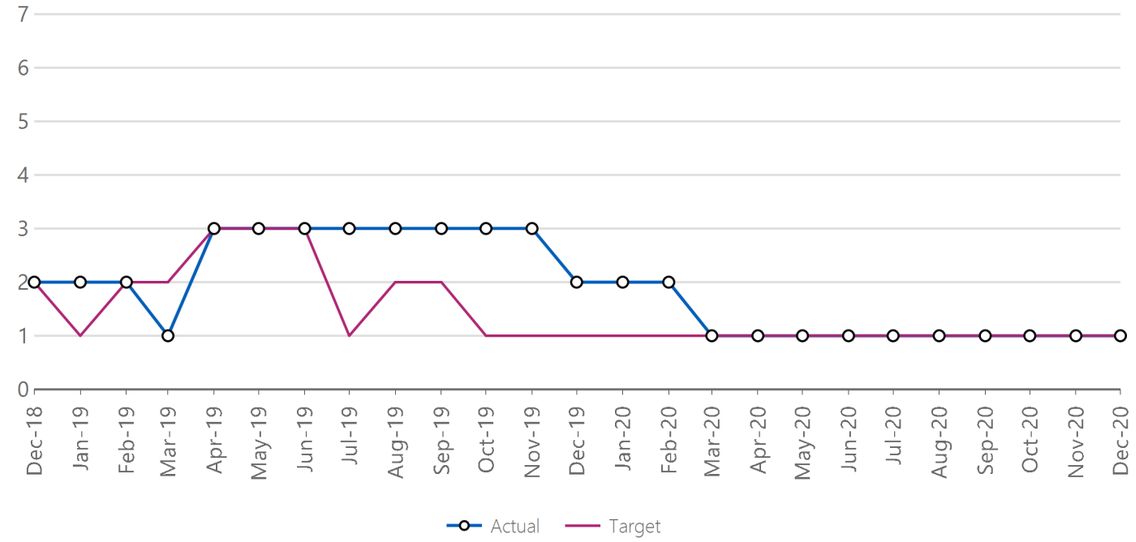
Integrated Performance Report

Narrative

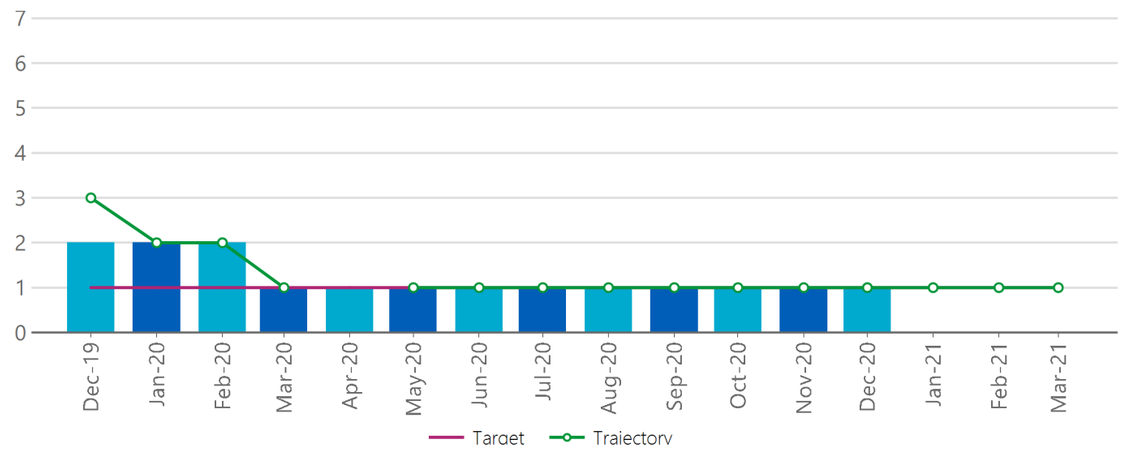
UOR 1 (Best)

Note - No formal UOR plan in place during 20/21, monitoring against historical indicators.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2	2	2	1	3	3	3	3	3	3	3	3	2	2	2	1	1	1	1	1	1	1	1	1	1	1

Integrated Performance Report
December – Month 9

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Reading guide

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

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

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

Key

Key Performance Indicator RAG Ratings

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

KPIs reported in arrears

KPIs reported in arrears, for which no current-month values are available, are marked with an asterisk (*) next to their name. The latest values for these KPIs are from the previous reporting month.

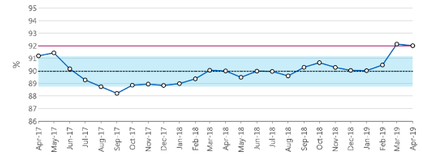
Data Quality Indicator

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

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

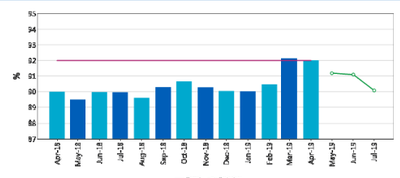
Trend graphs

Each KPI has a trend graph (or Statistical Process Control (SPC) where appropriate), which summarises performance over a rolling 24-month period.



Trajectories

Where available, three-month trajectory data is included to indicate expected future performance. Historical trajectory data will be kept to compare actual performance with forecast performance.



Bullet graphs

Bullet graphs provide a clear visualisation to understand how well a KPI is performing against its target.

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st December 2020

Income and Expenditure £'000s

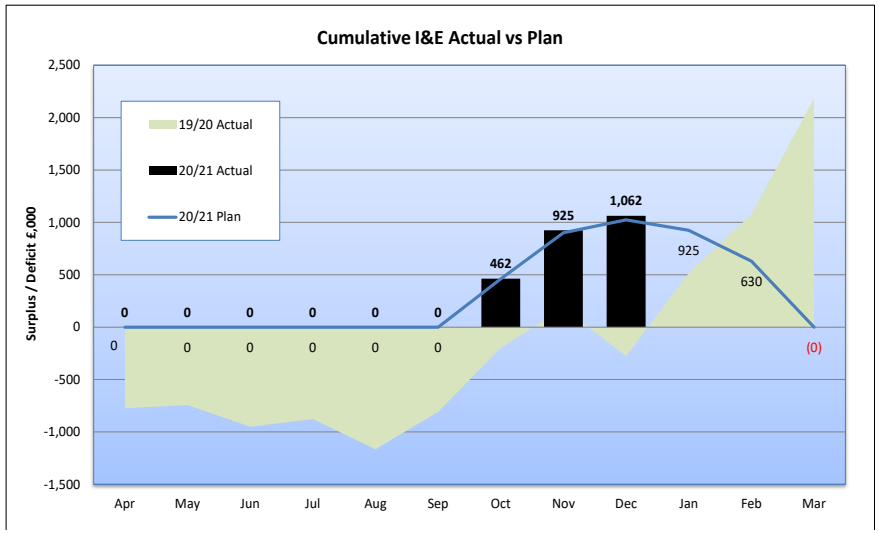
Category	Annual Plan	In Month Position			Year To Date Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	97,326	8,013	7,411	(602)	73,287	72,790	(497)
System Discretionary Funding	980	127	127	(0)	598	597	(1)
System Top Up Funding	2,560	427	427	0	1,280	1,280	0
Covid-19 Funding	1,452	242	242	0	726	726	0
Private Patient income	1,880	286	387	100	934	1,064	130
Other income	6,552	530	545	14	5,261	5,303	42
Pay	(67,678)	(5,671)	(5,464)	207	(50,337)	(49,965)	372
Non-pay	(38,083)	(3,431)	(3,121)	310	(26,936)	(26,671)	265
EBITDA	4,989	524	554	29	4,813	5,124	311
Finance Costs	(5,520)	(445)	(460)	(15)	(4,186)	(4,461)	(275)
Capital Donations	1,170	100	0	(100)	415	123	(292)
Operational Surplus	639	179	93	(86)	1,042	787	(255)
Remove Capital Donations	(1,170)	(100)	0	100	(415)	(123)	292
Add Back Donated Dep'n	531	45	44	(1)	398	400	1
Control Total*	0	124	138	13	1,025	1,063	38
EBITDA margin	4.7%	5.9%	6.5%	0.7%	6.0%	6.4%	0.4%

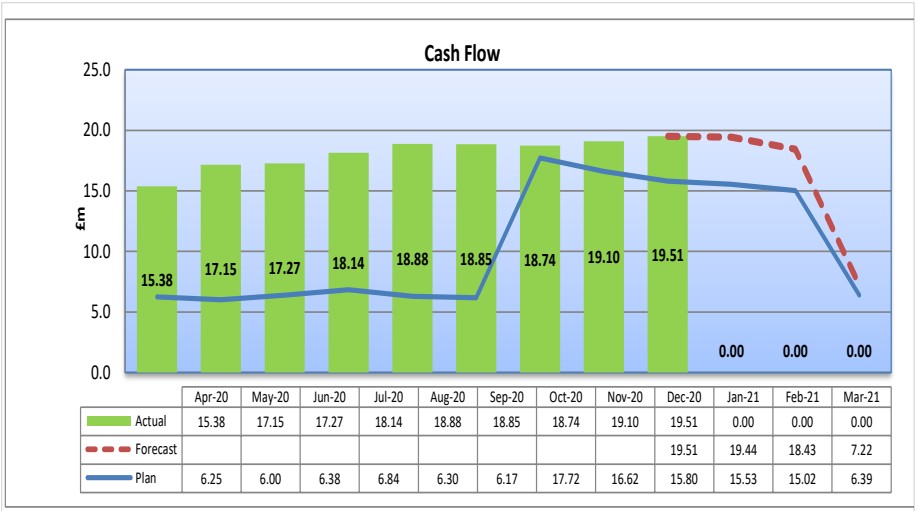
Capital service	1	I&E Margin	1
Liquidity (days)	1	Variance in I&E Margin	1
Agency	1		
Overall UOR			1

	YTD
Debtor Days	16
Creditor Days	35

Statement of Financial Position £'000s

Category	Nov-20	Dec-20	Movement	Drivers
Fixed Assets	76,643	76,602	(41)	
Non current receivables	983	1,179	196	Injury Cost Recovery notifications increase
Total Non Current Assets	77,626	77,781	155	
Inventories (Stocks)	1,275	1,204	(71)	
Receivables (Debtors)	6,097	4,661	(1,436)	Education (HEE) invoices paid
Cash at Bank and in hand	19,097	19,511	414	
Total Current Assets	26,469	25,376	(1,093)	
Payables (Creditors)	(20,508)	(19,474)	1,034	Repayment of April top up to NHSI/E not required (relating to M1 - M6 financial regime)
Borrowings	(1,326)	(1,335)	(9)	Interest payable accrual
Current Provisions	(199)	(194)	5	
Total Current Liabilities (< 1 year)	(22,033)	(21,003)	1,030	
Total Assets less Current Liabilities	82,062	82,154	92	
Non Current Borrowings	(5,058)	(5,058)	0	
Non Current Provisions	(958)	(958)	0	
Non Current Liabilities (> 1 year)	(6,016)	(6,016)	0	
Total Assets Employed	76,046	76,138	92	
Public Dividend Capital	(35,486)	(35,486)	0	
Revenue Position	(17,703)	(17,703)	0	
Retained Earnings	(694)	(786)	(92)	Current period surplus
Revaluation Reserve	(22,163)	(22,163)	0	
Total Taxpayers Equity	(76,046)	(76,138)	(92)	





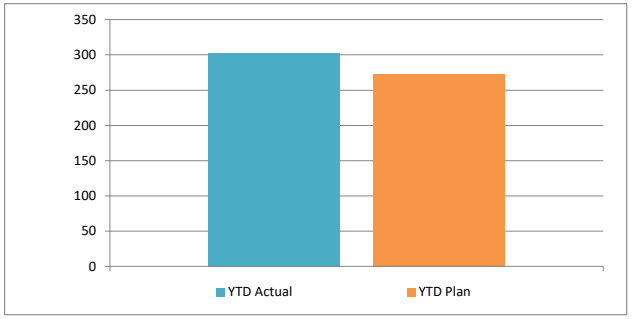
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	15.38	17.15	17.27	18.14	18.88	18.85	18.74	19.10	19.51	0.00	0.00	0.00
Forecast									19.51	19.44	18.43	7.22
Plan	6.25	6.00	6.38	6.84	6.30	6.17	17.72	16.62	15.80	15.53	15.02	6.39

Note: Assumes April 2021 blocks will not be prepaid in March 2021.

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st December 2020

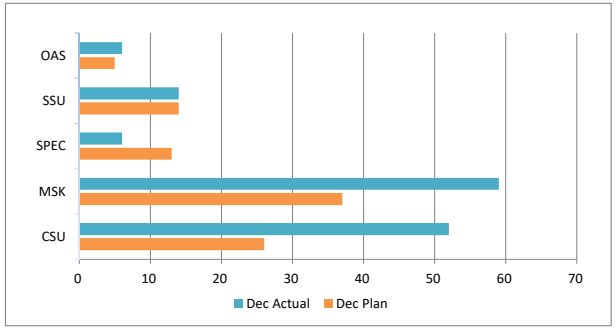
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's

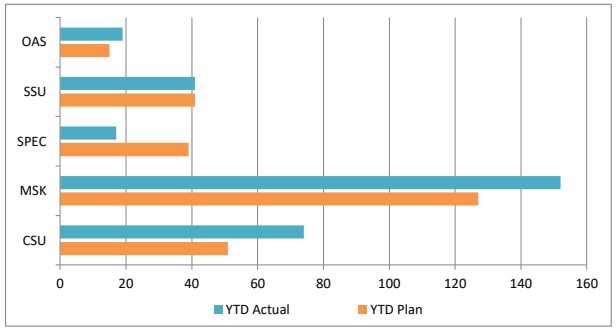


Efficiencies by Theme

In Month Efficiencies Achievement £000's



Year To Date Efficiencies Achievement £000's



Capital

Position as at	2021-09	Capital Programme 2020-21				
Project	Annual Plan £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s	Forecast Variance £000s
Diagnostic equipment replacement	1,545	945	1,071	-126	1,422	-123
EPR planning & implementation	200	90	0	90	0	-200
Backlog maintenance (System CIR)	500	370	385	-15	500	0
I/T investment & replacement	295	235	207	29	380	85
Equipment & service continuity	600	400	340	60	591	-9
Project management	50	25	32	-7	59	9
Scheme slippage from 19/20	135	135	79	56	86	-49
Salix energy improvements	1,210	1,080	1,085	-5	1,210	0
E-job planning	86	86	51	35	86	0
Covid-19	0	0	36	-36	36	36
Contingency	1,165	565	27	538	293	-872
Restoration Schemes (System CIR)	0	0	82	-82	82	82
NHS Capital Funding	5,786	3,931	3,393	538	4,745	-1,041
Veteran's facility	3,000	1,500	187	1,313	300	-2,700
Donated medical equipment	100	75	124	-49	170	70
Total Capital Funding (NHS & Donated)	8,886	5,506	3,703	1,803	5,215	-3,671

Forecast

Category	Forecast		
	Plan	Actual	Variance
Clinical Income	97,326	96,538	(788)
System Discretionary Funding	980	479	(501)
System Top Up Funding	2,560	2,560	0
Covid-19 Funding	1,452	1,452	0
Private Patient income	1,880	1,299	(581)
Other income	6,552	7,144	592
Pay	(67,678)	(67,677)	1
Non-pay	(38,083)	(36,487)	1,596
EBITDA	4,989	5,308	319
Finance Costs	(5,520)	(5,840)	(320)
Capital Donations	1,170	878	(292)
Operational Surplus	639	346	(292)
Remove Capital Donations	(1,170)	(878)	292
Add Back Donated Dep'n	531	533	1
Control Total	0	0	0

Forecast Assumptions

Continuation of Welsh income penalties at current run rate of £0.4m per month.

No reduction in English income associated with the transaction of the Elective Incentive scheme.

Reduction in the run rate for Non NHS income in Quarter 4 attributable to the COVID response.

Reduced cost base versus plan linked to the marginal cost of reduced activity attributable to the COVID response.

Recognition of expected annual leave accrual requirement by year end

Vaccination costs incurred are fully recharged

Covid expenditure remains at current run rate

Improvement in forecast offset against system discretionary support income to maintain break-even

Operational Planning 21/22

0. Reference Information

Author:	Kerry Robinson	Paper date:	28/01/2021
Executive Sponsor:	Kerry Robinson	Paper Category:	Planning
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 Board of Directors and what input is required?

The attached correspondence was published 23rd December 2020 in relation to operational planning for the remainder of the year and 2021/22. The Board are asked to note this correspondence together with recent information received via webinar from NHSEI.

2. Executive Summary

2.1. Context

The attached correspondence was published 23rd December 2020 in relation to operational planning for the remainder of the year and 2021/22.

Subsequently, due to increasing covid pressures National guidance has informed that there will be no planning requirement in the last quarter of this financial year. It is anticipated that 2021/22 planning guidance will be published end of March/early April for Q2 to Q4, therefore a rollover of current plans for Q1 is expected, but will remain under review.

2.2. Summary

The correspondence sets out the focus for the remainder of this financial year together with expectations for the future.

In summary;

Responding to covid demand;

- Remain in level 4 incident at least until the end of the financial year.
- Mobilise surge capacity.
- Maximise use of the independent sector.
- Provide mutual aid
- Make use of specialist hospitals and hubs to protect cancer and urgent elective activity.
- Support staff in flexible redeployment

Implement vaccination programme;

- Critical vaccinations take place in line with JCVI guidance
- Minimise wastage, ensure unfilled appointment slots are used to vaccinate healthcare workers in an equitable manner.
- Ready to mobilise additional vaccination sites.

Maximise capacity;

- Use of independent sector
- Ockendon review.

Emergency demand and winter pressures;

- Flu vaccination programme

Planning 2021/22;

- Recover non-covid services
- Maximise recovery with top quartile performance in productivity on high volume clinical pathways,
- Board level executive lead per Trust and per system for elective recovery
- Grow the workforce; improve EDI, access to health and wellbeing support
- Address health inequalities; reduce variation in outcomes
- Effective partnership working at place and system level
- Introduction of a minimum shared care record in all system by Sept 21

2021/22 Financial framework;

- Funding distributed at system level
- Baseline contract values in line with funding envelope
- Plan to reduce and eliminate covid costs
- System capital envelopes
- Further detail in future on non-recurrent funding of elective recovery

2.3. Conclusion

The Board of Directors is asked to ***note*** the correspondence aligned to current actions taking place.

Skipton House
80 London Road
London
SE1 6LH

23 December 2020

To:
- STP and ICS Leaders
- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers
- GP practices and Primary Care Networks
- Providers of community health services
- NHS 111 providers

CC:
- NHS Regional Directors
- Regional Incident Directors & Heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of adult social care
- Chairs of Local Resilience Forums

Dear colleague

Important – for action – Operational priorities for winter and 2021/22

As we near the end of this year, we are writing to thank you and your teams for the way you have responded to the extraordinary challenge of Covid-19 and set out the key priorities for the next phase.

An extraordinary 2020

In the past year we have cared for more than 200,000 of those most seriously ill with Covid-19 in our hospitals. At the same time NHS staff have also worked incredibly hard to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and restore non-urgent services that had to be paused. Community nurses, pharmacists, NHS 111 staff and other NHS workers have cared for countless others, and been supported by the wider NHS team, from HR and finance to admin and clerical staff. The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year. And we have had a record number of people vaccinated against flu, including a higher percentage of NHS staff than in the last three years. It has been an incredible team effort across our health and care system.

The response to the pandemic has also demonstrated our health service's enormous capacity for innovation with rapid development and implementation of new treatments, such as dexamethasone, rolling out of pulse oximetry and at-home patient self-monitoring, and the move to virtual and telephone consultations. We are already in the third week of our world-leading vaccination programme – the largest in NHS history.

We know that this relentless pressure has taken a toll on our people. Staff have gone the extra mile again and again. But we have lost colleagues as well as family and friends to the virus; others have been seriously unwell and some continue to

experience long-term health effects. The response of the NHS to this unprecedented event has been magnificent. We thank you and your teams unreservedly for everything that you have given and achieved and the support you continue to give each other.

You have asked us for a short statement of operational priorities going forward. This letter is therefore intended to help you and your staff over the next few months by:

- ensuring we have a collective view of the critical actions for the remainder of this financial year, and
- signalling the areas that we already know will be important in 2021/22.

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS. Our task is five-fold:

A. Responding to Covid-19 demand
B. Pulling out all the stops to implement the Covid-19 vaccination programme
C. Maximising capacity in all settings to treat non-Covid-19 patients
D. Responding to other emergency demand and managing winter pressures
E. Supporting the health and wellbeing of our workforce

In addition, as the UK approaches the end of the transition period with the European Union on 31 December 2020, we will provide updates as soon as the consequences for the NHS become known. We are following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. All CCGs and NHS trusts should have an SRO to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for Covid-19, EU transition and winter.

A. Responding to ongoing Covid-19 demand

With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.

All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

B. Implementing the Covid-19 vaccination programme

On 8 December, after the MHRA confirmed the Pfizer BioNTech vaccine was safe and effective, the biggest and most ambitious vaccine campaign in NHS history began.

The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.

If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine.

C. Maximising capacity in all settings to treat non-Covid-19 patients

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.

To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.

The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

D. Responding to emergency demand and managing winter pressures

Alongside providing £80m in new funding to support winter workforce pressures, we are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We know that maximising capacity over the coming weeks and months is essential to respond to seasonal pressures. We are asking all systems to improve performance on timely and safe discharge, as set out in today's letter, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data.

- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS).

- To minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services in your locality, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.

- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

E. Supporting the health and wellbeing of our workforce

Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

Planning for 2021/22

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

In the meantime, systems should continue to:

- **Recover non-covid services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of

how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

- Strengthen delivery of local **People Plans**, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.

- Address the **health inequalities** that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.

- Accelerate the planned expansion in **mental health** services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.

- Prioritise investment in **primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.

- Build on the development of effective **partnership working at place and system level**. Plans are set out in our Integrating Care document.

These priorities should be supported through the use of data and digital technologies, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

The 2021/22 financial framework

For the reasons set out above, we won't know the full financial settlement for the NHS until much closer to the beginning of the new financial year, reflecting, in particular, uncertainty over direct Covid-19 costs. We will, however, need to start work early in the new year to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:

- Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would

have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

- Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.
- Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.
- **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

We will aim to circulate underlying financial numbers early in the new year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

Conclusion

This year has arguably been the most challenging in the NHS's 72-year history. But even in these most testing times, people across the service have responded with passion, resilience and flexibility to deal with not only the virus but also the needs of patients without Covid-19. The rollout of the vaccine will bring hope to 2021 and we will need to maintain the energy and effort to meet the needs of all we serve throughout the year. Thank you for all that you have done and continue to do to achieve this.

With best wishes,

Amanda Pritchard
Chief Executive, NHS Improvement and
NHS Chief Operating Officer

Julian Kelly
NHS Chief Financial Officer

Review of Standing Financial Instructions & Scheme of Delegation

0. Reference Information

Author:	Diana Owen, Head of Financial Accounting	Paper date:	28 January 2021
Executive Sponsor:	Craig Macbeth, Chief Finance Officer	Paper Category:	Governance / Performance
Paper Reviewed by:	Audit Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2. Summary

Both documents have been reviewed. No changes to the SFIs are proposed. There are 2 minor changes proposed to the Scheme of Delegation, both relating to changes in job titles:

- Change "Director of People" to "Chief People Officer"
- Change "Medical Director" to "Chief Medical Officer".

Note that there was a comprehensive review of the Scheme of Delegation last year when the new Trust structure was implemented.

The proposed amendments and revised policies were reviewed by the Audit Committee at its meeting on 11 January 2021 and recommended for approval.

Both documents are attached for information.

2.3. Conclusion

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Standing Financial Instructions		
Unique Identifier:	POL028	**Document Type:**	Policy
Version Number:	8.0	**Status:**	Draft
Responsible Director:	Craig Macbeth, Chief Finance Officer		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Trust wide		
Replaces:	Version 7.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Scheme of Delegation Matters Reserved to the Board		
Keywords:	SFI, SFIs, Standing Financial Instructions, Scheme of Delegation		

Considered By Executive Owner:	Craig Macbeth, Chief Finance Officer	**Date Considered:**	15/12/2020
Endorsed By:	Audit Committee	**Date Endorsed**	11/01/2021
Approved By:	Trust Board	**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Friendly · Caring · Excellence · Professional · Respect

Trust Values

Standing Financial Instructions

1. Contents

2. Introduction

2.1 General

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

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

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

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

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

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

2.2 Terminology

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

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

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

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

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

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

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

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

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

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

"Chief Finance Officer" means the chief financial officer of the Trust;

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

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

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

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

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

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

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

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

2.3 Responsibilities & Delegation

2.3.1 The Trust Board exercises financial supervision and control by:

(a) Formulating the financial strategy;

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

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

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

(e) Receiving regular reports on financial performance

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

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

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

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

2.3.6 The Chief Finance Officer is responsible for:

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

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

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

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

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

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

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

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

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

(b) Avoiding loss;

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

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

(e) Maintaining effective risk management arrangements.

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

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

3. Audit

3.1 Audit Committee

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

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

In particular, the Committee will review the adequacy of:

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

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

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

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

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

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

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

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

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

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

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

3.2 Chief Finance Officer

3.2.1 The Chief Finance Officer is responsible for:

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

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

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

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

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

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

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

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

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

(d) Explanations concerning any matter under investigation.

3.3 Role of Internal Audit

3.3.1 Internal Audit will review, appraise and report upon:

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

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

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

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

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

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

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

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

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

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

3.4 External Audit

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

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

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

3.5 Fraud & Corruption

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

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

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

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

3.6 Security Management

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

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

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

4. Business Planning, Budgets, Budgetary Control & Monitoring

4.1 Preparation & Approval of Plans & Budgets

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

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

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

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

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

(b) accord with workload and manpower plans;

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

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

(e) identify potential risks.

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

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

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

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

4.2 Budgetary Delegation

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

(a) The amount of the budget;

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

(c) Individual and group responsibilities;

(d) Achievement of planned levels of service;

(e) The provision of regular reports.

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

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

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

4.3 Budgetary Control & Reporting

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

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

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

(ii) Movements in working capital;

(iii) Movements in cash and capital;

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

(v) Explanations of any material variances from plan;

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

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

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

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

(e) Arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

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

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

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

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

4.4 Capital Expenditure

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

4.5 Monitoring Returns

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

5. Annual Accounts & Reports

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

5.2 The Chief Executive will direct the Chief Finance Officer to:

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

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

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

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

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

6. Bank & Government Banking Service Accounts

6.1 General

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

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

6.2 Bank & Government Banking Service Accounts

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

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

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

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

6.3 Banking Arrangements

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

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

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

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

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

6.4 Tendering & Review

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

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

7.1 Income Systems

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

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

7.2 Fees & Charges

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

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

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

7.3 Debt Recovery

7.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

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

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

7.4 Security of Cash, Cheques & other Negotiable Instruments

7.4.1 The Chief Finance Officer is responsible for:

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

(b) Ordering and securely controlling any such stationery;

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

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

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

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

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

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

8. Tendering & Contracting Procedure

8.1 General

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

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

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

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

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

8.2 Formal Procurement Procedures (Competitive Tenders & Quotations)

8.2.1 General Applicability

The Trust shall ensure that competitive tenders and quotations are invited for:

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

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

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

(d) for disposals.

8.2.2 Exceptions and instances where formal procurement procedures need not be applied

Formal procurement procedures (competitive tenders and quotations) need not be applied where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed the lower limit laid down in the Scheme of Delegation (currently £15,000); it is a breach of SFIs to split contracts to avoid these thresholds;

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

Competitive tenders and quotations may be waived in the following circumstances:

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

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

(e) Where contracts have been awarded for the benefit of Public Sector Bodies, to which the Trust is entitled to access (e.g. framework contracts);

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

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

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

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

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

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

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

8.2.3 Where it is decided that formal procurement procedures are not applicable and competitive tenders or quotations should be waived

The fact of the waiver and the reasons should be documented on a "Competition Waiver Form" (available from Procurement or from the Trust intranet), authorised by the Chief Finance Officer and/or Chief Executive, and forwarded to Procurement for final approval by the Head of Procurement or their deputy.

All waivers must be reported to the next Audit Committee meeting.

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

8.3 Contracting/Tendering Procedure

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

8.3.1 Invitation to tender

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

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

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

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

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

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

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

8.3.2 Receipt and safe custody of tenders

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

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

8.3.3 Opening tenders and register of tenders (paper tenders)

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

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

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

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

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

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

(iii) The date the tenders were opened;

(iv) The persons present at the opening;

(v) The price shown on each tender;

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

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

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

8.3.4 Opening tenders and register of tenders (electronic tenders)

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

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

8.3.5 Admissibility

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

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

8.3.6 Late tenders

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

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

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

8.3.7 Acceptance of formal tenders

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

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

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

(i) Experience and qualifications of team members;

(ii) Understanding of client's needs;

(iii) Feasibility and credibility of proposed approach;

(iv) Ability to complete the project on time.

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

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

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

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

(ii) That best value for money was achieved.

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

8.3.8 Tender reports to the Trust Board

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

8.3.9 Approved firms

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

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

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

8.4 Quotations: Competitive and Non-Competitive

8.4.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £15,000 but not exceed £49,999. This is for expenditure where more than one supplier is generally available and excludes:

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

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

8.4.2 Competitive Quotations

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

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

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

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

8.4.3 Non-Competitive Quotations

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

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

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

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

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

8.5 Authorisation of Competitive Tenders and Quotations

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

Quotations	
Designated budget holders	Up to £2,499
Operational Delivery Lead / Service Lead	Up to £9,999
Non-Board Directors	Up to £19,999
Board Director / Managing Director / Operational Director of Finance	Up to £49,999
Tenders	
2 Executive Directors	Up to £249,999
Trust Board	Over £250,000

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

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

8.6 Where Formal Competitive Tendering/Competitive Quotation is not required

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

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

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

8.7 Significant & Material Transactions

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

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

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

8.8 Compliance Requirements for all Contracts

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

(a) The Trust's Constitution and SFIs;

(b) EU Directives and other statutory provisions;

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

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

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

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

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

8.9 Agency or Temporary Staff Contracts

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

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

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

8.11 Disposals (see overlap with SFI No. 15)

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

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

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

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

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

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

8.12 In-House Services

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

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

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

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

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

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

8.12.4 The evaluation team shall make recommendations to the Board.

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

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

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

9. Contracts for the Provision of Healthcare Services

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

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

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

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

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

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

10.1 Remuneration & Terms of Service

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

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

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

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

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

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

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

10.2 Funded Establishment

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

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

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

10.3 Staff Appointments

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

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

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

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

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

10.4 Processing Payroll

10.4.1 The Chief Finance Officer is responsible for:

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

(b) The final determination of pay and allowances;

(c) Making payment on agreed dates;

(d) Agreeing method of payment.

10.4.2 The Chief Finance Officer will issue instructions regarding:

(a) Verification and documentation of data;

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

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

(d) Security and confidentiality of payroll information;

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

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

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

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

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

(j) Pay advances and their recovery;

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

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

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

10.4.3 Appropriately nominated managers have delegated responsibility for:

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

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

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

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

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

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

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

11. Non-Pay Expenditure

11.1 Delegation of Authority

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

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

11.1.3 The Chief Executive will set out:

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

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

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

11.2 Ordering, Receipt and Payment for Goods and Services

11.2.1 Requisitioning

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

11.2.2 System of Payment and Payment Verification

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

The Chief Finance Officer will:

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

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

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

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

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

(ii) Certification that:

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

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

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

- The account is arithmetically correct;

- The account is in order for payment.

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

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

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

11.2.3 Prepayments

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

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

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

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

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

11.2.4 Official orders

Official Orders must:

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

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

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

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

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

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

11.2.5 Duties of Managers and Officers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.2.6 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within ESTATECODE or CONCODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

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

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

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

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

12. Financial Framework

12.1 External Borrowing

12.1.1 The Chief Finance Officer will advise the Board concerning the ability of the Trust to pay interest and make repayments on any proposed new borrowing. The Chief Finance Officer

is also responsible for reporting periodically to the Board concerning any loans or overdrafts.

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

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

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

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

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

12.2 Investments

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

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

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

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

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

13.1 Capital Investment

13.1.1 The Chief Executive:

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

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

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

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

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

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

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

(iii) Appropriate project management and control arrangements.

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

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

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

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

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

(a) Specific authority to commit expenditure;

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

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

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

13.2 Private Finance (including Leasing)

13.2.1 When the Trust proposes to use private finance or leasing the following procedures shall apply:

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

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

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

13.3 Asset Registers

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

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

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

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

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

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

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

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

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

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

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

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

13.4 Security of Assets

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

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

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

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

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

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

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

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

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

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

14. Stores & Receipt of Goods

14.1 General

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

(a) Kept to a minimum;

(b) Subjected to annual stock take;

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

14.2 Control of Stores, Stocktaking, Condemnations & Disposals

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

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

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

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

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

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

14.3 Receipt of Goods

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

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

15. Disposals & Condemnations, Losses & Special Payments

15.1 Disposals & Condemnations

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

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

15.1.3 All unserviceable articles shall be:

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

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

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

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

15.2 Losses & Special Payments

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

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

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

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

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

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

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

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

16. Information Technology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Patient's Property

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

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

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

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

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

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

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

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

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

18. Funds Held on Trust

18.1 Corporate Trustee

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

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

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

18.2 Accountability to Charity Commission & Secretary of State for Health

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

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

18.3 Applicability of Standing Financial Instructions to Funds Held on Trust

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

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

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

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

20. Retention of Records

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

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

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

21. Risk Management & Insurance

21.1 Programme of Risk Management

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

21.1.2 The programme of risk management shall include:

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

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

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

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

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

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

(g) Arrangements to review the Risk Management programme.

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

21.2 Insurance: Risk Pooling Schemes Administered by NHS Resolution

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

21.3 Insurance Arrangements with Commercial Insurers

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

21.4 Board Arrangements to be Followed in Agreeing Insurance Cover

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

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

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

Policy Review

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

This policy will be reviewed every year.

Policy updated: January 2021
Next review due by: January 2022

Record of Amendments

Date	Section number	Amendments
Mar 2018	Various	Minor amendments & clarification to terminology, titles, etc.
	8.2	Clarified that the single source waiver form for waiver of competitive tendering is authorised by the Chief Finance Officer and/or Chief Executive

	8.3	Added in requirements for electronic tenders as well as the existing paper ones
	13.1	Requirement for business cases for all new capital investments
Jan 2019	8.5.1	Amended individual authorisation limits for accepting tenders to match those in the Scheme of Delegation
	21	Changed “NHS Litigation Authority” to “NHS Resolution”
Jan 2020	8.2 & 8.5	Clarification around tendering & quotation procedures & amending levels of approval to match those in the revised Scheme of Delegation
	Various	Amended “Director of Finance” to “Chief Finance Officer”

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Scheme of Delegation		
Unique Identifier:	POL030	**Document Type:**	Policy
Version Number:	9.0	**Status:**	Draft
Responsible Director:	Craig Macbeth, Chief Finance Officer		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Trust wide		
Replaces:	Version 8.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Standing Financial Instructions (SFIs) Matters Reserved to the Board		
Keywords:	Scheme of Delegation, Delegation		

Considered By Executive Owner:	Craig Macbeth, Chief Finance Officer	**Date Considered:**	15/12/2020
Endorsed By:	Audit Committee	**Date Endorsed**	11/01/2021
Approved By:	Trust Board	**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Detailed Scheme of Delegation

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

DELEGATED MATTER	AUTHORITY DELEGATED TO
1. Management of Budgets	
1.1 Responsibility of keeping revenue expenditure within budgets	
(a) Designation of Budget Holder for each area e.g. corporate, operations	Chief Executive
(b) Designation of delivery unit Budget Holders	Nominated Executive / Clinical Chair
(c) At cost centre level	Managing Director or responsible manager
(d) Other areas (e.g. reserves)	Operational Director of Finance
1.2 Responsibility of keeping capital expenditure within budgets	Chief Finance Officer
1.3 Responsibility for activity income	Operational Director of Finance
2. Investment & Banking	
2.1 Opening & closing of bank accounts	Operational Director of Finance
2.2 Investment of surplus cash	
(a) National Loans Fund (up to £5m) • Up to 3 months • Over 3 months	 Operational Director of Finance Chief Finance Officer and Finance Planning & Digital Committee
(b) Other institutions (up to £2m) • Up to 1 month • Up to 3 months • Over 3 months	 Operational Director of Finance Chief Finance Officer Chief Finance Officer and Finance Planning & Digital Committee
2.3 External borrowing	Trust Board
DELEGATED MATTER	**AUTHORITY DELEGATED TO**

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

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

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

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

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

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

12.3 Special payments : expenses claims for cancelled clinics/operations	
a) Up to £50	Clinic staff
b) Over £50	Head of Financial Accounting
12.4 Special payments : other	
Compensation under legal obligation, personal injury claims, loss of personal effects & maladministration	
a) Up to £1,500	Head of Financial Accounting
b) Up to £50,000	Chief Finance Officer
c) Between £50,001 and £100,000	Chief Finance Officer and Chief Executive
d) Over £100,000	Chief Finance Officer and Chief Executive and a member of the Audit Committee
12.5 Notification of novel, contentious or repercussive special payments to the Department of Health	Chief Finance Officer
13. Reporting of Incidents to the Police	
a) Where a criminal offence is suspected	Duty Manager in conjunction with Local Security Management Specialist
b) Where a fraud is involved	Chief Finance Officer in conjunction with Local Counter Fraud Specialist.
14. Petty Cash Reimbursements	
a) Expenditure up to £50	Authorising manager for non-pay expenditure
b) Expenditure over £50 (exceptional circumstances only)	Head of Financial Accounting
c) Reimbursement of patients monies up to £100	Head of Financial Accounting
d) Reimbursement of patients monies in excess of £100	Head of Finance
15. Implementation of Internal & External Audit Recommendations	Appropriate Director
16. Maintenance & Update of Trust Finance Procedures	Operational Director of Finance
DELEGATED MATTER	**AUTHORITY DELEGATED TO**
17. Receiving Hospitality	
Individual & collective hospitality (small items such as pens, diaries or chocolates need not be declared)	All staff required to make declaration in Trust's Hospitality Register & follow Trust's

	Standards of Business Conduct
18. Investment of Funds (including Charitable Funds)	Operational Director of Finance in conjunction with Finance Planning & Digital Committee
19. Authorisation of New Drugs (inclusive of VAT) Estimated total yearly cost (inclusive of VAT) up to £25,000 Estimated total yearly cost (inclusive of VAT) above £25,000	 Chief Medical Officer and Chief Finance Officer following advice from Drugs & Therapeutics Committee Chief Medical Officer and Chief Executive in conjunction with Executive Team, following advice from Drugs & Therapeutics Committee
20. Authorisation of Clinical Sponsorship Deals	Chief Medical Officer
21. Authorisation of Research Projects	Chief Medical Officer
22. Authorisation of Clinical Trials	Chief Medical Officer and Chief Nurse
23. Insurance Policies	Chief Finance Officer
24. Risk Management	Chief Executive
25. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico-legal complaints : co-ordination of their management	 Chief Nurse Chief Nurse Chief Nurse
26. Infectious Diseases & Notifiable Outbreaks	Chief Nurse
27. Relationships with Press a) Enquiries within hours b) Emergency enquiries outside hours	 Chief Executive or Head of Communications Duty Officer or Senior Manager on call
DELEGATED MATTER	**AUTHORITY DELEGATED TO**
28. Extended Role Activities Approval of nurses to undertake duties/ procedures which can properly be described as beyond the normal scope of nursing practice	 Chief Nurse

29. Patient Services a) Variation of operating and clinic sessions within existing number for outpatients, theatres & others b) Proposed changes in bed allocation & use - Temporary Change - Permanent Change	Managing Directors Chief Nurse Chief Executive
30. Facilities for Staff not Employed by the Trust to Gain Practical Experience. a) Professional recognition, honorary contracts & insurance of medical staff b) Work experience students	Chief People Officer in accordance with Trust Policy Chief People Officer in accordance with Trust Policy
31. Review of Fire Precautions	Chief Finance Officer
32. Review of all Statutory Compliance with Legislation and Health & Safety Requirements Including Control of Substances Hazardous to Health Regulations	Chief Nurse
33. Review of Medicines Inspectorate Regulations	Chief Nurse in conjunction with Chief Pharmacist
34. Review of Compliance with Environmental Regulations (e.g. those relating to clean air and waste disposal)	Chief Finance Officer in conjunction with Director of Estates & Facilties
35. Review of Trust's compliance with Data Protection Act	Chief Nurse
36. Monitor Proposals for Contractual Arrangements Between Trust and Outside Bodies	Chief Finance Officer
37. Review of Trust's Compliance with Code of Practice for Handling Confidential Information in the Contracting Environment and Compliance with "Safe Haven" per EL 92/60	Chief Finance Officer
DELEGATED MATTER	**AUTHORITY DELEGATED TO**
38. Keeping of a Declaration of Interests Register	Trust Secretary
39. Attestation of Sealings in Accordance with Standing Orders	Chairman/Chief Executive or nominated deputy

40. Keeping of a Register of Sealings	Trust Secretary
41. Keeping of the Hospitality Register	Trust Secretary
42. Retention of Records	Chief Executive
43. Clinical Audit	Chief Medical Officer

Key
SHPS : Shropshire Health Procurement Service

Policy Review

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

This policy will be reviewed every year.

Policy updated: January 2021
Next review due by: January 2022

Record of Amendments

Date	Section number	Amendments
Mar 2018	Various	Minor amendments & clarification to terminology, titles, etc.
	2	Amended investment and borrowing limits to reflect those quoted in the Treasury Management Policy
	5	Added note differentiating electronic tender opening from paper ones
Jan 2019	Various	Minor amendments & clarification to terminology, titles, etc.
	6.2	New section on sign-off of tender submissions
	9.2	Increased approval limit by fund managers for charitable funds expenditure
	12	Change of approval for low value special payments, including mileage claims for cancelled clinics
	14	Increased limit for petty cash expenditure & change of approval for requests over the limit
Jan 2020	Various	Change Financial Planning & Investment Committee to Financial Planning & Digital Committee
	Various	Changes of post names and levels of approval as a result of the new Trust structure
Jan 2021	Various	Changes of post names

0. Reference Information

Author:	Stacey Lea Keegan	Paper date:	28/01/2021
Executive Sponsor:	Stacey Lea Keegan	Paper Category:	Quality and Safety
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 Board of Directors and what input is required?

This paper presents the recently published Ockendon Report which outlines the findings of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. The papers is presented for the Board's information.

2. Executive Summary

2.1. Context

In mid-2017 the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review of the maternity services at SaTH following concerns raised by a number of bereaved families. The initial terms of reference had a limited scope but in 2019 this was widened following a large number of families coming forward. At its conclusion, the review is estimated to have reviewed 1,862 cases.

Whilst a significant amount of the report is focussed on the specifics of a maternity service, the review did identify a number of themes which can be translated across all aspects of healthcare and these are therefore worth of consideration in order that any wider learning and opportunities for improvement within the Trust can be identified.

2.2. Summary

There are four key themes that should be considered further by the Trust to ensure that its processes are robust and any opportunities to improve are identified and embedded across the organisation. It is proposed that these are explored further through the appropriate assurance committee as follows:

Quality and Safety Committee

- Listening to patients and families concerns and responding with compassion and kindness
- Ensuring investigations lead to lasting and meaningful change
- Getting bereavement care right

People Committee

- Listening to staff and ensuring they are able to escalate any concerns they have and that these concerns are then responded to appropriately

The Trust has a good culture for incident reporting and has consciously amended its investigation processes to ensure these are more patient centred but there is always opportunity to do more. Likewise there has been significant work on creating an open and transparent culture within the

organisation to ensure that staff are able to raise concerns but it is worth revisiting this in the context of the recommendations of the Ockendon Report.

The report will be taken through each of the identified Committees in more detail for oversight of any opportunities to enhance the Trust's culture, leadership and processes around patient safety.

2.3. Conclusion

The Board of Directors is asked to ***note*** the Ockendon Report.

OCKENDEN REPORT

Emerging Findings and Recommendations
from the Independent Review of

MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Our First Report following 250 Clinical Reviews

10 December 2020

Return to an Address of the
Honourable the House of Commons
dated 10 December 2020 for

Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

Our First Report following 250 Clinical Reviews

HC 1081

Ordered by the House of Commons to be printed on 10 December 2020

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at https://contactus.dhsc.gov.uk

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

10 December 2020

Dear Secretary of State

I publish this emerging findings report at a time when the NHS is facing further challenging months ahead as a result of the Covid 19 pandemic. We are all aware that frontline NHS staff have, day after day, risen to these challenges, demonstrating their commitment to providing excellent care in what are often seen and described as the most difficult of circumstances.

Whilst this year, especially, has been about the pride our country has quite rightly in our NHS, this independent maternity review is about those families who have suffered harm as a result of their NHS care at a time when they had planned for a joyous event. Families have told us of their experiences of pregnancies ending with stillbirth, newborn brain damage and the deaths of both babies and mothers. These families have shared with us their accounts of the overwhelming pain and sadness that never leaves them.

We have met face to face with families who have suffered as a result of the loss of brothers and sisters or, from a young age, have also been carers to profoundly disabled siblings. We have met many parents where there have been breakdowns in relationships as a result of the strain of caring for a severely disabled child, the grief after the death of a baby or resultant complications following childbirth.

Following the review of 250 cases we want to bring to your attention actions which we believe need to be urgently implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning that we recommend be shared and acted on by maternity services across England.

Your predecessor, the former Secretary of State Jeremy Hunt, requested an *'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust'*. When I started work as chair of this review, 23 cases had been identified after considerable efforts by the parents of Kate Stanton Davies and Pippa Griffiths who both died just after their births in 2009 and 2016, respectively. Since the review commenced, the number of families who have directly contacted my team, together with cases provided by the Trust for review, has now reached 1,862. When the review is completed, this is likely to be the largest number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

Understandably, examining the details of 1,862 cases is taking time and we continue to face many challenges which are out of our control, including adapting to new ways of working during the COVID19 pandemic.

Due to the significant increase in numbers, I was asked by the Minister of State for Mental Health, Suicide Prevention and Patient Safety to do my utmost to enable initial learning for The Shrewsbury and Telford Hospital NHS Trust and the wider NHS in this calendar year. Therefore, I publish this first emerging first report arising from the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.

My team and I have also held conversations with more than 800 families who have raised serious concerns about their care. These are in addition to the 250 cases considered in this

report and have also informed our findings in this report. We would like to pay tribute to all the families who have approached us to share their experiences.

We have identified a number of important themes which we believe must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement we are sharing emerging findings and themes, have formed **Local Actions for Learning** and make early recommendations which we see as **Immediate and Essential Actions**. We appeal for these to be implemented at The Shrewsbury and Telford Hospital NHS Trust as soon as practically possible and recommend these for thorough consideration within all maternity units across England.

Secretary of State, through our work to date we have recognised a need for critical oversight of patient safety in maternity units. This oversight must be strengthened by increasing partnerships across trusts within local networks of neighbouring trusts. Neighbouring trusts and their maternity services **must** work together with immediate effect to ensure that local investigations into all serious incidents declared within their maternity services are subject to external oversight by trusts working together. This is essential to ensure that effective learning and impactful change to improve patient safety in maternity services can take effect using a system wide approach and in a timely manner.

We have no doubt that, had a similar structure of partnership working been in place, The Shrewsbury and Telford Hospital NHS Trust would have been alerted much earlier for the need to scrutinise its governance processes and learn from its serious incidents.

For this structure to be effective we have identified the need to give increased authority and accountability to Local Maternity Systems (LMS) to ensure safety and quality in the maternity services they represent. They must have knowledge of all serious maternity incidents within their LMS with input to and oversight of these investigations and their resultant outcomes and recommendations. Of significance is that we are convinced that an LMS cannot function effectively when limited to one maternity service only. We also consider it imperative that family voices are strongly and effectively represented in each LMS through the Maternity Voices Partnerships.

This is just one of seven **Immediate and Essential Actions** we outline in this first report. We will add to and strengthen these recommendations in our final report following completion of this review as per the terms of reference. We are certain that these **Local Actions for Learning** and **Immediate and Essential Actions** will improve safety in the maternity service at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England provided that implementation is approached with urgency and determination.

Thank you Secretary of State for your ongoing support.

Yours sincerely,

Donna Ockenden
Chair of the Independent Maternity Review

Acknowledgements

This first report and the work that will follow owes its origins to Kate Stanton Davies and her parents Rhiannon Davies and Richard Stanton and to Pippa Griffiths and her parents Kayleigh and Colin Griffiths.

Kate's death in 2009 and Pippa's death in 2016 were avoidable. Their parents' unrelenting commitment to ensuring their daughters' lives were not lost in vain continues to be remarkable. In a void described by the families as 'incomprehensible pain', they undertook their own investigations to highlight the deaths of their newborn daughters, and to insist upon meaningful change in maternity services that would save other lives.

Rhiannon, Richard, Kayleigh and Colin persisted in their call for an independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust; through their tenacity and efforts this review was instigated.

We remain indebted to all the families contributing to this maternity review. Their experiences continue to shape the learning which will transform maternity care for the better. Finally, we convey our sincere gratitude to the many families who tried to raise serious concerns about maternity care and safety at the Trust who have told us they were not listened to.

Why This Report is Important

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones.

The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

CONTENTS

Explanation of Maternity specific terminology used in this report

Throughout the text this report sometimes uses terms and words that may be unfamiliar to some readers. Although use of these are kept to a minimum, on occasions they are essential because this is a report about maternity services. These terms and words are highlighted in ***bold italics*** at the first use with further explanations for them found in the Glossary at the end of this report.

Chapter 1

Introduction

1.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

1.2 The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families. The current terms of reference can be found in Appendix 1.

1.3 Since the commencement of this review many more families have directly approached the review team, voicing similar concerns to those raised by the original cohort of 23 families. Intermittent publicity regarding the work of the review led to a continual increase in families wanting their stories and voices to be heard and their questions and concerns answered. Between June 2018 and the summer of 2020 a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.

1.4 In addition, The Shrewsbury and Telford Hospital NHS Trust , supported by NHS Improvement and NHS England, undertook its own two-stage review of electronic and paper records of cases of ***stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3)*** and ***maternal deaths.*** Through these reviews, known as the 'Open Book', which first occurred in October 2018 as an electronic review and then in July 2020 with paper records included, the review team were notified by NHS Improvement and subsequently the Trust of over 750 cases of poor outcomes across these 4 categories in the period 2000 to the end of 2018. The review team were first able to make contact with these families in April and July 2020.

1.5 Direct contact from families together with the Trust's referrals led to us reporting in July 2020 that the review numbers had increased to encompass 1,862 families. We are aware that a number of families made multiple attempts, sometimes over many years to raise concerns with the Trust, but at this stage we are unable to say whether all of the poor outcomes reported to us occurred as a result of poor care.

1.6 It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019. However, where families contacted us directly with concerns preceding the year 2000, we agreed to review those cases where records exist as per the revised terms of reference. Throughout the review, the care and treatment provided and the quality of any internal reviews, investigations and learning undertaken by the Trust will be considered with reference to the guidance and standards of the day by experienced clinicians who were in clinical practice at the time.

1.7 It is important that we explore the experiences of staff working in the maternity units at The Shrewsbury and Telford Hospital NHS Trust. To do this we will scrutinise staff surveys where available and are working towards a process to hearing from staff directly. In addition we aim to examine past and current governance procedures within maternity services at the Trust that are applicable for the core period of this review.

1.8 To carry out a review of this size and to give each case the attention it deserves will take some time. It is important that expert clinicians lead the process, ensuring that each case is considered carefully and consistently using a standardised methodology. With the review now at 1,862 families, we anticipate a publication date for the second and final report in 2021.

1.9 To date, the review team have already identified emerging themes that should be addressed by the Trust and the wider maternity community across England as soon as possible. Therefore we have decided to publish this first report of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final report, with the full support of NHS England and Improvement, the Department of Health and Social Care and the Secretary of State for Health and Social Care.

1.10 For this first report 250 cases were investigated which are drawn from the entire period of the review and include the original cohort of 23 families. We also refer to in depth conversations and contact with a further 800 families, but we are mindful that these cases have not yet been subject to systematic and independent review by our team.

1.11 Our first objective in publishing these emerging themes and findings and their corresponding **Local Actions for Learning** is to support the improvement work currently underway in the maternity services at the Trust. A second objective is to ensure that these emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** are carefully considered by all maternity services in England. We strongly believe we have identified a need for structural changes which, if implemented nationwide with our recommendations will reduce cases of harm to mothers and babies.

1.12 It is important to note that we would not have been able to identify these objectives without carefully considering the voices of families which underpin this report.

1.13 Over the years, many important recommendations from previous national maternity reviews[1] [2] [3] and local investigations which might have made a significant difference to the safety of mothers and babies receiving care at the Trust have either not been implemented or the implementation has failed to create the intended effect of improving maternity care. From this review of 250 cases we can confirm that we have identified missed opportunities to learn in order to prevent serious harm to mothers and babies. However, we are unable to comment any further on any individual family cases until the full review of all cases is completed.

1.14 Having listened to families we state that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is our call to action. We expect to see real change and improved safety in maternity services as a result of

1 Northwick Park (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557922/ https://www2.harrow.gov.uk/documents/s30776/Maternity%20Review%20Report.pdf

2 Morecambe Bay (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

3 Saving Babies Lives (2019) https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

findings from these 250 case reviews and our resultant **Local Actions for Learning** and **Immediate and Essential Actions** whilst we continue to work towards completion of the full and final report.

1.15 Furthermore, we recommend that the **Immediate and Essential Actions** which we have identified should also inform the decision-making of those who lead maternity services at local, regional and national levels.

1.16 Everyone has a part to play. The Shrewsbury and Telford Hospital NHS Trust Board and local commissioners must urgently focus on expediting implementation of the **Local Actions for Learning** and **Immediate and Essential Actions** outlined within this first report. This will ensure that consistently safe maternity care is provided to its local population.

1.17 The NHS England and Improvement regional improvement team must ensure that they give appropriate support and oversight to the Trust. Regulators and professional bodies including the **Care Quality Commission**, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health must strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** in order that they translate into safer maternity care across England. To do nothing is not an option.

1.18 Repeatedly, families have told us of two key wishes. Firstly, they want questions answered in order that they understand what happened during their maternity care. Secondly, they want the system to learn, so as to ensure that any identified failings from their care are not repeated at the Trust or occur at any other maternity service in England. The scale of this review has reinforced their perceptions that their cases were not thoroughly investigated and that there may have been missed opportunities for learning and change and thereby a failure to prevent future harm.

1.19 We owe it to the 1,862 families who are contributing to this review to bring about rapid, positive and sustainable change across the maternity service at The Shrewsbury and Telford Hospital NHS Trust. Implementation of the recommendations from this first report and the final report in 2021 will be their legacy.

Chapter 2:

How we approached this Review

What kind of clinical incident is this review considering?

2.1 This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

2.2 In addition, a small number of earlier cases have emerged where families have raised significant concerns with the review team. These are being reviewed by the independent team wherever medical records are available from which it may then be possible to answer family questions. These earlier cases are those proactively reported to us by families, rather than systematically provided to us by the Trust. In all likelihood these are not the actual number of events. The earlier cases which occurred in the years immediately prior to 2000 are of importance to this review to establish whether there is evidence of embedded learning in subsequent cases.

2.3 The total number of families to be included in the final review and report is 1,862. The original plan was to publish one complete report, when the reviews of all the cases had been completed. However, as numbers of affected families continued to grow, in July 2020 it was agreed with the Minister of State for Mental Health, Suicide Prevention and Patient Safety, that early learning from the review of cases so far be shared with the Trust and the wider maternity services this calendar year. This has led us to publish this first report whilst our work continues towards completion of the remaining cases.

Methodology

2.4 For this first report the care that 250 mothers and their babies received has been reviewed as fully as possible on the evidence available. All clinical reviews have been undertaken by a team of independent expert clinicians. All review team members work outside the Trust and region and have no current or previous association with the Trust.

2.5 All reviews have been undertaken to date with benchmarking and consideration of the standards of care, policies and practice that would have been considered acceptable at the time the incident or concern occurred. The review team have had access to a range of local and national policies and guidance whilst undertaking their work. All the team members reviewing each case are experienced in clinical practice at the time the issue or incident of concern occurred.

2.6 The review team comprises obstetricians, midwives and neonatologists working collaboratively. Where specialist advice is required, for example in obstetric anaesthesia, maternal medicine, or other medical specialities such as adult cardiology or neurology, appropriate clinicians are available in the review team.

Listening to family voices

2.7 Family voices have been heard by the review team, either through face to face individual interviews held in Shrewsbury in a non-NHS location or via telephone or a

videoconferencing platform. Interviews are recorded electronically and typed up using a transcribing service of which a copy of the transcript is then shared with the family. There is a comprehensive support service available to all families in the review following initial assessment with a trained professional. The review team works in collaboration with SANDS, Child Bereavement UK and Bereavement Training International in offering this service. From early 2021 this will be extended to include support from the Midlands Partnership NHS Foundation Trust.

Listening to the views and voices of staff working at the Trust

2.8 Arrangements are under way to ensure that staff voices of current and former employees within the maternity and neonatal services at the Trust will be heard and carefully considered. We will review the information already available about staff views over the years from a number of sources, including staff surveys undertaken by the Care Quality Commission, the ***'Mat Neo' Collaborative***[4] and the NHS annual staff survey[5]. Following analysis of this information we will offer both former and current employees of the Trust the opportunity to speak with members of the review team in confidence.

Review of the Trust's maternity governance processes

2.9 The maternity review team has received a large volume of governance documentation from the Trust that is of importance and is of relevance to the review. It is now believed that the Trust have provided us with all the governance documentation that they have available that refers to the main time period under review. Findings following consideration of this documentation will be included in our final report.

2.10 For the governance documentation considered so far for this report the review team have found inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.

2.11 To date, the review team have also found inconsistent multiprofessional engagement with the investigations of maternity serious incidents at the Trust. There is evidence that when cases were reviewed the process was sometimes cursory. In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care. The review team has also seen correspondence and documentation which often focussed on blaming the mothers rather than considering objectively the systems, structures and processes underpinning maternity services at the Trust.

2.12 Further, whilst the action plans and recommendations that the review team have seen so far provide some limited evidence of feedback to staff, we have found clear examples of failure to learn lessons and implement changes in practice. This is notable in the selection of, or advice around, place of birth for mothers, the management of labour overall, the injudicious use of oxytocin, the failure to escalate concerns in care to senior levels when problems became apparent, with continuing errors in the assessment of fetal wellbeing.

2.13 This indicates that opportunities for valuable learning to improve care and the prevention of similar occurrences in the future were lost. The frequency with which particular issues have re-occurred, even within the limited group of cases reviewed so far, is entirely consistent with that conclusion. In the sections below we have provided anonymised

4 https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/

5 From 2003 to 2019 and provided by the Trust to the review team 10.11.20

vignettes of some of the mothers' and babies' stories; these are illustrative of the types of incidents which have occurred, and which might have been avoided had lessons been learned from previous events and changes in practice been implemented accordingly.

2.14 Within the 250 cases reviewed to date, we have also found that a number of the earlier cases of significant concern were not investigated at the time, although this appears to improve over the period under review. The Trust underwent external review and scrutiny by the CQC in 2015, 2018 and 2020[6], and by The Royal College of Obstetricians and Gynaecologists (RCOG)[7] in 2017. However, even within this later timeframe, there is evidence that some serious incidents were not investigated using a systematic and multiprofessional approach, and evidence is lacking that lessons were learned and applied in practice to improve care.

6 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report 2015

7 https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-Trust/

Chapter 3

Trust Board oversight and External Reviews

3.1 As we have progressed with this review a number of apparent themes have emerged in the 250 cases and family interviews considered to date. These themes will be further scrutinised as we review the remaining cases, but the following are noted by the maternity review team at this early stage:

Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory

3.2 We understand from documents supplied to us by the Trust that there have been ten Chief Executive Officers (CEOs) from 2000 to early 2020, with eight in post between 2010 and the current day. Four of those eight were employed as interim CEOs[8]. Since 2000 there have been ten Executive Board Chairs. There has also been considerable Board level turnover amongst both Executive and Non-Executive Directors since the year 2000.

3.3 We have concluded that, it is probable that this lack of continuity at Board level has resulted in a loss of organisational memory. As new CEOs started at the Trust there was a tendency, until at least 2019, to regard problems at the Trust as *'historical'* or as a *'legacy'* from previous years. Indeed, one of the groups of cases of potentially significant concern submitted to the review team by the Trust, ranging from between 1998 and 2017 and therefore, includes some relatively recent cases, was titled *'The Legacy'* cohort by the Trust.

What the Care Quality Commission (CQC) said about the Trust

CQC Reports

3.4 The CQC reports in 2015[9], 2018[10] and 2020[11] vary considerably. We note that the two later reports are critical of leadership at the Trust. The 2015 CQC report graded the maternity and gynaecology services *'good'* across all five domains of safe, effective, caring, responsive and well led, with an overall rating of *'good'*. (CQC 2015, page 21). Oswestry, Ludlow and Bridgnorth Midwifery Led Units (MLUs) were also rated *'good'* across all 5 domains. The 2015 report noted that *'The Trust had recently opened the new Shropshire Women and Children's Centre at the Princess Royal [hospital] site. This had seen all consultant led maternity services and inpatient paediatrics move across from the Royal Shrewsbury [hospital] site. We found that this had had a positive impact on these services.'* (CQC 2015, page 2)

The CQC reports in 2018 and 2020

3.5 We note that in the 2018 and 2020 reports the Trust's overall rating of the domain *'well led'* was *'inadequate'*. The 2020 report states that there is a lack of stability in the Executive team. Overall, the CQC told the Trust they must *'ensure that there are effective governance systems and processes in place to effectively assess, monitor and improve the quality and safety of services'.* (CQC 2020, page 6).

8 'Who's Who at the Trust – internal document – received by the review team 9th September 2020

9 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report January 2015

10 https://www.cqc.org.uk/provider/RXW CQC report 29th November 2018

11 https://www.cqc.org.uk/provider/RXW CQC report January 2020

3.6 In respect of maternity services at the Princess Royal Hospital, the CQC advised that the Trust must:

- *Ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults*
- *Ensure high risk women are reviewed in the appropriate environment by the correct member of staff*
- *Ensure grading of incidents reflects the level of harm, to make sure the duty of candour is carried out as soon as reasonably practical*
- *Ensure all women receive one to one care when in established labour*
(CQC 2020, page 8)

The review team will further consider these CQC reports of the maternity service and the Trust's responses to them in its final report.

MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)

Overview of MBRRACE reports: perinatal mortality rates at the Trust 2013-2017

3.7 Stillbirths, neonatal deaths and perinatal mortality rates for the UK are published by MBRRACE-UK in Perinatal Mortality Surveillance Reports[12]. These reports publish stabilised and adjusted mortality rates to adjust for chance variation due to small numbers and for key factors known to increase the risk of perinatal mortality such as mother's age, socio-economic deprivation, baby's ethnicity, baby's sex, multiple births and gestational age at birth (for neonatal deaths only).

3.8 MBRRACE issues individual reports to NHS Trusts indicating the local perinatal mortality rates. These Trust-specific reports recommend that Trusts should review existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care have been implemented.

3.9 MBRRACE reports show that for the years 2013-2016 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were up to or more than 10% higher than comparable UK NHS Trusts. For the year 2017 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were reported as up to 5% higher or up to 5% lower than the UK average (suggesting roughly comparable rates with other UK Trusts). Perinatal mortality rates for 2018 were not published at the time of writing this report.

Clinical Commissioning Group (CCG) oversight of the Trust

3.10 There are two CCGs in the local area, Telford and Wrekin CCG and Shropshire CCG. They were formally established in April 2013 and from 2019 have engaged in *'bringing their decision-making processes closer together'*[13].

12 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

13 https://www.healthwatchtelfordandwrekin.co.uk/news/new-board-members-join-shropshire-ccg-and-telford-and-wrekin-ccg/

3.11 The Maternity review team will have the opportunity to consider a range of maternity specific documentation from the two CCGs. As commissioners, the interactions with the Trust and the CCGs and the ***Primary Care Trusts (PCTs)*** before them, will provide valuable insight into the local external oversight the Trust's maternity services received during the timespan of the maternity review.

3.12 We note that during the inaugural Telford and Wrekin CCG Board meeting in April 2013[14] there appeared to have been some concerns raised about maternity services at the Trust, leading to the CCG intending to write to the Trust *'with regards to concerns with Midwifery numbers.'* (page 4).

3.13 In June 2013 the Telford and Wrekin CCG Quality and Safety report[15] describes that, following concerns raised by both CCGs, a 'Risk Summit' led by the NHS England Area Team had been held in May 2013. Concerns specific to maternity services were: *'Maternity services model and the number of SIs reported (in particular 1 high profile case and coroner's inquest and a 2nd SI...'* (page 5). In July 2013 a CCG led review of maternity services at the Trust[16] was commenced with the stated *'Lack of improvement in maternity services'* recorded as a 'risk' as follows:

'Risk 3 - Lack of Improvement in Maternity Services
External review of maternity services across the local health economy has now formally commenced and will report to Boards by September 2013.' (page 4)

3.14 The resulting report[17] published jointly by both CCGs in October 2013 will be considered more fully in the final report, as will further documentation received from the CCGs.

The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust

3.15 Prior to its demise in 2017 the purpose of statutory supervision of midwives was to protect the public by ensuring a safe standard of midwifery practice through enhanced quality and safety.

3.16 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by supervisors of midwives at the Trust. The review team will continue to consider all available supervisory governance documentation relating to any individual cases in this maternity review.

14 See Telford and Wrekin CCG, Minutes of Governing Board Meeting 090413 –page 4
https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/may-3/444-03-ccg-board-minutes-9th-april-2013-v1/file

15 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/june-3/542-10-5-twccg-board-quality-and-safety-june-2013-report/file

16 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/july-3/585-11-3-ccg-board-quality-and-safety-report-9th-july-2013/file

17 https://shropshireccg.nhs.uk/media/1197/maternity-services-review-msr-report-281013.pdf

Review of Maternity Services 2007- 2017

3.17 In June 2017 the Trust conducted an internal review of maternity services[18]. It considered the history of maternity services between 2007 and 2017, focussing on issues of patient safety, learning, and engagement with bereaved parents. The report concluded that '*all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service.*' The report further stated that the service must '*create a coordinated approach to the maternity safety improvement plan*' and that '*safety in maternity is protected by the efforts of the staff and supported by leaders.*' (2017, page 28.)

18 https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

Chapter 4

Multidisciplinary Review: Our findings following review of 250 cases

Midwifery and Obstetric issues identified in the review of 250 cases at the Trust

The roles of midwives and obstetricians in the multidisciplinary maternity team

4.1 Midwives and obstetricians work closely together providing maternity care. Midwives are specialists in the provision of normal pregnancy care throughout the pregnancy pathway. Obstetricians are the lead clinicians providing care for complex pregnancies and births in an obstetric unit working in collaboration with midwives and other health care professionals including obstetric anaesthetists. The following is a reflection of emerging themes identified from the 250 cases reviewed to date by the independent review team.

4.2 The midwifery and obstetric issues identified from these cases are merged for the purposes of this report, which recognises the close working relationship that is required between midwives and obstetricians for the benefit of mothers and babies within their collective care.

Compassion and kindness

4.3 One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust. Healthcare professionals are in a privileged position caring for women and their families at a pivotal time in their lives. Many of the cases reviewed have tragic outcomes where kindness and compassion is even more essential. The fact that this has found to be lacking on many occasions is unacceptable and deeply concerning.

4.4 Evidence for this theme was found in the women's medical records, in documentation provided by the Trust and families, in letters sent to families by the Trust and from through the families' voices heard through the interviews with the review team. Inappropriate language had been used at times causing distress. There have been cases where women were blamed for their loss and this further compounded their grief. There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.

4.5 *Follow up letter sent after discharge which states: 'If you would like to come and have a chat with me about the death of your baby…' There were no words of condolences or sympathy within the body of the letter. (2001)*

4.6 *A woman was in agony but told that it was 'nothing'; staff were dismissive and made her feel 'pathetic'. This was further compounded by the obstetrician using flippant and abrupt language and calling her 'lazy' at one point. (2011)*

4.7 *A woman was in great pain after delivery and left screaming for hours before it was identified that there were problems that needed intervention. The attitude of some of the midwives also made the situation worse. (2013)*

4.8 There are several examples from the cases reviewed to date indicating that minimal learning has occurred and that this lack of compassion and kindness has persisted. There are some examples of midwives and doctors who have made a huge difference to the women and families due to the care they provided and kindness they showed. However, kind and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team.

Place of birth: Assessment of risk

4.9 At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth. This can be at home, a midwifery led unit or an obstetric-led unit. Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate. In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth. There is evidence from interviews with women and their families, that it was not explained to them in case of a complication during childbirth, what the anticipated transfer time to the obstetric-led unit might be.

4.10 *A woman was considered appropriate for birth in a remote stand-alone birth centre despite developing known risk factors in the weeks leading up to her delivery. There were then errors in the fetal monitoring in labour. After birth the baby was not monitored appropriately despite clear warning signs, and was transferred, too late, to a specialist unit where the baby died. (2009)*

4.11 *A woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

4.12 *A woman who delivered in a stand alone birth centre suffered a catastrophic haemorrhage requiring transfer to the consultant unit, where she died. Her family stated that there had not been an explanation of the risks of birth in a midwifery led unit, nor information on the need for transfer if complications arose. (2017)*

Clinical care and competency: management of the complex woman

4.13 At the point of registration a midwife will have achieved competency in the required academic and clinical subject areas and therefore qualify for entry to the Nursing and Midwifery Council register. In a significant number of cases the review team found evidence that the clinical care and decision making of the midwives did not demonstrate the appropriate level of competence, with consequences for the mothers and babies in their care. One aspect is failure to recognise deviation from the norm and so failure to escalate appropriately.

4.14 In some cases the review team has found evidence of poor consultant oversight of mothers with high-risk pregnancies; they either remained under midwifery-led care or were managed by obstetricians in training without appropriate and timely escalation.

4.15 *A woman in the early third trimester of her pregnancy was admitted to the antenatal ward with severe pre-eclampsia, characterised by new onset hypertension and proteinuria. Shortly after her discharge home she had an eclamptic seizure and was taken to a neighbouring unit, where she delivered. (2011)*

4.16 *A woman developed severe high blood pressure and was managed on the labour ward. There was a delay in treating her high blood pressure and, following delivery, there was a further delay in seeking senior clinical advice. She subsequently died in another hospital. (2011)*

4.17 *A pregnant woman who was known to have large uterine fibroids had midwifery led care and was not referred to an obstetrician as her condition should have required. There were errors in the interpretation of the baby's growth and an obstetric opinion or ultrasound scan was not obtained. The baby was delivered around ten weeks early, was growth restricted and died the same day from a severe hypoxic birth injury. (2016)*

Escalation of concerns

4.18 In the cases reviewed so far, concerns regarding escalation have evolved as an overarching theme. The cases show repeated failures to escalate for further opinion and review. This is a key element of the role of the midwife and an integral part of safe practice. There is also evidence that when concerns were escalated they were not then acted upon appropriately or escalated further to the appropriate level. This may indicate a lack of multidisciplinary communication and collaboration and/or senior clinical supervision, both of which are key to providing safe care.

4.19 The reviewers found a significant number of instances both of failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants. From the 250 cases reviewed to date these problems appear to continue across the review period, suggesting a failure to learn from other previous serious incidents which had resulted in stillborn or severely brain damaged babies.

4.20 *A woman was induced for raised blood pressure at 37 weeks. The fetal heart rate was normal on arrival on labour ward. After artificial rupture of the membranes there was a failure by the midwife to record the fetal heart rate or escalate any concern and the baby was subsequently stillborn. The family did not feel that they were involved in the investigation and did not receive an apology. (2015)*

4.21 *A woman who was admitted with contractions and early signs of infection late in her second trimester of pregnancy was seen by a junior doctor and discharged without higher level assessment. Her management was not subsequently discussed with a senior colleague. Several hours later she was re-admitted and delivered a premature baby. (2015)*

Management of labour: monitoring of fetal wellbeing, use of oxytocin

4.22 Fetal heart rate (FHR) monitoring is an essential component of the safe management of labour. When labour is managed in a midwife-led setting the FHR is monitored using intermittent auscultation (IA). On the labour ward setting the FHR is usually monitored continuously with the ***cardiotocograph*** (CTG). The review team found significant problems with the conduct of intermittent auscultation and in the interpretation of CTG traces.

4.23 Oxytocin is an intravenous infusion commonly used in obstetric labour wards to increase the frequency, strength and length of uterine contractions. There are guidelines for its use and it should be used carefully and reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns. Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour.

4.24 Long labour exacerbated by use of oxytocin can result in an obstructed labour leading to fetal distress and also difficult caesarean delivery because the fetal head is deeply in the pelvis. Long labours can also increase the risks of infection and excessive haemorrhage after birth. The review team noted many examples where oxytocin was used injudiciously; these cases occurred across the time period of the 250 cases reviewed, which suggests a failure to learn from previous cases where the outcome was poor.

4.25 *A woman who had a previous caesarean section was induced and had a long labour using oxytocin. The baby's head was in the occiput posterior position and this made the delivery by caesarean section difficult. The mother said afterwards that she had the impression that the Trust were trying to keep the caesarean section rate low. (2000)*

4.26 *A mother, admitted in labour with a breech presentation, had inappropriate use of oxytocin for her long labour with CTG concerns. Standard obstetric teaching is to avoid the use of oxytocin in breech labour and especially in this case, where there was the added complication of FHR abnormalities. Her baby was born in very poor condition and died a few days later. (2006)*

4.27 *A woman presented in labour at 39 weeks. There were CTG abnormalities in labour, which were not escalated. Oxytocin was used despite an abnormal CTG. The baby was delivered normally but developed a hypoxic brain injury and cerebral palsy. (2006)*

4.28 *A woman had a prolonged labour at a birth centre despite earlier concerns over abnormal CTG tracings during the antenatal period. She was transferred to the labour ward but her baby was stillborn shortly afterwards. Despite the failure to adequately monitor both the mother and the baby there was no investigation or learning. The mother and father did not receive an apology. (2007)*

4.29 *A woman was in labour and there were fetal heart rate concerns. Despite the abnormal CTG oxytocin use was continued throughout the labour. At the caesarean section there was evidence that there had been an obstructed labour. The baby suffered from hypoxic brain injury and died some months after birth. (2009)*

4.30 *A woman had oxytocin commenced in the later stage of delivery with CTG abnormalities. There was a ventouse delivery and the baby was delivered in poor condition and developed a hypoxic brain injury. (2010)*

4.31 *A woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change clinical practice in future. (2014)*

4.32 *A woman had a previous caesarean section followed by a normal delivery. The following pregnancy she was induced at term. Oxytocin was used in the presence of CTG*

abnormalities and there was excessive uterine action (hyper stimulation). There was also a failure to monitor the fetal heart during siting of epidural. An emergency caesarean section was performed and the baby was delivered in a poor condition. The investigation did not address the management of labour and CTG interpretation or the injudicious use of oxytocin. (2014)

4.33 *A woman was admitted in normal labour. There were CTG abnormalities in the second stage, which were not recognised and later it was also not recognised that the maternal heart rate was being recorded rather than the fetal heart. The baby was born in poor condition, developed hypoxic brain injury, and died several months later. (2015)*

4.34 *A woman had a failed ventouse delivery and emergency caesarean section in a previous pregnancy. In the next pregnancy the baby was found to be macrosomic (large) on scan at 36 weeks. The woman was admitted in labour and despite requests for a caesarean section she was persuaded to attempt a vaginal birth. This was complicated by a pathological CTG in labour with inappropriate use of oxytocin and shoulder dystocia. The baby died a few days later from hypoxic brain injury and complications of the shoulder dystocia. The family were dissatisfied with the investigation. The investig*ation failed to acknowledge omissions in care, which prevented future learning. (2015)

4.35 *A woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation, and correspondence with the Trust, and said during a meeting with the Review Chair that they had been 'put off, fobbed off and had obstacles put in our way'. (2016)*

Traumatic birth

4.36 Some cases involving long labour with injudicious use of oxytocin resulted in women becoming fully dilated and consequently being assessed for instrumental vaginal delivery. The review team found evidence in a number of cases of repeated attempts at vaginal delivery with forceps, sometimes using excessive force; all with traumatic consequences. There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.

4.37 *A woman laboured and had repeated attempts at forceps delivery. The baby sustained multiple skull fractures and subsequently died. (2007)*

4.38 *A woman who was known to have a big baby was refused her request for a caesarean section and encouraged to labour. She had a forceps delivery and the baby had* **shoulder dystocia** *with a resulting fractured* ***humerus****. In her letter to the Trust afterwards the mother wrote that she felt her request for a caesarean section was refused because the Trust wanted to keep their caesarean section rates low. There was no incident form or investigation. (2012)*

4.39 *A baby died following a traumatic forceps delivery. There were repeated attempts by two doctors to deliver the baby with forceps. (2013)*

4.40 *A woman had repeated attempts to deliver the baby using forceps. The baby was found to have skull fractures after birth and subsequently developed cerebral palsy. There was no investigation. The family were very dissatisfied with the Trust's response to their concerns. (2017)*

4.41 The reviews of these and other cases indicate that efforts to ensure a vaginal delivery either should not have been attempted or should have been abandoned and the baby delivered by caesarean section. Some of these deliveries were undertaken by consultant obstetricians, which was particularly concerning.

Caesarean section rates at The Shrewsbury and Telford Hospital NHS Trust

4.42 Caesarean section rates have risen in the UK over the two decades of this review. It is notable that for this period the caesarean section rate at The Shrewsbury and Telford Hospital NHS Trust has consistently been 8%-12% below the England average and those of its neighbouring units (Table 1). Over the years this has been positively reported in the local press with it widely known in the local community.

Table 1. Comparison of Caesarean section rates between The Shrewsbury and Telford Hospital NHS Trust, neighbouring Hospital Trusts, and the rates in England.

	The Shrewsbury and Telford Hospitals NHS Trust	University Hospitals of North Midlands NHST	Royal Wolverhampton Hospitals Trust	NHS Hospitals England
2006-2007	11.8%	24.3%	25.5%	24.2%
2007-2008	15.5%	23.5%	26.1%	24.6%
2008-2009	16.8%	24.1%	25.0%	24.6%
2009-2010	15.8%	25.6%	24.9%	24.8%
2010-2011	No data	-	-	-
2011-2012	14.9%	26.3%	25.9%	24.4%
2012-2013	16.3%	25.4%	25.4%	24.8%
2013-2014	16.3%	27.6%	27.9%	26.2%
2014-2015	16.3%	26.0%	28.0%	26.5%
2015-2016	19.5%	29.0%	28.2%	27.1%
2016-2017	20.8%	29.8%	26.6%	27.3%
2017-2018	21.0%	30.0%	28.0%	29.0%

(Data from NHS Maternity Statistics NHS Digital)

4.43 The review team came across many cases where women said that they had been aware The Shrewsbury and Telford Hospital NHS Trust wished to keep caesarean section rates low. A typical quote during interviews was that *'they didn't like to do caesarean sections'*. The review team observed that women who accessed the Trust's maternity service appeared to have little or no freedom to express a preference for caesarean section or exercise any choice on their mode of delivery.

4.44 The review team have the clear impression that there was a culture within The Shrewsbury and Telford Hospital NHS Trust to keep caesarean section rates low, because this was perceived as the essence of good maternity care in the unit. Whereas it is not possible to correlate this culture with overall poor obstetric outcomes, the previous vignettes show that in some individual cases earlier recourse to a caesarean delivery would have avoided death and injury.

Overall there did not seem to be a consideration of whether this culture contributed to unnecessary harm.

Bereavement care

4.45 It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a significant effect on the wellbeing of parents and their families in the time immediately following the loss and in the longer term.

4.46 The Stillbirth and Neonatal Death Society (SANDS)[19] states that high quality bereavement care involves a recognition of parenthood using sensitive and effective communication, whilst enabling informed choice in all aspects of care and decision making. This may be decision making with regards to delivery, seeing their baby, funerals and post mortem, to name a few aspects. Midwives and obstetricians need to have an awareness of these key issues and also an awareness of the grief and trauma that families may be going through. Compassion and kindness in care and communication by midwives, obstetricians and all members of the maternity team parents may encounter is essential. Such compassion can have a positive and long lasting influence on the experience families have at this time.

4.47 Whilst there is some limited evidence that parents were supported to spend time with their baby after death and to create memories from the very limited time they were able to spend together, there is also little evidence of follow up support being provided as would be expected and recommended. There are several instances where the bereavement care was either inadequate or non-existent, which had a negative impact on the wellbeing of the parents and their overall experiences.

4.48 Not only was bereavement care poor in a number of the 250 cases reviewed to date, there are also examples of completely inappropriate comments made to some family members after the loss of their baby. There are several examples where mothers say that they were made to feel responsible by Trust staff for the loss of their babies.

4.49 *One mother complained about the consultant obstetrician's attitude when seen on the neonatal ward. She described the consultant as being rude and completely dismissive of the family's concerns. She also complained about postnatal care saying that the staff were not aware of the issues and she had to keep explaining distressing details at every shift change. There was no investigation or learning. (2009*)

4.50 *A woman whose baby died after a particularly traumatic delivery was seen by the consultant afterwards. The consultant was described as having 'no compassion or understanding of the trauma experienced'. (2013)*

4.51 *The family had received limited bereavement support on Day 17 after birth. The family found this unhelpful and unprofessional. …….bereavement care was lacking to the point of being completely inadequate. The Trust's bereavement service should have made contact much sooner. There is no record that any follow up support and advice was given. (2016)*

4.52 *A mother experienced a neonatal death at 17 hours of age. She and her partner described the bereavement service 'as offering no support, lacking in compassion and actually making it so many times worse'. (2016)*

19 https://nbcpathway.org.uk/about-nbcp/national-bereavement-care-pathway-background-project

4.53 *A woman had an apparently uncomplicated homebirth. Later the same day and overnight she repeatedly rang the midwifery unit to say that she was concerned that the baby wasn't feeding properly. She was reassured but the baby collapsed and died the next day. The family felt they had to 'push for an investigation' and that the Trust did not listen to them. They believed that the bereavement care they received was inadequate. (2016)*

LOCAL ACTIONS FOR LEARNING: MATERNITY CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.54** A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.
- **4.55** All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.
- **4.56** The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.
- **4.57** These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2[20] (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.
- **4.58** Staff must use NICE Guidance (2017)[21] on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.
- **4.59** The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.
- **4.60** The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse

20 https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

21 https://www.nice.org.uk/guidance/cg190

outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015[22].

- **4.61** Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.
- **4.62** There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training[23].
- **4.63** Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.
- **4.64** The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.
- **4.65** The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.
- **4.66** The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

Maternal Deaths

4.67 Between the years 2000 and 2019, there were 13 maternal deaths at The Shrewsbury and Telford Hospital NHS Trust. The review team were also contacted by two families who had experienced the death of their mothers whilst under maternity care at the Trust before 2000. These will be reviewed if clinical records become available.

4.68 The review team identified recurrent themes in the care of some mothers who died, which present opportunities for important learning from the initial evaluation of these occurrences.

4.69 In the cases reviewed from 2000 onwards there appears to have been a lack of antenatal multidisciplinary team planning for women with significant pre-existing comorbidities and/or other medical risk factors. Whilst the women appear to have been correctly identified as 'high risk' at booking, the review team were unable to identify the lead clinician with overall responsibility for the care of the woman in the majority of cases. Whilst pathways seem to have existed for referral to other medical specialities, once referred for specialist care, the resultant assessments were frequently conducted by junior doctors. There appear to have been no joint clinics and multidisciplinary care planning for antenatal monitoring, labour, delivery or postnatal care.

22 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

23 https://www.hsib.org.uk/documents/261/HSIB_Delays_to_intrapartum_intervention_once_fetal_compromise_is_suspected_Report.pdf

4.70 In some cases there was poor completion of the ***maternal early warning score (MEWS)*** which might have prompted escalation if completed appropriately, and there was frequently a failure to recognise the deteriorating patient. High risk and significantly sick women on the delivery suite were reviewed by junior medical staff without involvement of consultant obstetricians or consultant obstetric anaesthetists for lengthy time periods. There were delays in initiating appropriate investigations and treatment which also led to delayed escalation. These delays impacted on timely transfers to a higher level facility such as high dependency or intensive care.

4.71 The review team is further concerned about the rigour and quality of investigations after serious incidents such as a maternal death. In some cases no investigation was initiated. Some cases were investigated internally by a small governance team, no learning appears to have been identified and the cases were subsequently closed with it deemed that no further action was required. A number of investigations lacked visibility and input from the wider multidisciplinary team, resulting in missed opportunities for important learning.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.72** The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.

- **4.73** Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.

- **4.74** There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.

Obstetric Anaesthesia

4.75 Obstetric anaesthetists are an integral part of the labour ward team. Over 60 % of all women entering the labour ward require anaesthetic interventions, and many more are assessed by an obstetric anaesthetist in the antenatal or postnatal period[24]. The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work[25].

24 RCoA Guidelines for the Provision of Anaesthesia Services (GPAS); Chapter 9: Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020 "Raising the Standards", RCoA Quality Improvement Compendium, 4th Edition, May 2020, page 241-268; www.rcoa.ac.uk

25 OAA/AABGI Guidelines for Obstetric Anaesthesia Services 2013

4.76 The number of women requiring advanced levels of medical and anaesthetic care from maternity services has risen over the last 20 years, due to a number of factors including increasing levels of maternal obesity and its associated co-morbidities such as Type 2 diabetes, high blood pressure and cardiac disease. More women conceive with pre-existing medical problems and/or are delaying motherhood until they are older and may therefore have developed more underlying medical conditions[26].

4.77 The trend towards an older obstetric population with increasing morbidities and significant levels of maternal obesity means obstetric anaesthetists are increasingly required to take on the role of peri-partum physician dealing with the management of these underlying medical conditions in labour and in acute settings, as well as providing their traditional services such as pain relief in labour and anaesthesia for operative delivery or immediate surgery postpartum. The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability 'around the clock', as maternity is a 24 hours a day and 7 days a week service.

4.78 In considering the cases for this first report, the review team have identified several areas of concern relating to obstetric anaesthesia practice. The reviewers found a tendency towards simple task focus, e.g. siting an epidural, or administering anaesthesia, without a holistic assessment of the patient and appreciation of the wider clinical picture.

Poor obstetric anaesthesia practice

4.79 *A woman with severe and rapidly progressive pre-eclampsia and uncontrolled blood pressure (BP) was taken to theatre for an emergency caesarean section. The labour ward team failed to control her blood pressure and the duty anaesthetist compounded the issue when inducing general anaesthesia without administration of any drugs to attenuate the potential BP rise during intubation. This failure exposed the woman to an increased risk of cerebrovascular accident (CVA) or a stroke. (2011)*

4.80 *A woman requested epidural analgesia in labour. She had frequent contractions and felt the urge to push, although diagnosed as being in the first stage of labour. There were significant concerns about fetal wellbeing on the basis of the cardiotocograph (CTG). Despite this, the CTG was discontinued for a significant time to site the epidural. When the CTG was recommenced immediately after siting of the epidural, the fetal heart rate was difficult to obtain and an emergency caesarean section was indicated. The anaesthetist did not seek clarification on the CTG and possible urgency of delivery before siting the epidural. The baby was born in poor condition, requiring neonatal resuscitation. (2014)*

Lack of escalation to, and involvement of, senior anaesthetists

4.81 We also found several examples of lack of senior involvement from the consultant anaesthetists on call. Even in periods of high workload there was limited support by the consultant anaesthetist responsible for the delivery suite out-of-hours. Complex obstetric complications, for example severe sepsis or pre-eclampsia, or women with significant pre-existing underlying co-morbidities, were treated by very junior staff for extended periods of time even when the complexity of work clearly required senior input. There were some cases where there was an evident delay in escalating to the

26 Knight M et al on behalf of MBRRACE-UK. Saving Lives, Improving Mother's Care- Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013 – 2015. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017

consultant anaesthetist on call. However, when requested by junior doctors, we also found instances where the consultant anaesthetist failed to attend in a timely manner.

4.82 *A woman who had an epidural for pain relief in childbirth developed a significant headache and unspecific neurological symptoms after birth. She was seen over several days by a junior doctor. Only one review was documented in the notes. There was a significant delay requesting further diagnostic tests and involving the consultant anaesthetist. Subsequent imaging showed significant pathology that should have been detected earlier. The delay put the woman at significant risk for further complications. (2012)*

Limited consultant anaesthetist representation in incident investigation and multidisciplinary team meetings after significant incidents

4.83 The review team found instances of maternal deaths or cases of severe complications, where the obstetric anaesthesia team was requested by the obstetric risk management team to 'perform their own incident investigation' and not participate in any wider investigation or contribute recommendations to prevent such occurrences in future. Sometimes only junior anaesthetic staff attended initial root cause analysis meetings or obstetric anaesthetists were not represented at all in investigation panels or team meetings. This undermines the concept of multidisciplinary team working and indicates to the external review team that obstetric anaesthetists were not perceived as an integral part of the maternity team.

4.84 As late as 2016 the review team saw serious incident investigations without input from obstetric anaesthetists or relevant other sub-specialities. The lack of a well-functioning multidisciplinary team represented a significant weakness in the structure of the Trust's maternity services with a significant impact on wider learning from adverse events and ultimately a detrimental impact on patient safety.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.85** Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.
- **4.86** Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.
- **4.87** Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.

Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.

- **4.88** Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.

- **4.89** The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice' [27].

- **4.90** The Trust must ensure appropriately trained and appropriately senior/ experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.

- **4.91** The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

Neonatology

4.92 From our review of patient clinical records in 250 cases to date, for most babies the quality of neonatal care at the Trust appears to have been satisfactory or good and at times excellent. The period 2000 - 2019 includes the time when services across England and Wales were moving from a situation where many units delivered intensive care to one where all units became part of networks within which certain units were designated intensive care units and others were not.

4.93 Prior to 2006, the neonatal unit at the Royal Shrewsbury Hospital regularly delivered neonatal intensive care, as was appropriate at that time. From 2009 the unit was designated as a Local Neonatal Unit (LNU). LNUs are not expected to deliver ongoing neonatal intensive care. It appears that there was a period between 2006 and 2011 when the local network was transitioning from one model of neonatal care to another.

4.94 We have found a small number of cases where the neonatal care was substandard. However, these were very much the exception and we have to date found no evidence of systemic poor practice or lack of care in the neonatal service.

4.95 It appears from the majority of the 250 medical records reviewed to date that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents.

27 http://www.csen.com/GPAS.pdf

4.96 Review of the medical records show that advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. It appears that their practice has been sound and likely to have contributed to the maintenance of good standards of neonatal practice within the Trust.

LOCAL ACTIONS FOR LEARNING: NEONATAL SERVICE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their neonatal services.

- **4.97** Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.

- **4.98** There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.

- **4.99** The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.

- **4.100** There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

Chapter 5

Immediate and Essential Actions to Improve Care and Safety in Maternity Services

We include these **Immediate and Essential Actions** because the Minister of State for Mental Health, Suicide Prevention and Patient Safety has expressly asked us, as part of this first report, to make recommendations which will help to improve safety in maternity services across England. We are aware that to date, there has been a mixed approach to implementing change from national safety reports and reviews into maternity services triggered by concerns relating to safety, such as this review.

Recommendations are of limited use if they are not implemented; indeed, had earlier recommendations been followed at The Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes we are investigating might not have occurred. Relying on the strength of our collective clinical experience we have named our conclusions as **Immediate and Essential Actions** – i.e. these are things which we say must be implemented now if not already done so.

As a team of clinicians we are engaged in practice across eleven Trusts in London and the South East and South West of England. In addition to clinical practice, our current roles, or those we have held in the recent past include midwifery, clinical and divisional director roles, consultant midwives, leads for governance, labour ward coordinators, clinical matrons and educational leads. Many of us have been active in leading and supporting regional and national maternity safety initiatives and have published their expertise in maternal and child health on a national and international level[28].

Many of our **Immediate and Essential Actions** are not newly developed; they are largely formed from recommendations made in previous reports and publications, to which we have referred below. We have formed our 'musts' from recurrent themes we have identified from investigating the selected 250 cases of concern referred to in this first report, with the objective being to positively impact safety in all maternity services across England.

28 http://www.ockendenmaternityreview.org.uk/

1: ENHANCED SAFETY

Essential Action

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.

Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.
- An LMS cannot function as one maternity service only.
- The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY	
Essential Action There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	• Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services.

5: RISK ASSESSMENT THROUGHOUT PREGNANCY	
Essential Action Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	• All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING	
Essential Action **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**	• The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice. • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT	
Essential Action **All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	• All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women must be enabled to participate equally in all decision making processes and to make informed choices about their care. • Women's choices following a shared and informed decision making process must be respected.

Our Ongoing Work

I am grateful to my Independent Review Team who continue to support me with this review. We have taken these initial steps, through the publication of this first report, towards making a significant difference in helping to improve safety in maternity services. This review of 250 cases at the Trust can now impact positively on the maternity care provision for women and their families in Shropshire with the Trust working with their commissioners to ensure this happens.

As our work continues, we implore maternity services across England to also carefully consider this first report, and to make ambitious plans to ensure timely implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** takes place.

Donna Ockenden

Appendix 1: Terms of Reference

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.

2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.

3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

   a. appropriate investigations were conducted; and

   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.

6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.

7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.

8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:

a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;

b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;

c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;

d. Consider how the parents, patients and families of patients were engaged with during these investigations;

e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and

f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:

a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Key Principles

14. The review will be expected to:

a. Engage widely, openly and transparently with all relevant parties participating in the review process;

b. Be respectful when dealing with individuals who have been impacted by the incidents being investigated;

c. Adopt an evidence-based approach;

d. Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and babies;

e. Consider links to national policy and best practice in relation to midwifery, maternity, neonatal and obstetric care and investigation management that were relevant at the time; and

f. Consider the challenge of implementing proposals, including the workforce.

g. Handle data and information with care and in accordance with good information governance practice

15. For families who have contacted the Chair of the Secretary of State commissioned Independent Review directly, and whose cases were originally investigated by the Trust, the investigations of these cases will be reviewed. The review process will consider the investigations and associated action plans from each incident investigation to ensure these appropriately addressed the relevant concerns and were implemented by the Trust at the time.

16. All cases will be reviewed in relation to Trust policy and national guidance that was relevant at the time.

17. In 2018 NHS Improvement commissioned an 'Open Book' review of Trust records. Shrewsbury and Telford Hospital NHS Trust was requested to 'open its books' in relation to specific maternity data held by the organisation from 1 January 1998, when national incident reporting on the Strategic Executive Information System (STEIS) began, to 27 September 2018. The scope included patients from England and Wales (Powys).

18. The purpose of the review was to determine as far as reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to:

a. Maternal deaths

b. Stillbirths

c. Neonatal deaths

d. Babies diagnosed with hypoxic ischemic encephalopathy (Grade 2 & 3)

19. This has identified over 300 cases which don't appear to overlap with many other cases known to the review team. The independent review will now consider how to incorporate these cases, and any others which arise through the investigation, into its scope to assess whether their outcomes were the result of failings.

Resources

20. Resource requirements will be agreed between the Chair of the review, NHS Improvement and NHS England and the Department of Health and Social Care to ensure the review is adequately supported.

Timeframe

21. The overall timeline will be agreed between the Chair of the review, NHS Improvement and NHS England and Department of Health and Social Care, in light of the extended scope of the review.

22. The final review report and proposals should be available within one month of the review being completed.

Appendix 2: Glossary

Definitions and Medical and Midwifery terms used throughout this Report

Glossary of terms used

Birthing centre	A birth centre staffed by midwives, they may be 'stand alone', (some distance from a Consultant led unit) or alongside- often in the same building/ on the same floor as a Consultant led unit
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Clinical Commissioning Groups (CCG)	Groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anesthetists. They have a neonatal unit staffed by neonatologists and nurses
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
HSIB	The Healthcare Safety Investigation Branch. They investigate incidents that meet the Each baby Counts criteria and their defined criteria for maternal deaths https://www.hsib.org.uk/maternity/what-we-investigate/

Hypoxic ischaemic encephalopathy (HIE)	A newborn brain injury caused by oxygen deprivation to the brain. Graded into HIE grades 1-3 depending on severity
Humerus	The long bone in the arm
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Maternal Death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
MatNeo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a 'Modified Early Obstetric Warning System'
MBRRACE-UK	(Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK) – a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life - Early neonatal death – a liveborn baby who died before 7 completed days after birth - Late neonatal death – a liveborn baby who died after 7 completed days but before 28 completed days after birth
Non Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation

Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Perinatal death	A stillbirth or early neonatal death
Pre-eclampsia	A disease of high blood pressure, proteinuria and organ dysfunction occurring in pregnancy
Primary Care Trust or PCT	were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups or CCGs.
Shrewsbury and Telford Hospital NHS Trust or the Trust	
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal

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Chair's Assurance Report

Quality and Safety Committee - 19th November 2020

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	28th January 2021
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1. Purpose of Paper

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

This paper presents an overview of the Quality and Safety Committee Meeting held on the 19th November 2020 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The meeting was well attended
- There was good progress of actions from the previous meeting with all actions completed.
- The Committee received an update on the following standard agenda items:
  - Trusts Serious Incidents and Never Event management
  - Chair Reports reporting to Quality and Safety Committee
  - Review of the Work plan and Attendance Matrix
- The Committee received reports on Infection Control Report and Legal Claims for consideration for the Quarter 2 period.
- The Committee reviewed and discussed the following updates:
  - Harms review
  - Covid-19 outbreaks
  - Specialist Unit Quality Report

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Quality and Safety Committee which met on 19th November 2020. The meeting was quorate with three Non-Executive Directors and 2 Executive Directors present. A full list of the attendance is outlined below:

Attendance:	
Present:	
Chris Beacock	Non-Executive Director (Chair)
David Gilburt	Non-Executive Director
Paul Kingston	Non-Executive Director
Stacey Keegan	Chief Nurse and Patient Safety Officer
Steve White	Chief Medical Officer
In Attendance:	
Shelley Ramtuhul	Trust Secretary
Hilary Pepler	Trust Board Advisor
Nicki Bellinger	Assistant Chief Nurse – Specialist Unit
Sara Ellis Anderson	Assistant Chief of Professions – Clinical Services Unit
Ian Maclennan	Assistant Chief Nurse – MSK Unit
Rachael Flood	Matron for Surgery
Mark Salisbury	Operational Director of Finance
Larissa McElroy	Minute Secretary
Sian Langford	Deputy Facilities Manager (part)
Apologies:	
Kirsty Foskett	Matron
Nia Jones	Managing Director for Clinical Services Unit
Sue Sayles	Infections and Prevention Nurse

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Serious Incidents and Never Events		
There is currently one SI/Never Event under review relating to a deceased spinal ward patient. This report was due to be submitted to the CCG on 21st October 2021 however the Trust was asked to report additional information relating to the Duty of Candour. The Trust can now confirm this has been completed including a full review and appendices to provide reassurance. There has also been one SI/Never Event closed since the previous meeting which related to oncology referral and treatment. The Committee discussed the reasons for the Trust being	**Y**	

reported as an outliner when reporting on the thematic review. The Committee discussed the two periods of increased incidents over a 14 year period and highlighted the 0 incidents reported in between. The Committee were reminded that the incidents being discussed are post-operative seizures and therefore no incidents have been reported relating to CSF leaks. The Trust reassured the Committee that the history of all the patients was taken to The Regional Network Weekly Meeting for a discussion within the Spinal Network. The Committee discussed the possibility of developing KPI's for Spinal Disorders similar to the National PROMS data. It was suggested that comparative data would provide further assurance to the Committee.		
Infection Control Report Q2.		
The Committee received the report it was highlighted that due to the substation of elective surgery and commencement of trauma services in April, there has not been any surgical site surveillance formed. Since the restoration of services commenced in September 2020, the BSSI surveillance will be commenced and will be reported in quarter 4. There have been 0 Clostridium Difficile and 0 MRSA. There were four cases of Escherichia coli blood stream infections reported during the course of the quarter. The Committee were informed that post infection review meetings have been initiated for each of the cases. A key theme has been identified relating to documentation – these were discussed in detail within the meeting and an action plans has been created which the Trust will continue to be monitor. The Trust reported that within Quarter 2 there had been 13 positive cases of Covid. The Trust agreed to incorporate Covid acquired hospital infections into the quarterly report. The Committee noted the Infection Control Report.	**Y**	
Legal Claims Q2.		
The Committee received the standard Legal Claims report for review. The Committee discussed the timeframe of the delay in a Specialist appointment. The Trust explained that NHS Resolutions would have appointed the expert and that the timeframe could be linked to the individual's availability and having sight of the Orthopaedic report. The members of the meeting discussed the possibility of providing benchmarking data in order to provide the committee with further assurance that the Trust are responding to claims appropriately.	**Y**	
Harms Review		
The Committee received a report on the Trust Harms which included the following areas: • Powys Local Health Board delays • Initial Appointments	Partial	The Committee were assured the Trust has identified the correct actions to improve the Harms process.

• Treatment Delays • Follow Up Backlog • Metal on Metal The Trust explained further actions are required to ensure full assurance can be reported to the Committee and the Board of Directors. Areas of improvement have been identified and the Trust is currently working to ensure processes are embedded. The Trust can report that few patients have been identified as having harms, which provides some assurance. The Committee discussed the impact of Covid-19 and how it has affected the follow up of patients which have increased. The Trust continues to prioritise patients on a risk based approach. Patients are currently waiting approximately 1-2 month review and there are patients that have been waiting over 12 months for their appointment were looked at as potentially being highest risk. The Trust advised the Committee that the Trust is not compliant with MHRA regulations relating to metal on metal patients. The Committee will continue to receive an update report.		Actions of improvement include: • Saturday Clinics • Review of harms through DATIX • Potential resource for the Arthroplasty team to support metal on metal patients. • Harms Policy
COVID-19 Outbreaks		
The Committee was reminded that the Trust had declared an outbreak at the beginning of Covid-19 linked with Sheldon Ward and a second outbreak in October 2020 linked to the Pre-Operative Assessment Dept. It has been identified that new clinical space in the pre-op area that was not previously used for clinical purposes could be improved. This has since been investigated by the Estates team and signed off on November 5th. Further staff training and education was carried out, alongside further support for staff who feel anxious. A further outbreak was then declared at the Trust on 5th November 2020 with a total number of three patients and eight members of staff from Powys Wards and HDU. Learning from these areas included, RIDDOR reporting and a possible breach of PPE and face masks not being used. The team are reviewing the isolation pre-operatively, by benchmarking against other Orthopaedic providers in other Trusts due to reports of patients being tested positive. Further actions include, restricting visiting times, deep cleaning areas has been reviewed and advice has been received from Public Health suggesting to screen asymptomatic staff 7 days after the first. A detailed presentation is being collated for the Board of Directors meeting to provide further information and assurance.	**Y**	
Integrated Performance Report		
The Committee received Integrated Performance Report and discussed the exception data reported for October. • Actions were taken for the two reported escherichia	Y	

coli cases. • There were 3 reportable incidents regarding medications; 2 being low harm and 1 moderate. The moderate harm is still under investigation but is suspected to be linked to a potential known allergy. • An increase in cancellations has been noticed – actions have been taken to ensure these are reduced. The Trust confirmed these cancellations were not due to Covid but patient's choice and DNA's. The Committee were pleased that the cancer targets are being consistently met.		
Specialist Unit Quality Report		
The Specialist Unit report was shared with the Committee and the exceptions reporting was discussed. These included: • Two serious incidents • A number of moderate and severe harms, which one of these was the delay in the patient's treatment • 4 high risks which are all being treated • Eight complaints in relation to the delay in accessing treatment due to Covid. • Friends and family testing will recommence at the beginning of December. • During the height of Covid, the spinal injuries unit did not have any delayed transfers of care or discharges. Since moving back from the emergency Covid CHC funding, the unit are seeing an increase in their delays. A process has been set up for the unit to meet with the Specialist Commissioners on a weekly basis to discuss each of those patients in detail. The Committee asked for further information to be provided on the high risks including the mitigations and initial risk rating. The Committee questioned the actions in place to ensure the increase of compliance of training. The Trust explained the managers have been spoken to within the individual areas and have been asked to prepare forecasting and projecting of compliance which will provide great progress. The Unit to celebrate that the pathology SLA has been approved.	**Y**	
Chair Report from Infection Control Committee		
Infection Control Committee - the Committee *noted* the Chair Report from the Infection Control Committee. **Research Committee** – the Committee *noted* the Chairs Report from the Research Committee and asked for further explanation of the financial situation which will be available at the next meeting.	Y	
Performance Improvement Minutes and Action Log		
The committee ***noted*** the minutes and action log from the Trust Performance and Operational Improvement Board Meeting.	Y	

Review of the Work Plan		
The Committee *approved* the work plan. It was noted that the 3 Internal Audit Reports linked to the Committee were due to be presented. The Trust agreed to follow up with the Internal Audit Team.	N/A	
Attendance Matrix		
The committee ***noted*** the attendance matrix.	N/A	
Top Risks		
The Trust tabled Top Risks for discussion to prompt the Committee to consider whether the risks are being discussed, covered effectively and whether there may be any risks that require to be escalated. Along with giving the Committee the opportunity to ask for any risks to undergo a full review and a deep dive to be presented. The Committee agreed the following: • Receive an update following the research financial discussion – this was agreed to be reported at the next meeting. • A risk linked to the ongoing number of patients waiting longer than expected for an appointment linked. The Trust explained this is already reported through the BAF and reiterated that following the Harms Review paper, full assurance cannot be given at the moment, that there is not a safety issue as well as an experience issue	**Y**	
Any Other Business		
Terms Of Reference - the Committee *approved* the Terms of Reference subject to minor amendments.	**Y**	

3.4 Approvals

In the course of its business the Committee approved the following agenda items:

- Quality and Safety Committee Terms of Reference
- Quality and Safety Committee Work Plan

3.5 Risks to be Escalated

In the course of its business the Committee did not identify any risks for escalation.

3.6 Conclusion

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