The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 10.01.2024

MEETING

10 January 2024 09:30 GMT

PUBLISHED

9 January 2024

Agenda

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Board Members and Senior Leaders Declarations of Interests

First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From & To dd-mm-yy		Comments, including action taken to mitigate any potential conflict of interest.
					From	To	
Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	October 2006	Ongoing	
			Non-Financial Professional Interests	Chair of Dudley Integrated Care NHS Trust, Dudley	July 2019	Ongoing	
Sarfraz	Nawaz	Non Executive Director	Financial Interests	Executive Director of Finance at National Citizens Trust	18/09/2023	Ongoing	No conflict between role at NCS and RJAH
			Non-Financial Professional Interests	Member of CIPFA	01/2021	Ongoing	
Martin	Evans	Non Executive Director	Financial Interests	Non-Executive Director at Dudley Integrated Health and Care NHS Trust	01/04/2020	Ongoing	
			Financial Interests	Director at MJE Associates Ltd	01/04/2020	Ongoing	
Penny	Venables	Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	January 2021	Ongoing	
			Non-Financial Professional Interests	Non-Executive Director –British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA and the Finance and Audit Committee.	June 2020	Ongoing	
			Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS. Currently acting chair during the ill-health of the substantive chair of the Board of Trustees .	December 2014 (vice chair) November 2023 (chair)	Ongoing	
Martin	Newsholme	Non Executive Director	Financial Interests	I am a Non executive director of Shropshire Doctors Co-operative Limited ("Shropdoc") which provides out of hours services to STW and Powys Health Commissioners. Shropdoc has no direct dealings with RJAH but is part of the same ICS.	01/08/2019	Ongoing	
Lindsey	Webb	Non Executive Director	Financial Interests	Vice Chair of Birmingham Hospice	January 2016	July 2023	
			Indirect Interests	My husband, Paul Taylor, is NED at BSOLICB.		Ongoing	
John	Pepper	Associate Non Executive Director	Financial Interests	NHS England GP Appraiser	01/07/2022	Ongoing	
Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA		Ongoing	
			Financial Interests	Employed by Black Country ICB	01/07/2022	10/04/2023	
			Financial Interests	Senior Advisor on Primary Care Delivery, Department of Health and Social Care	01/11/2023	Ongoing	
			Financial Interests	Director of Maubach Consulting Ltd		Ongoing	
Atif	Ishaq	Associate Non Executive Director	Financial Interests	Data Product Director at Haleon Plc	2022	Ongoing	No conflict between role at Haleon and RJAH
			Financial Interests	Owner of Digital Clinician Ltd	2018	Ongoing	No conflict between role at Haleon and RJAH
			Financial Interests	Digital Advisor and Webmaster to Pharmacy Care Matters LTD	2011	Ongoing	No conflict between role at Haleon and RJAH
			Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	2011	Ongoing	No conflict between role at Haleon and RJAH
			Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	2011	Ongoing	No conflict between role at Haleon and RJAH
			Financial Interests	Self-employed webhosting provider	2011	Ongoing	No conflict between role at Haleon and RJAH
			Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	2017	Ongoing	No conflict between role at Haleon and RJAH
Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	November 2019	Ongoing	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Craig	Macbeth	Chief Finance and Planning Officer	No interest to declare	N/A	N/A	N/A	
Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust May 2022 - May 2023	May 2022	Ongoing	
Denise	Harnin	Chief People and Culture Officer	No interest to declare	N/A	N/A	N/A	
Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
08 NOVEMBER 2023 AT 9.30AM IN MEETING ROOM 1, MAIN ENTRANCE AT RJAH

MINUTES OF MEETING

Voting Members in Attendance

Name	Role	Attending
Harry Turner	Chairman	✓
Sarfraz Nawaz	Non-Executive Director	✓
Martin Newsholme	Non-Executive Director	✓
Penny Venables	Non-Executive Director	✓
Lindsey Webb	Non-Executive Director	✓
Martin Evans	Non-Executive Director	✓
Stacey Keegan	Chief Executive Officer	✓
Craig Macbeth	Chief Finance and Planning Officer	✓
Paul Kavanagh Fields	Chief Nurse and Patient Safety Officer	✓
Ruth Longfellow	Chief Medical Officer	✓
Mike Carr	Chief Operating Officer	*x*

Others in Attendance

Name	Role	Attending
Paul Maubach	Associate Non-Executive Director	✓
John Pepper	Associate Non-Executive Director	*x*
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minutes)	✓
Chris Hudson	Head of Communications	✓
Caroline Nokes Lawrence	Associate Chief People and Culture Officer, EDI Lead	✓
Colin Chapman	Governor	✓
Victoria Sugden	Governor	✓
Sheila Hughes	Governor	✓
Kate Betts	Governor	✓

Ref.	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting and in particular, the Governors and Shelley Simpson, who joined the meeting to present her patient story.
1.1	**Apologies**
	Apologies were received from John Pepper and Mike Carr. It was noted that the Board was quorate.
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 05 September 2023 were approved as an accurate record on the meeting subject to the minor amendment: • Quality and Safety report – amend to 2 E.coli
1.4	**Matters Arising and Action Log**
1.4.1	There were no further matters to raise.
1.4.2	The Board agreed to close all actions noted within the action log with exception to the Board 360 review which HT agreed to provide a paper on at the next meeting in December.

Ref.	Discussion and Action Points
2.0	**Patient Story**
	PKF welcomed Shelley Simpson to the meeting who joined to share a verbal update on her patient journey at the Trust. Shelley described the following: • Attended the hospital for a total hip replacement in December 2022 following a fall at home, which related in a trauma appointment • Hoping that by sharing the story, it will be used as a powerful learning tool for other patients. • Was referred to RJAH in 2021 - believed it would be the best place for treatment. • Prior to surgery considered which anaesthetic was preferred. • All risks of surgery were explained fully. • Following surgery was transferred to Clwyd ward with no pain, and welcomed a visit from her husband. • Visited and assessed by a staff nurse and registrar – no concerns raised • Described numbness to legs as pain relief began to wear off and started to feel discomfort • A neighbouring patient called for help from ward staff as extreme pain started • Described the experience and frightening and therefore asked to see husband and children. • On-call doctor was called for that did not attend the ward which caused further distress. • Pain relief was prescribed however unaffected due vomiting • On-call doctor completed a review of the case of without a face-to-face assessment. • Began with respiratory problems and chest pain and therefore oxygen was supplied and transferred to HDU via the outreach team. • HDU eased pain and returned to Clwyd ward the day. • Requested a meeting with the Consultant following being discharged to discuss inpatient experience. • Noted the meeting with the Consultant was helpful and reassuring. However still required clarification on why pain management wasn't received. • After attending a post operative appointment with Consultant reassurance was received that the investigation was going to be completed. • Good progress was noted on the total hip replacement at six weeks review. • Concerns were still unanswered regarding the on-call doctor therefore requested a copy of the medical notes. • Contacted the complaints department to help support in answering my questions and concerns. • Attended a meeting with the staff members within the complaints team and those who were involved in my care. I received an apology for my experience. • In June 2023, there have been some changes implemented to clinical care and governance following the complaint submitted. • Received a formal apology from the Chief Executive Officer. On behalf of the Board, HT thanked Shelley for attending the Board meeting to share her distressing experience. The importance of listening to patients who have raised a complaint is extremely important and ensuring lesson and learnt and implementation of actions to improve process are embedded remains a priority for the Trust. RL expressed her disappointment in the story however, noted the positives that the processes have improved and, in the future, will support other patient experience. The Board agreed to refer to the complaint action plan to the quality and safety committee to scrutinise and assure the Board that all actions relating to this case have been implemented and sustained. The Committee agreed to presenting assurance at the next Board meeting. Once again, the Board thanked Shelley for attending the meeting and sharing her distressing story with the hope that assurances was obtained in order to gain closure from the experience.
3.0	**Chair and Chief Executive Officer (CEO) Update**
	HT provided a verbal update – sharing the following key points with the Board: • Attended the NOA conference and awards. Although the Trust did not receive an award the staff should be proud of the amazing presentation which were delivered.

Ref.	Discussion and Action Points
	• Tim Briggs spoke about the national direction on the MSK. The Trust attended and positive meetings with the ICS leadership regarding the national direction. Concerns have been raised in relation to winter planning and challenged within the system are noted. • National inpatient survey results to be shared – positive results for the Trust. • Attended the integration summit – Patricia Hewitt from Norfolk ICS has been commissioned to review the ICS as a whole. It was noted that ICS will continue to stand and therefore were encouraged to continue with collaboration and integration. SK provider an update on the CEO Report. The update covered the following areas: • **Industrial Action** – thank you for continued work and input from all staff. There has been no action planned for November and pleased to note that conversations are taking place. • **Inpatient survey** – pleasing set of results for the Trust as rated number 1 in the country again. There are some areas of improvement which will be monitored through an action plan. • **Deputy CEO** – congratulations to MC who has been appointed Deputy CEO. MC has commenced his role alongside his Chief Operating Officer role. • **STW ICB CEO** - congratulations to Simon Whitehouse who has been appointed substantive CEO for the system. • **Corporate objectives** - approved at the last public board. Further engagement across the organisation has been completed. The revised 5-year strategy will be discussed in the private session today ahead of presentation at the public meeting in January. • **GIRFT accreditation** – submitted an application to gain accreditation. The Trust preparing for the visit from the team. • **NOA** – attended the conference and awards recently. It was great to see members of the team presenting at the conference. Well done all involved! • **Exemplar for catering** – 1 of 21 Trusts have been awarded which will help learn/support and improve by aligning to standards. • **Gill and Dan** – competing in the final NHS Chef of the year competition. Commended them both their hard work and determination. • **Star Awards** – Congratulations to Chloe Ellis! Chloe was nominated by Lake for her drive and determination linked to SAND. Congratulations to Yasmin Heath, League of Friends Chairty administrator who supported the roll out of togetherness week for the Trust. SN queried whether PIDMAS had been implemented which is a digital patient choice platform. The Trust confirmed there were 51 patients requested withing the within the first week. On behalf of the Board, HT thanked CM for his support at Deputy CEO over the recent years.
4.0	**Risk and Governance**
	Board Assurance Framework The Board considered the submitted paper and members noted the following points in particular: • The framework has been considered at each of the assurance committees. • Included paragraph of the discussions which were held at the meeting for oversight. • Assurance chair reports also note the movements within the BAF. • The Board is asked to consider the risk and the content. • Agreed the corporate objectives. • The risk appetite with be presented and discussed at the private board session for comments. • Wider review of the BAF at a future Board meeting in the coming months. Following consideration of the report and subsequent discussion, the Board discussed: • Highlighted that BAF number 6 was not received at the Finance and Performance Committee and has been realigned to the Digital, Education, Research and Innovation Committee (DERIC) • Noted that the Chairs of the Committee meetings were assured with the process. • Suggested a wider review in relation to activity and financial challenges – this is to be reviewed at the next Finance and Performance Committee. • Suggested refresh of BAF number 2 - the score is to be reviewed as it is not currently a 16 following the work undertaken to mitigate the risk. • Noted that some of the risks do not have a score which was acknowledge as a timing issue of the report. • Consideration to be given to the risks where the score does not change – are they the risk which the Trust agree to tolerate, and should this be incorporated into the framework?

Ref.	Discussion and Action Points
	• Further scrutiny of BAF number 9 required specifically in relation to productivity as this is a significant risk for the Trust. • Noted the risk appetite session this afternoon will support the gaps within the framework. • Agreed the framework also needs to align to the system objectives. • Although there is clear progress and impact on the planned controls. Further information is required on the existing controls for example, how can BAF number 1 be measured? The Board acknowledged the ongoing review of the BAF which will be presented to the Audit and Risk Committee for oversight ahead of the next presentation at the Board. The Board approved the Board Assurance Framework.
4.2	**Corporate Risk Register** The Board considered the submitted paper and members noted the following points in particular: • The register has been reviewed at each assurance committees and the movement to the risk have been noted within chair reports from the committees. • High level summary provided to the Board for oversight. • 3 risks have been reduced and removed as below risk score of 15. • 1 proposed to be removed. The Board is asked to review and note the corporate risk register. Following consideration of the report and subsequent discussion, the Board: • Noted the corporate risk should be presented through the Committee Chair report to provide assurance to the Board. CRR should be presented through the chair reports. • Noted that following the committee effectiveness review there was a recommendation in relating to enhancing the reporting to the Board and therefore consideration to the reporting template is being given. • Risk 3078 – to be aligned to the Quality and Safety Committee The Board approved the corporate risk register, noted the comments and amendments suggested throughout the discussion.
4.3	**Fit and Proper Persons Test (FPPT)** The Board considered the submitted paper and members noted the following points in particular: • The revised process is being embedded following the circulation of the new arrangements for the FPPT. • This effects both Executive and Non-Executive Directors who will be requested to complete a series of tests. • The new framework has been launched and is to be implemented before the end of the financial year. • Going forward a standard template will be used for references. • There are a series of checks to be completed annually. The Trust are currently working through the practicalities of the processes. • The Trust is still awaiting the national leadership competency framework which was due to be launched at the end of the October. This framework will support the appraisal for board members and in time this will be aligned to the FPPT. Following consideration of the report and subsequent discussion, the Board commented: • The information is shared with the Council of Governors for oversight. The Board noted the FPPT information shared.
5.0	**Quality and Safety**
5.1	**Chief Nurse and Patient Safety Officer Update (verbal)**
	PKF provided a verbal update – sharing the following key points with the Board: • Peer review of Ludlow ward has been completed and the ward passed the review. • Noted increase in prevalence of measles – working with communication to cascade the relevant information. • Appointed the new safeguarding lead for the Trust – congratulations to Helen Harris • MCSI mother and baby – a package of care is to be completed with support from mother and baby will be cared for on Alice ward – thank you to all involved in supporting the patient. • Staff establishment reviews have been completed – there have been no fundamental changes or recommendations following the review. A formal report will be presented to the People and Culture Committee.

Ref.	Discussion and Action Points
	The Board thanked PKF for the update.
5.1.1	**Sexual Safety Charter**
	The Board considered the submitted paper and PKF highlighted the following points in particular: • The Trust has signed the charter - 1 of 88 organisation across the UK. • There is work to be completed as part of the implementation. • A working group to be established to supporting in implementing the 10 recommendations – these include support from safeguarding and people services. • Operational oversight will be aligned to the safeguarding meeting before upward reporting. The Board discussed the following: • Important initiatives and the importance of communicating the policy effectively to staff. • Communications have been drafted to support and raise awareness. • Highlighted areas for staff to gain advice from including people service and freedom to speak up guardian. • Need to be prepared for a potential increase in concerns being raised. • Confirmed the action plan will be overseen by the People and Culture Committee. • The next progress report will include next steps and time frames for implementation of the recommendations. Following a discussion, the Board agreed the assurance Committee should be the People and Culture Committee.
5.2	**Chief Medical Officer Update (verbal)**
	It was noted that RL was going to provide a verbal update on industrial action and GIRFT accreditation which has already been discussed throughout the meeting.
5.3	**IPR Exception Report**
	The Board considered the submitted paper and members noted the following points in particular: • 1 RJAH acquired CDI – one patient who has been classified as a relapse. A post infection review is currently being completed and will be reported through the Quality and Safety committee. • 2 SSI confirmed within November – the one together audit has been completed and both SSI will be reviewed under PSIRF process. • 1 unexpected death reported – the patient was known to have cardiac history. There have been no concerns raised in relation to lapse of care. The Board noted the steady performance update.
5.4	**Chair Report | Quality and Safety Committee**
	The Board considered the submitted paper and members noted the following points in particular: • Mental on Metal – a process of identify has commenced. The Committee requested further assurance on the level of harm following the review. • Received the BAF for consideration and agreed that risk number 4 can be reduce following the policies which are in place. • Peer review has been completed and further assurance in relation to the action plans have been requested at a future meeting. • Q2 claims report was considered and noted – there were no issues to raise to the Board. The Board were assured following the presentation of the chairs report and thanked the Trust and the Committee for their continued hard work.
5.5	**Inpatient Survey**
	PKF provided a briefing on the inpatient survey noting the detail of the survey can be located on the website. PKF provided the following highlights: • Patients are engaged with the review process within the Trust. • Areas of improvement to be considered. These will be reported through the patient experience group before onward report to the Quality and Safety Committee. The Board congratulated the Trust on another fantastic achievement and asked for consideration to be given on how the Trust can thank people for taking the time to complete the survey. PFK confirmed the communication are to cascade further information and a thank can be incorporated into the message.

Ref.	Discussion and Action Points
	SN highlighted that it is a fantastic achievement to receive similar recognition year on year from a different cohort of patients. The consistency over each year is commendable. ME suggested an advert or poster being placed within the Denbigh's restaurant to proudly share the results relating to the food. The Board commended the Trust and noted the report.
5.6	**IPC Annual Report**
	The Quality and Safety committee confirmed the annual report was considered at the recent meeting. The Committee held a helpful discussion on how further assurance can be provided which includes assurance against the national standards. The Board noted the IPC annual report.
5.7	**Controlled Drug Annual Report**
	The Quality and Safety committee confirmed the annual report was considered at the recent meeting. The Committee held a helpful discussion on how further assurance can be provided and the report will be revised ahead of the next annual report to focus on specific areas. The Board noted the annual report.
5.8	**Learning from Deaths Q2 Report**
	RL presented the Q2 report, highlighting the following: • Thank you to James Neil for compiling the report. • Highlighted the process of the reviews. • 1 death in July – a postmortem was completed, and it was confirmed the deaths was from natural causes. An investigation has been undertaking to support in learning and will be shared at clinical audit meeting once completed. • 1 death in September – no concerns relating to the death have been raised. • James Neil continues to deliver training on deaths certificates. The Committee confirmed assurance was received following the presentation of the paper at the meeting. The Board noted the learning from deaths Q2 report.
6.0	**People and Workforce**
6.1	**Improvewell Demonstration**
	The Board welcomed CNL who joined the meeting to present an update in Improvewell. • Noted the Improvewell flyer has been circulated for information. • Engagement session with theatre staff have been completed. • Encouraging to note that staff have been asked to part of the pilot. • Noted as a digital solutions which links with compassion and civility. • The pilot will be reviewed before the full roll out of the app. • Exciting to receive real time feedback and engagement from staff. • Noted to be implemented within other NHS organisations. Following the presentation, the Board discussed the following: • Confirmed the data can be broken down and Executive can be responsive. • There are different function available for corporate# and clinical services. • There is an a app for staff to download • There is an option to dig deeper in to detail even via professional groups. • Managers can gain feedback from staff and wards from patients. CNL confirmed the process and timeline as follows: • Pilot early December (staff survey closes end of November). • Assessment of the pilot to be completed in the new year. • Review of Improvewell to be provided before the roll out to all staff. The Board welcomed a report back to the meeting and present a demonstration of the app in due course.
6.2	**WRES and WDES annual report**
	CNL presented the annual reports to the Board, highlighting the following: • There is a requirement to publish the annual reports on the website by 31st October. • The annual reports have been uploaded to the website subject to the approval. • The annual report and actions plan for the WRES and WDES were presented to the Board for consideration and approval.

Ref.	Discussion and Action Points
	• Noted there is one overarching action plan for both reports. • Confirmed metrics are used from the staff survey Following a discussion, it was noted the WDES annual report was considered by the People and Culture Committee however the WRES annual report was not reviewed. The Board asked for annual report to be reported to the next People and Culture Committee for scrutiny and report back to the Board via the chairs report to confirm assurance. PV suggested further consideration to be given to improving and developing staff. The Trust confirmed there is access to the high potential scheme, coaching and mentoring. The Board approved the annual reports.
6.3	**Guardian of Safe Working Hours Q2 Report**
	RL provided the following comments on the Q2 report: • Thank you to Chris Marquis who compiled the report. • Noted the Trust has received 2 exception reports which have been aligned to junior doctors. • The exception were flagged following the trainee exception report from a period of time in Wales. • This is currently being addressed and there isn't not a similar process embedded in Wales. On behalf of the People and Culture Committee, ME thanked Chris Marquis for taking the time to attend the meeting to present the report where assurance was received and noted work is ongoing to review the process with Wales. The Board noted the Q2 report.
6.0	**Performance and Finance**
6.1	**Chief Operating Officer Update (verbal)**
	JB provided a verbal update – sharing the following key points with the Board: • Activity recovery remains a key agenda on the Financial Recovery Group meeting which is held weekly. • Enhanced recovery all surgeons will commence the programme from September. There was a presentation delivered at the MDCAM meeting earlier this year which was well received. • MC continue to chair the West Midlands imaging network. • Attended the ICB development session relating to MSK transformation programme
6.1.1	**Industrial Action (verbal)**
	There has been no industrial action since September however, further action is expected in November. The Trust will continue to the well embedded process in order to keep patient and staff safe.
6.2	**IPR Exception Report**
	The Board considered the submitted paper and members noted the following points in particular: • Cancer – September 62 weeks 0% return (1 patient) due to an admin error. Following a review there has been a change in process to support. • Focusing on diagnostic as there is an issue with workforce and capacity. The Board noted the update relating to the performance indicators.
6.3	**Long Waiters (presentation)**
	JB delivered a presentation on the long waiting patients. The presentation covered the following areas: • Overall NHS 65 week waiters are on track. • 104 and 78 weeks are monitored daily. • Performance remains positive. • Keeping pace on moving patient on to pathways. • Welsh patients – the Trust continue to liaise with partners for support. • Supporting Shropshire community trust with the long waits. • Continue to support the system and patients. Following the highlights being presented, the Trust confirmed discussions were held at the Finance, Performance and Digital Committee and noted the members of the meeting were assured with the processes in place to support patients.
6.4	**Activity Mitigation Plan**

Ref.	Discussion and Action Points
	JB delivered a presentation on activity mitigation plan the Trust have embedded. The presentation covered the following areas: • The presentation was considered the recent Finance and Performance Committee • Noted the shortfall in September and therefore requested a cases per session deep dive to be completed. • Key issues related to the 12 theatre challenges. • Theatre utilisation remains high – discussed at the weekly meeting to check and challenge the process and improve the overall plan. • Key is to ensure patients are seen as soon as possible. • Noted improvement relation to outpatient, SOOS and physio – good improvement plan is being presented through the Financial Recovery group. The Board discussed the following: • Noted the evolving plan. • Further review to be completed to understand the underlying performance and the reasons. • Noted the challenges faced with industrial action and case mix however, the Trust would still not have reached the original plan. • Deep dive to be completed to support the understanding and provide assurance to the Finance and Performance Committee • Consideration to be given to late starts and early finishes and the effect of complex patients. • Further work to be done to diagnose that is happening to the underlying performance to ensure this is mitigated for the next financial year. • Suggested a review of coding – the Trust confirmed a coding review was presented the FRG meeting and there have been further areas identified to support. This improvement should be noted from next month. • Required to maintain focus on posts which are going to have an impact. • high level of workforce metrics are being shared which is helpful, this included supernumery positions which are being challenged. • There is a step change with the additional theatre however noted the delays with the construction phrase – the workforce structure needs to be in place. • Consideration to be given as to whether the attendance to operational level for the FRG meeting is to be broader. The Board asked the Trust to consider how the remaining gaps can be mitigated, confirmation of the waiting list figures and how this effects the financial plan.
6.5	**Agency Reduction Plan**
	PFK provided a verbal update on the agency reduction plan, the Board noted the following: • Agency controls in place from NHS England. • The Trust have established a task and finish group. • The task and finish group has been incorporated into the non-medical group with a focus on OJP and LLP. The Board asked for reassurance on the resource that agency staff have been used for 2 years – do they have long term rights? It was noted that if they are employed by the Trust they will have employment rights. The Boarded noted the following: • Gladstone and Wrekin are the spinal disorder wards and the nature of the patients require a difference skill set from due to the high dependency upon staff. • The Trust is aware of which patients this is required type of care is require for. • That pipeline is expected to be delivered imminently. On behalf of the People and Culture Committee, ME confirmed the detail of the report was presented to the meeting and assurance was received.
6.6	**Finance Performance Report**
	The Board considered the submitted paper and members noted the following points in particular: • Noted the deteriorated position in September. • Shortfall of £2.1m a drift from plan.

Ref.	Discussion and Action Points
	• The key drivers include industrial action (the Trust is awaiting guidance on financial mitigation which may be available), productivity and the lack of achievement of the session within the theatres. • Theatre sessions were short of plan by 52 in month. • Increase costs of the activity have been noted – this is believed to be relation to case mix complexity. The Trust is completed a further review to understand the detail. • There are incurring pay costs relating to bank and agency as the Trust have continued to mitigate gaps with supernumery staff. • The Financial recovery group has been going into further detail on the route causes. • The forecast continues to evolve. • Most likely scenario has been presented at £5.7m adverse to plan which included £3.4m pressure from industrial action. This leaves the Trust will a £2.3m deficit which is noted as a challenge. The Board welcomed a further update at the next meeting to include other mitigations identified to support the achievement of the plan.
6.7	**Chair Report | Finance and Performance Committee**
	The Board considered the submitted paper and members noted the following points in particular: • Noted the main concerns have been discussed in detail throughout the meeting. • Main cause of concern still relates to the Trust achieving the operational and financial plans. • Acknowledged the mitigations which have already been presented by MC – recognised there is further work to be completed. • Efficiency programme on plan The Board noted the challenges and risks relating to the plans and thanked SN for the update
6.7.1	**Treasury Management Policy**
	Following consideration at the Finance and Performance Committee, the members of the Committee recommended the Board approved the Treasury Management Policy. The Board approved the policy.
6.7.1	**Chair Report - DERI Committee**
	PV provided the following update: • The Committee held a positive meeting • Noted there are still some housekeeping arrangements being agreed. • Debated the terms of reference and asked for some amendments to be reflected, therefore, they will be shared with the Board for approval at the December meeting. • Agree to add in more on information relation to innovation. • Draft committee workplan was discussed and consideration given on how to link in the reporting committees. • Noted it will be a wide and complex agenda. • Consideration being given to having flexible meeting days to ensure the key people can attend the meeting – focus items at each meeting. • Cross cover with the assurance committee – agreed the responsibility for clinical audit ill remain with Quality and Safety however, asked for consideration from the Quality and safety Committee chair as and when required. • Draft BAF received – noted further work is to be undertaken. Overall, there was a positive reflection of the meeting. Discussed the potential links with university and other avenues of which the Trust can explore. The Board thanked PV and the team for the update
7.0	**Chair Report - Audit and Risk Committee**
	MN provided the following update in relation to the Committee: • There are no matters of noncompliance or concerns to raise to the Board. • Requested further assurance on the theatre wastage paper. Recommended this is presented to the Finance and Performance Committee to gain assurance at the next meeting to which the Board agreed. • Code of governance is ongoing – a further update will be provided at the next meeting. • Conflicts of interest – reviewing the register and making sure the Trust are able to demonstrate any potential conflicts of interest.

Ref.	Discussion and Action Points
	• Internal Audit progress report - addressed the recommendation papers as there was a noted disappointed the follow up of recommendation from a review not being implemented by the Trust. I was suggested each assurance committee is to gain assurance on the reviews aligned to their committee – to which the Board agreed. • Risk management - education of risk register continues and actions are being implemented to improve the risk including a reviewing the age profile of older risks. The Board noted the update and were assured.
7.0	**Questions from the Public and the Governors**
	The governors raised the following comments: • **WDES Annual Report** – consideration to be given to inaccessibility of the Trust Office and Office above physio. Agreed to discussed adaptation through People and Culture Committee however noted that any new buildings are built with relevant access. • **People and Culture Committe**e – great work going on which will support future retention and empowering staff to make a difference. The app will be well received - well done! • **Patient Story** – disturbed by the story and welcomed the assurance update through the Quality and Safety Committee. Suggested keeping Shelley up to date with the assurance provided at the Board meeting next month. • **Patient Story** – commended the Board for inviting and encouraging Shelley to share her story. There were no members of the public in attendance.
8.0	**Any Other Business**
	There were no further items of business discussed. HT closed the meeting by thanking all attendees for joining.
8.1	**Date and time of next meeting**
	Public Board of Directors Meeting | 10 January 2024| RJAH Conference Suite, Main Entrance

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director – Public Meeting, 10 January 2024

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

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

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

Recommendations:

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

Acronyms	
GIRFT	Getting It Right First Time
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
STW	Shropshire, Telford and Wrekin
PRH	Princess Royal Hospital
ARAP	Afghan Relocations and Assistance Policy
ASCOT	Autologous Stem cells, Chondrocytes Or the Two
ACI	Autologous Chondrocyte Implantation
RAF	Royal Air Force
BCRT	Bone Cancer Research Trust

1. Success in our bids to be accredited as an Elective Surgical Hub and a Paediatric Hub

I was delighted that we were successful in our accreditation applications to Getting It Right First Time (GIRFT). As a result, we are now accredited as both an Elective Surgical Hub and a Paediatric Hub. In the case of the Paediatric Hub, we are in the very first tranche of organisations in the whole country to receive this kitemark of quality. It's a significant achievement, and one of which everyone in the Trust should feel very proud. To me, it felt very much like a huge and extremely welcome early Christmas present! GIRFT aims to supports systems nationally to ring-fence elective capacity through this hub model and increase capacity nationally by 30% by the end of 2024/25. Being accredited as an Elective Surgical Hub is seen as a visible marker of high standards and excellent quality and I want to congratulate and thank all staff who have made this possible.

2. Launch of our Trust Strategy 2023 - 2028

Our staff want an innovative future for our patients, our colleagues and our communities. We know this because they have told us so in numerous forums over recent months. Now, we are delighted to have set out our new five-year strategy, which lays out how we will look to begin the journey of delivering that innovative future over the next five years. We launched the strategy last month (December) with two all-staff briefing sessions, and the feedback we gained on that day was invaluable and will help us as we look to achieve the ambitious goals we have set for ourselves. We had already launched our strategic objectives for the next 18 months, and those objectives align completely with our longer-term strategy. I feel there is an exciting opportunity for us over the next five years to build on what we already have here at RJAH, and ensure we continue to grow and continue to thrive long into the future.

3. Sexual Safety Charter

NHS England recently unveiled a new Sexual Safety Charter. We at RJAH have signed up to that and formally launched it within the Trust in December. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace and to take appropriate actions. The Trust fully endorses and adopts the Charter and has already been involved in responding to concerns raised about inappropriate workplace behaviours and where necessary this has led to appropriate investigation. The Trust has already demonstrated that it will take allegations of this nature extremely seriously. We fully recognise our duty of care and wish to support and work with our employees who speak up about these issues. Our priority is always the welfare of our employees, and it is paramount that we do the right thing to support colleagues.

4. Supporting system pressures

Unfortunately, it remains a challenging time for health and care services, and the festive period was another difficult one for our urgent and emergency care colleagues across Shropshire, Telford, and Wrekin (STW). Like all system partners, here at RJAH we need and want to play our part – and we made 16 beds available on Kenyon Ward as surge capacity for the system. Those beds were used to take patients from the county's acute and community hospitals in order to create some extra capacity for flow across the system. At the time of writing, we are still closing those beds down, but it is the intention that the area will have gone through a deep clean and restored to elective MSK use by the date of our Board meeting.

Another programme of work to support over the winter period is the transfer of in-patient elective orthopaedics from the Princess Royal Hospital (PRH) to RJAH enabling escalation capacity at PRH to assist with urgent and emergency care pressures. This programme enables patients deemed high

clinical priority or those waiting longest (65 week waits) to access surgery and our clinical partners to continue to operate or work within their speciality field.

5. RJAH supporting health needs of Afghan families

RJAH has recently taken on a lead role supporting the health needs of a cohort of Afghan families who have escaped from the Taliban after giving service to the UK Armed Forces. Hundreds of individuals have already passed through the nearby Nesscliffe Barracks in recent weeks, where they have been placed while more permanent arrangements are made in other parts of the country. More will follow in the next few weeks. Their passage to the UK has been arranged via the Afghan Relocations and Assistance Policy (ARAP), which is supporting individuals and their families who were at risk from the Taliban after working with the UK Armed Forces in roles such as translators and interpreters. While at Nesscliffe, RJAH has agreed with NHS Shropshire, Telford, and Wrekin to take a lead on supporting their health needs. Rebecca Warren, our Enhanced Recovery Lead, and a serving reservist, has been overseeing the project, liaising with other agencies including Shropshire Community Health and primary care.

6. NHS Providers annual conference

In November, alongside Harry Turner and Mike Carr I attended the two-day NHS Providers conference, this year's theme was 'Vital', representing the essential care the provider sector delivers, the deep commitment of staff, and the importance of ensuring our health service is sustainable for the future. There was a series of roundtables, expert case studies, interactive debates and importantly an opportunity to connect and network with other provider colleagues.

7. NHS Pastoral Care Quality Award

I was delighted that our work on international recruitment and our commitment to providing a gold standard quality of pastoral care has been recognised with a prestigious national award: the NHS Pastoral Care Quality Award. The award scheme aims to standardise the quality and delivery of pastoral care internationally educated nurses and midwives across England receive, and to achieve it we had to meet a series of standards outlining best practice pastoral care. We know that enhanced pastoral support has a positive impact on both recruitment and retention, and supports staff wellbeing, and I'm incredibly proud of the work that's been undertaken to ensure the safe arrival, induction, and ongoing support for our internationally educated or recruited colleagues.

8. Celebration to mark end of ASCOT Trial

At the start of December, the Trust hosted a celebratory day to mark the end of the ASCOT Trial, which has been running for a decade. It has helped to transform the lives of people suffering with damage to their knee joint or cartilage and has been running in partnership with Keele University and supported by the Orthopaedic Institute Charity, Versus Arthritis and the Medical Research Council. ASCOT (Autologous Stem cells, Chondrocytes Or the Two), is a trial in which stem cells from the patient's bone marrow were also used to repair damage, alongside cartilage cells (the more well-established treatment). The trial aimed to determine if there are differences in patient outcome when using stem cells from bone marrow, either alone or in combination with Autologous Chondrocyte Implantation (ACI), and I look forward to hearing more about the findings in the coming months and years.

9. Veterans' Orthopaedic Centre celebrates first birthday

Our pioneering Headley Court Veterans' Orthopaedic Centre celebrated 12 months of welcoming veterans and members of the Armed Forces community through the doors in December. The dedicated centre opened on 1 December 2022 – where former Royal Air Force (RAF) Wing

Commander Alex Baxter, from Shrewsbury, was the first patient to be seen in the £6 million building. Since then, it has seen over 2,000 patients and continues to go from strength to strength. To celebrate the occasion, a birthday party was held in the Centre, with staff, volunteers, patients, and visitors attending.

10. Double shortlisting for 'Bone Idol' in prestigious awards

We always like to see teams and individuals from our Trust getting recognition in national award schemes, so it was pleasing to see the excellent and personalised care we provide for patients with primary bone cancer coming under the spotlight. The Bone and Soft Tissue Tumour Service and Miss Karen Shepherd, Consultant Orthopaedic and Oncological Surgeon, have been announced as finalists in this year's Bone Idol Awards, run by the Bone Cancer Research Trust (BCRT). The team have been shortlisted in the Team of the Year Award for providing outstanding holistic care to bone cancer patients, dedicating themselves to providing a highly personalised service. Miss Shepherd is a finalist in the Surgeon of the Award after being nominated not only for her exceptional surgical skills, but also for her passion and commitment in the field of primary bone cancer.

11. RJAH Stars Award

Every month, I present an RJAH Stars Award to one individual or team, in recognition of outstanding achievement or performance. There have been two winners of the RJAH Stars Award since our last public Board meeting:

- The November winner was Julie Rae, one of our Medical Secretaries. Julie, who is Medical Secretary to Consultant Surgeon Mr Simon Hill, was nominated by patient David Davies. David said: "Julie goes above and beyond her role as secretary to Mr Hill. If I need to know something she will help and she will respond with 'if you need any help, you know where we are and don't hesitate in calling'. Behind every brilliant Consultant is an even more brilliant Secretary."

- The December winner was Jessica Hatton, one of our Theatre Scrub Practitioners, after being described as compassionate and demonstrating professionalism and composure. The nomination came from Dr James Pattison, Consultant Anaesthetist, after an especially difficult emergency case in the Theatre Department. Dr Pattison said that in his 20 plus years of anaesthesia, her professionalism and composure stood out as some of the best he had ever seen. She was flexible, proactive, and her communication with the team exemplary. After the patient was stabilised for transfer, she expressed such compassion for the patient and family.

Congratulations to both of our latest winners!

11. Conclusion

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

Trust Strategy

Committee / Group / Meeting, Date

Board of Directors, 10 January 2024

Author:		Contributors:
Name:	Nia Jones	
Role/Title:	Managing Director for Planning and Strategy	Trust-wide contribution

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

The Trust Strategy have been developed following a comprehensive series of sessions with patients, staff, system providers and enabling services.

The first draft Strategy was reviewed by the private board of directors meeting in November and December 2023 where recommendations and subsequently incorporated into the final version.

A launch of the Trust Strategy has commenced with the Trust presenting the document to the Trust Management Group and holding staff engagement sessions. The staff engagement sessions have been fundamental in the next steps of shaping the revised direction of the Trust as we look to review the Trusts mission statement and values.

Strategic objectives and associated risks:

The Trust strategy outlines the aims associated with the strategic objectives and informs future corporate objectives.

Recommendations:

The Trust Board approved the Trust Strategy in December 2024 and is presented at the public Board meeting for information and wider circulation.

Report development and engagement history:

The engagement in the development of the Trust Strategy is contained within the document.

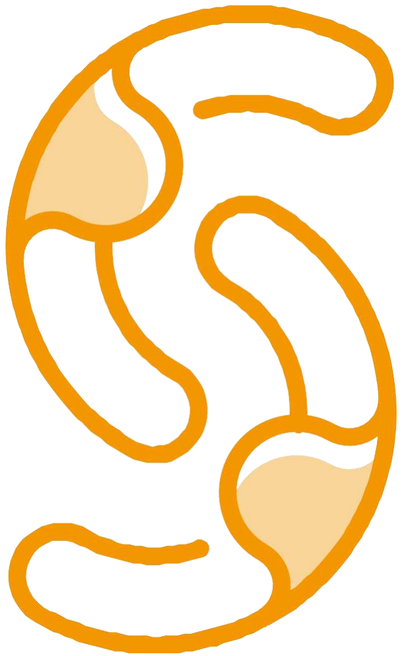
Appendices

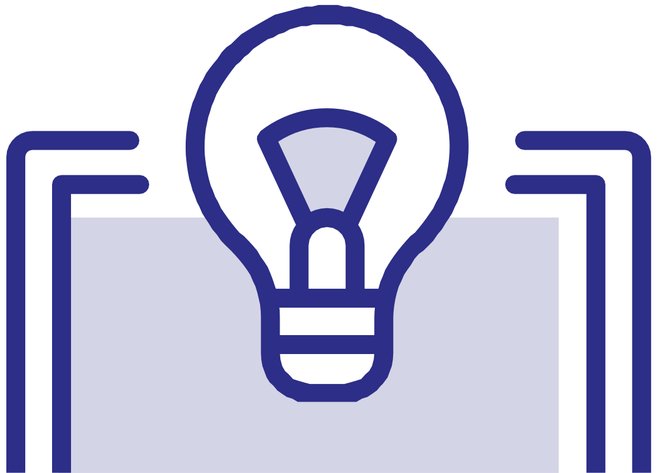
Appendix A Trust Strategy

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Trust Strategy

2023 – 2028





About us

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is one of the UK's five Specialist Orthopaedic Centres. It is a leading orthopaedic centre of excellence with a reputation for innovation.

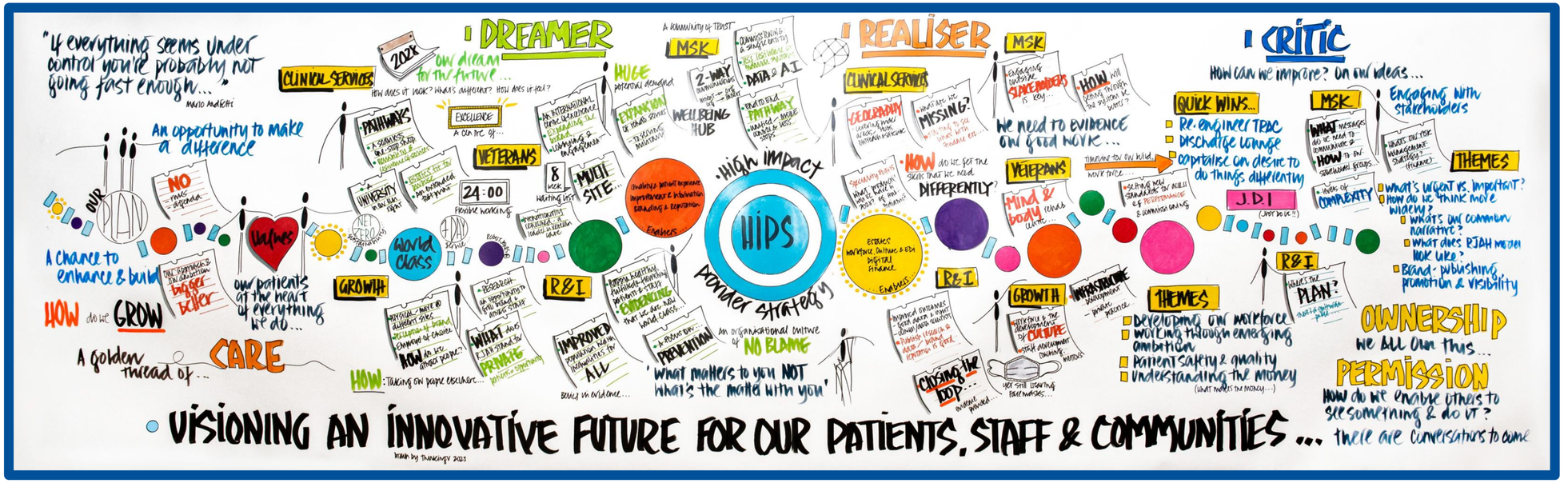
The Trust provides both specialist and routine orthopaedic care to its local catchment area and nationally. It is a specialist centre for the treatment of spinal injuries and disorders and also provides specialist treatment for children with musculoskeletal disorders. The hospital has nine inpatient wards including a private patient ward; 12 operating theatres, including a day case surgery unit; and full outpatient and diagnostic facilities.

The Trust works with partner organisations to provide specialist treatment for bone tumours and community-based rheumatology & orthotic services.

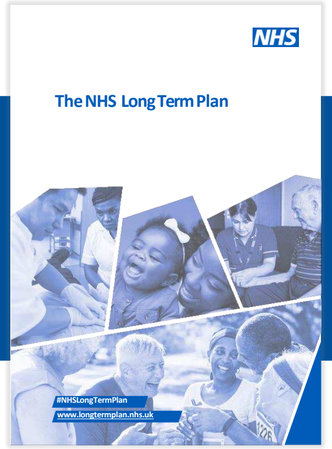
The Trust is based on a single site in Oswestry, close to the border with Wales. The surrounding geographical area includes Shropshire, Wales, Cheshire, and the Midlands. As such, we serve the people of both England and Wales, as well as a wider national catchment. We also host some local services which support the communities in and around Oswestry. We value our links with the local community, who are strong supporters of the hospital. The Trust has contracts with a number of commissioners.

Our staff pride themselves on the standards we achieve, and, in the feedback, we receive from our patients on the quality of the care and services that we provide.

Our staff want an innovative future for our patients, staff and communities



National Context



NHS Long Term Plan

The NHS Long Term Plan set out the 10 year strategy for the National Health Service (NHS).

- the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.
- the actions the NHS will take to strengthen its contribution to prevention and health inequalities
- the NHS's priorities for care quality and outcomes improvement
- how current workforce pressures will be tackled, and staff supported
- a wide-ranging programme to upgrade technology and digitally enabled care across the NHS

NHS Five Year Forward View

The NHS Five Year Forward View outlines the vision for the future of the National Health Service (NHS) in England in delivering the:

1. **Vision:** a better NHS, emphasizing the need for improved prevention and care for patients. It aims to place the NHS on a more sustainable footing.
2. **New Models of Care:** Advocating for new models of care, emphasizing better integration across various services. This includes GP, community health, mental health, and hospital services, as well as collaboration with home care and care homes.
3. **Patient Engagement:** The report calls for a more engaged relationship with patients, carers, and citizens to promote well-being and prevent ill health.
4. **Quality, Funding, Integration, and Innovation:** Focussing on quality improvement, funding, integration of services, and fostering innovation within the NHS.

Armed Forces Act & Veterans Covenant Hospital Alliance

The Chavasse Report (2014) provided recommendations to the NHS to ensure the on-going care of musculoskeletal problems for all service personnel by the NHS.

In 2021 the Armed Forces Act gained Royal Assent to enshrine the Armed Forces Covenant in law for the first time to help prevent service personnel and veterans being disadvantaged when accessing essential services like healthcare, education and housing.

The VHCA accreditation process is the framework to support Trusts compliance with the Armed Forced Covenant and the updated Armed Forced Act. Veterans Covenant Hospital Alliance (VC HA) is a group of over 70 NHS acute hospitals and Health Boards which have volunteered to develop, share and drive the implementation of best practice that will improve UK Armed Forces veterans care.

National Context

The People Plan

The People Plan 2020/21:action for us all, published at the end of July 2020 along with Our People Promise, built on the Interim People Plan to set out a range of actions to deliver this.

These are organised around four pillars:

- looking after our people – with quality health and wellbeing support for everyone
- belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
- new ways of working and delivering care – making effective use of the full range of our people's skills and experience
- growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

NHS Digital Strategy

The strategy for technology in health and care is to digitise services, connect them to support integration and, through these foundations, enable service transformation.

The **Plan for Digital Health and Social Care** sets out a vision for a digitally enabled health and social care system and how we can achieve it, it collates existing digital strategies, plans and guidance into one single action plan. It is aimed at health and social care leaders across the system, and industry partners to help them plan for the future.

The **What Good Looks Like guidance** sets out a common vision for good digital practice to empower frontline leaders to accelerate digital transformation in their organisations

NHS IMPACT

NHS (Improving Patient Care Together) is the new, single, shared NHS improvement approach to support organisations, systems and providers to shape their strategy underpinning this with continuous improvement, and to share best practice and learn from one another.

NHS IMPACT's five components set out are designed to underpin a systematic approach to continuous improvement:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

Aligning our Strategic Objectives to national strategies and priorities

	NHS Long term plan	Five year forward view	Veterans Covenant Hospital Alliance	The People Plan	NHS Digital Strategy	NHS IMPACT
1. Deliver high quality clinical services	✓	✓	✓	✓	✓	✓
2. Develop our Veterans Service as a nationally recognised centre of excellence	✓	✓	✓			
3. Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓	✓		✓	✓	✓
4. Grow our services and workforce sustainably	✓	✓	✓	✓		
5. Innovation, education & research at the heart of what we do	✓	✓		✓	✓	✓

Shropshire, Telford and Wrekin Strategic Objectives

We want everyone in Shropshire, Telford and Wrekin to have great start in life and to live healthy, happy and fulfilled lives.

We will work together with our communities and partners to improve health and wellbeing by tackling health inequalities, encouraging self-care, transforming services and putting people at the heart of what we do.

Our ambition is to provide our communities across Shropshire, Telford and Wrekin with safe, high-quality services and the best possible experience from a health and care system that is joined up and accessible to all.

By transforming how and where we work, improving access to services and using our resources in the very best way for our communities, we will meet the needs of our population now and in the future.

We will focus on our places and our communities to create truly integrated care including working across our boundaries and borders.

Our ICS Vision, Pledges and Strategic Priorities are summarised in the diagram below:

Shropshire, Telford and Wrekin Integrated Care Strategy Plan On A Page

We want everyone in Shropshire, Telford and Wrekin to live happy, healthy and fulfilled lives

Improve Outcomes
In population health and outcomes

Tackle Inequalities
Outcomes, experience and access

Enhance **productivity and value for money**

Support broader **social and economic development**

We will improve **safety and quality**	We will integrate services at **place and neighbourhood level**	We will tackle the problems of **ill health and access to health care**	We will tackle improvements in **mental health, learning disability and autism provision**	We will support economic regeneration to help improve the **health and wellbeing of our population**	We will respond to the treat of **climate change**	We will **strengthen our leadership and governance**	We will increase our **engagement and accountability**	We will create a **financially sustainable system**	We will make our ICS a **great place to work** so that we can attract and keep **the very best workforce**

Reducing Health inequalities
- Wider determinants
- Tackling Healthcare Inequalities

Improving Population Health
- Best start in life
- Healthy weight
- Alcohol, drugs & domestic abuse
- Mental Health & Wellbeing

Improving Health & Care
- Strenghten prevention, early detection and improve treatment outcomes – mental health, heart disease, diabetes, cancers, musculoskeletal disease
- Urgent and emergency care
- Integrated persoon centred care within communities – strong focus on primary & community care

Equitable access to care services	**Workforce culture & OD**	**Engagement, co-design and co-production**	**Live within our means**	**Subsidiarity & Self-care**	**Population health management & wider determinants of health**	**Person centred care**

Aligning our Strategic Objectives to the ICS Strategy

	Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Support broader social and economic development
1. Deliver high quality clinical services	✓	✓	✓	
2. Develop our Veterans Service as a nationally recognised centre of excellence	✓	✓		✓
3. Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓	✓	✓	✓
4. Grow our services and workforce sustainably	✓	✓	✓	✓
5. Innovation, education & research at the heart of what we do	✓	✓	✓	

Our Trust Strategic Objectives

1. Deliver high quality clinical services

2. Develop our Veterans Service as a nationally recognised centre of excellence

3. Integrate the MSK pathways across Shropshire, Telford and Wrekin

4. Grow our services and workforce sustainably

5. Innovation, education & research at the heart of what we do

1 Deliver high quality clinical services

We will:

- Be recognised for delivering outstanding standards of care for our patients
- Address health inequalities for our English and Welsh population and ensure a fair, equal and inclusive culture across the Trust
- Develop our services through partnership and shared decision making with our clinicians, patients and partners
- Empower departments to innovate and continuously improve our services for our patients
- Recruit, retain and transform our workforce to provide an exemplar experience for our staff and patients

equality
diversity
inclusion

VETERAN AWARE

ARMED FORCES COVENANT

VETERANS ORTHOPAEDIC SERVICE

FACTA NON VERBA

2 Develop our Veterans Service as a nationally recognised centre of excellence

We will:

- Honour our commitment to the Armed Forces Covenant and maintain our gold Veterans Awareness accreditation
- Increase the number of patients accessing the holistic care provided at the Headley Court Orthopaedic Centre
- Further develop our services to create a regional rehabilitation pathway providing best practice care
- Strengthen partnerships with armed forces and veterans friendly organisations

3 Integrate the MSK pathways across Shropshire, Telford and Wrekin

We will:

- Develop a single seamless MSK service working collaboratively with our partners and our patients
- Deliver and develop an MSK service that ensures equity of access, improves outcomes and improves population health by meeting the needs of our population
- Attain recognition of our surgical excellence through Elective Hub Accreditation

Musculoskeletal Services
Shropshire & Telford

4 Grow our services and workforce sustainably

We will:

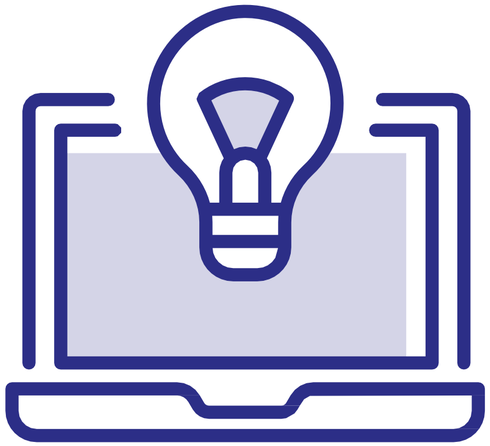
- Provide specialist orthopaedic outreach services and expertise to other organisations across England and Wales
- Develop our commercial and business expertise to enable services to thrive
- Build partnerships with other specialist providers
- Expand our private practice services and facilities to deliver market share growth in this sector

Quality Data Provider Award 2023

Gold

for commitment to patient safety through the registry

CERTIFICATION FOR DATA SUBMISSION & QUALITY



NIHR | National Institute for Health Research

5 Innovation, education & research at the heart of what we do

We will:

- Enhance capability and opportunities for education and research across all professions to hospital university level standards
- Create the culture to promote continuous improvement to enhance productivity, value for money and quality of services
- Optimise the potential of technologies to transform care and improve outcomes in population health and healthcare

Our measures of success

1 Deliver high quality clinical services	→	Recognised as outstanding for quality of care
2 Develop our Veterans Service as a nationally recognised centre of excellence	→	Centre of Excellence for Veterans rehabilitation
3 Integrate the MSK pathways across Shropshire, Telford and Wrekin	→	Single seamless local MSK service
4 Grow our services and workforce sustainably	→	Outreach of our specialist expertise
5 Innovation, education & research at the heart of what we do	→	Hospital University level education, research and innovation

Enabling Strategies

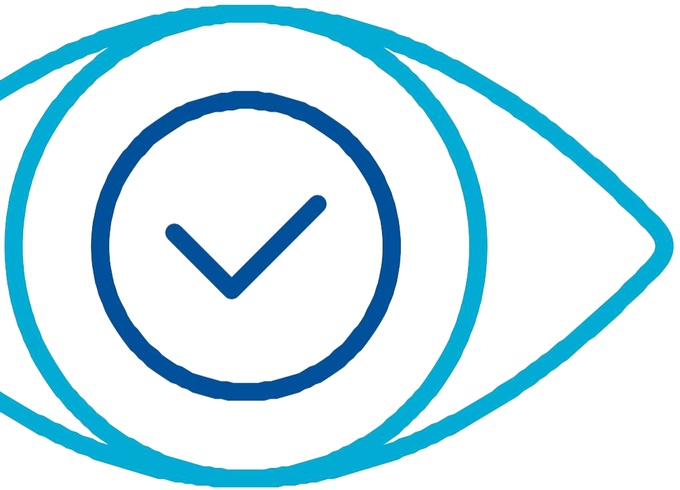
Enabling strategies to support the delivery of trust strategy are essential to ensure we achieve our outcomes. Our key enabling strategies include:

- → Quality Strategy
- → Clinical Strategy
- → Inclusion Strategy
- → Research Strategy
- → Patient Experience Strategy
- → Nursing and AHP Strategy
- → Innovation Strategy
- → Workforce Strategy
- → Digital Strategy
- → Estates Strategy
- → Financial Strategy
- → Quality Improvement Framework
- → Private Practice Strategy
- → Commercial Strategy

Our existing enabling strategies and frameworks are at various stages of development and review to ensure alignment to our Trust Strategy.

Co-design of our strategy

Continuous communication and engagement is the cornerstone of ensuring our strategic aims are achieved. This started at the development stage of our strategy and will continue throughout its implementation stage to ensure our direction of travel becomes business as usual.



Co-design

Engagement and involvement in the strategic planning process has included:

- The work starting in earnest in April 2023 with a huge engagement event involving more than 140 members of staff from across the organisation
- Clinicians across the Trust have been working up their own departmental strageies and presenting to their units and Trust Management Group meetings with executives, clinical leads and senior mangager teams across the Trust
- Strategic priority development sessions for a single seamless MSK service for our patients and Veterans rehabilitation
- Enabling strategy leads have held their own engagement sessions to co-design their vision for the future
- Engagement sessions for patients and the wider community

Communication and Engagement

Cascading our Strategy

Our communications strategy will involve various approaches to cascade our strategy:

1. Strategy Launch
2. Existing meeting communication channels – Trust Management Group, Unit Board Meetings, departmental meetings and departmental buddy visits
3. Wider system partners – Shropshire, Telford and Wrekin system planning meetings and ICS Strategy Committee and Powys Health Board Workshop scheduled for December
4. Patients – Trust Patient Panel engagement sessions

We have designed our strategy in preparation for it to be interactive to enable our patients and staff to access our strategic plans at a level that is suitable for their level of interest.

Each of our key strategic themes has been given its own recognisable brand for the purpose of ensuring that developments associated with these workstreams are identifiable back to our strategic priorities as we progress our journey to implementation.

Communication and Engagement

Combining strategy with business as usual

Our Corporate Objectives provide the platform for translating our strategy to deliverables for our staff each year. Our Corporate Objectives for 2023-2025 are aligned to the strategy and have been agreed by our board and cascaded through our units to departments.

Celebrating Success

Our interactive platform will enable us to celebrate our success through regular updates being uploaded to our internet, through the Trust's social media platforms and celebrated through our regular communications to staff, local partners and sharing our best practice nationally.

Corporate Risk Summary

Committee / Group / Meeting, Date

Board of Directors, 10 January 2024

Author:

Name: Dylan Murphy
Role/Title: Trust Secretary

Contributors:

Risk Owners / Executive Leads.

Report sign-off:

N/A

Is the report suitable for publication:

Yes

Key issues and considerations:

Strategic versus operational risk

Strategic Risks relate to delivery of the strategic objectives of the Trust. They can be affected by factors such as capital availability; political, legal and regulatory changes; reputational issues etc. These will usually be identified at Board, or Executive level, and are generated "from the top down'. These strategic risks are captured in the Board Assurance Framework.

Operational risks concern the day-to-day running of the Trust. These are usually identified by departments or business units and are captured on local risk registers. As such, these are usually generated "from the bottom up". Where these risks become sufficiently serious they are escalated to the corporate risk register. Each entry on the corporate risk register is reviewed on a monthly basis, has an identified executive lead, and is overseen by a committee of the Board. The benchmark for consideration for inclusion on the corporate risk register has been set as 15 or above.

Risk Management Group

In accordance with the revised Risk Management Policy, a Risk Management Group has been established. This Group is chaired by the Chief Nurse and Patient Safety Officer and reports into the Audit and Risk Committee. The Group has met on three occasions.

The Group has considered the process for reviewing and escalating risk within the Trust to clarify the various checkpoints through which a risk should pass before agreed "corporate risks" are presented to the Board Committees.

These arrangements are in their infancy and the revised Corporate Risk Register process continues to develop. As part of the process:

- staff across the organisation continue to manage operational risk;
- the risk management training programme continues – the next steps include targeted support to individuals who are responsible for managing a large number of risks (particularly high scoring risks) that have not yet attended a session;
- the Trust Performance and Operational Improvement Group, chaired by the Chief Operating Officer, continues to monitor high level risks and associated mitigating actions;
- the Risk Management Group and clinical governance team continue to develop the processes and procedures necessary to implement the revised arrangements – this has included arranging dedicated sessions for "corporate" functions that have not made as much progress as the Units in reviewing their risks and establishing dedicated governance support to these functions. It is anticipated that this will result in a number of risks being reworked / rescored / closed.

A summary of the risks considered at the November Risk Management Group was considered at the December round of Board sub-Committees, after having been shared with the executive owners for review. The summary position reported to the Committees is included in **Table 1**. Any areas for escalation will be identified in the Assurance Reports from the relevant committee.

The Digital, Education, Research and Innovation Committee has yet to consider all corporate risks relevant to its remit but had a session focussed on the implementation of the Electronic Patient Record which included consideration of the associated risks.

Corporate Risk Update

Table 1: "Corporate risks" considered by Board committees during October meetings

Ref	Title	Exec Owner	Oversight Committee/s	Current Score	Previous reported score	Comment
2934	Patient waiting times outside of national targets	Mike Carr	F&P	**16**	**16**	Risk to be reworked as the current risk description reflects the previous focus on achieving the waiting list reduction targets. Performance against long waits has been regularly considered at the Committee and good progress has been made against target. Thought is now being given to recasting the risk to focus on the patient experience and the impact of long waits, rather than performance against national performance requirements (as they do not take account of the disparity between English and Welsh waiting targets).
2993	Registered Nurse unavailability impacting safe staffing levels	Paul Kavanagh-Fields	P&C	**12**	**16**	Score reduced to reflect progress in recruitment and retention and removed from CRR.
3007	Diabetic demand into the Orthotics service	Mike Carr	Q&S / P&C	**Tbc**	**16**	Risk currently under review and awaiting approval. Draft description is: *IF: We do not invest in increasing the capacity of the orthotics team to meet the increasing demand of diabetic patients.* *THEN: Patients will not be seen in the stipulated timeframes.* *RESULTING IN: Potential patient harm and increased backlogs of patients awaiting treatment.*
3027	Variable Income Performance linked to Elective Activity Performance	Mike Carr	F&P / P&C	**20**	**16**	Score increased and remains on CRR. Regular review via financial recovery group.
3052	Financial Plan Delivery - Non Contract Activity Overperformance	Craig Macbeth	F&P	**12**	**15**	Score reduced and removed from CRR.

Corporate Risk Update

Ref	Title	Exec Owner	Oversight Committee/s	Current Score	Previous reported score	Comment
3054	Financial Plan Delivery - Industrial Action	Craig Macbeth	F&P	**16**	**16**	Score remains at 16. Retained on CRR.
3056	Non-compliance with Legislation/Guidance Relating to FFP3 Face Masks	Paul Kavanagh-Fields	Q&S	**15**	**15**	Score remains at 15. Retained on CRR. The proposed employment of a fixed-term fit-testing resource to be shared with Shropshire Community Health Trust was not supported by SCHT so the IPC Working Group proposed an in-house solution. The Trust is to identify a lead and plan to ensure staff are FFP3 mask fitted appropriately.
3066	Consultant Anaesthetist vacancies and recruitment impacting on operational plan	Mike Carr	F&P / P&C	**12**	**16**	Score reduced to reflect progress in recruitment and removed from CRR.
3078	There is a risk that the tumour service may not be able to maintain delivery	Ruth Longfellow	F&P	**16**	**16**	Score remains at 15. Retained on CRR. Locum appointed but risk to be retained until in post.
3097	Insourcing Arrangements - Regulatory Intervention	Craig Macbeth	F&P	**15**	**15**	Score remains at 16. Retained on CRR.
3105	Insufficient clinical capacity to follow up patients with a Metal on Metal Implant in line with national guidance	Mike Carr	Q&S	**9**	**16**	Score reduced and removed from CRR (though consequence score to be reviewed).
3132	*IF: the Trust is unable to secure long term accommodation for international recruits within the locality due to lack of availability and a competitive rental market.* *THEN: international recruits will not have a good experience, their wellbeing will be adversely affected, and RJAH will not be an employer of choice for new recruits.*	tbc	P&C	**Tbc**	**n/a**	The unmitigated risk is scored at 15. This risk is under development and will be reviewed via the regular risk review process to determine the current and target risk scores. As such, the risk description is subject to revision as it works through the review and approval process.

Corporate Risk Update

Ref	Title	Exec Owner	Oversight Committee/s	Current Score	Previous reported score	Comment
	RESULTING IN: an inability to attract and retain staff which will affect quality and delivery of the Trust's activity plan (which will, in turn, have financial consequences for the Trust).					

Corporate Risk Update

Strategic objectives and associated risks:

This work supports all of the Trust's objectives.

Recommendations:

That the Board NOTE the risks rated at 15 or above, and the risks that have recently been reduced from a score of 15 or above, as considered by the Board Committees during December 2023.

Report development and engagement history:

The Risk Management Group is now in operation and revised reporting arrangements have been agreed to ensure appropriate check and challenge of high rated risks.

The Board sub-committees considered the detail of each risk they oversee during the October round of meetings. This report provides a summary of the content considered in more detail at the committee meetings.

Next steps:

The Risk Management Group will continue to meet on a monthly basis and work with staff to implement the revised risk management arrangements. The Board sub-committees will continue to review risks rated at 15 or above that align with their remit.

Risk Management training will continue, including targeted support to key individuals / teams. The training and Risk Management Policy will be updated to reflect the revised risk appetite (once it has been approved by the Board).

Risk Appetite Statement

Committee / Group / Meeting, Date

Board of Directors, 8 November 2023

Author:	Contributors:
Dylan Murphy Trust Secretary	Board of Directors

Report sign-off:

The attached draft document has been reviewed by the executive team.

Is the report suitable for publication?:

YES

Key issues and considerations:

The attached document is a proposed risk appetite statement for the trust. It is intended to replace the risk appetite that was agreed in 2019. Since that time, the NHS has experienced the Covid-19 pandemic, has faced greater financial and operational pressures, and is now working through new organisational structures such as integrated care boards. It is therefore an opportune time to revisit the trust's approach to risk management.

GGI, a specialist consultancy which works with public sector clients, undertook a project with the trust to revise its risk management policy and develop a risk management training programme for staff. The final stage of this project was to draft a risk appetite statement, based on the outcome of a workshop discussion held with the board.

Risk appetite represents the balance organisations aim to achieve between opportunities and the threats that change can present. Risk is inherent to the provision of healthcare but needs to be identified, assessed and managed. It is essential for the boards of NHS foundation trusts to be clear about their appetite for, and tolerance of risk. Doing so prevents them from taking excessive risks while at the same time enabling the organisation to take advantage of opportunities such as developing new services or expanding existing ones.

The proposed statement defines risk appetite across five domains:

- clinical quality;
- finances;
- workforce;
- compliance with regulatory standards; and
- reputation (defined as relationships with external stakeholders).

Risk appetite is measured using a six point scale which ranges from 'significant' appetite to risk, to none. Risk tolerance is defined in terms of the maximum target score (the level to which we aim to mitigate the risk, not the level which the risk is at currently) that is acceptable for risks in each domain. For each domain there is a short narrative which explains the approach to that type of risk and what it means in practice.

Corporate objectives and associated risks:

The following corporate objectives are relevant to the content of this report:

Objective		
1	Deliver high quality clinical services	✓
2	Develop our Armed Forces and Veterans service as a nationally recognised centre	✓
3	Integrate MSK pathways across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation and research at the heart of what we do	✓

If the risk appetite statement is not adopted, managers and staff may be unclear about the trust's approach to taking and managing risks in the course of their work.

Recommendations:

The Board is asked to review and approve the updated risk appetite statement.

Report development and engagement history:

The Board of Directors held an informal workshop discussion as part of a developmental session facilitated by GGI on 4th October, following which this risk appetite statement was drafted, reflecting the outcome of that discussion. The draft was shared with the executive team before being presented to the Board for consideration.

The Board considered a paper by Joe Roberts, Governance Consultant at GGI at a private session in November 2023. At that session, the Board approved the risk appetite statement subject to a couple of revisions to the narrative. These are outlined below in tracked-change style:

Quality

*The trust exists to provide optimal clinical care and treatment. Therefore, we take a **cautious** approach – we prefer to avoid risks which would adversely affect the quality of services but recognise that it is rarely possible to develop new services or change pathways without some degree of risk. We will pursue innovation in order to make improvements but when making significant decisions about clinical services, we will carefully assess any associated risks to patient safety, patient experience and clinical effectiveness, and put in place control measures to mitigate them. We continuously monitor the impact on quality, using both statistical data and feedback from patients and carers.*

Regulatory

*It is important for us to remain in good standing with regulatory bodies ~~our regulators such as the Care Quality Commission~~ because this provides assurance over the quality of our services and reinforces public confidence in our trust. However, we recognise that regulators will closely scrutinise and challenge significant changes and innovations to our services. We are **open** to this risk in cases where we are confident that we are acting in the interests of patients and can demonstrate that our actions are consistent with relevant legislation and professional standards.*

Next steps:

The risk management policy will be updated to include the revised risk appetite statement. It The risk management training material will also be updated to reflect the updated risk appetite statement.

Risk appetite is not fixed and can change over time according to circumstances. Therefore the risk appetite should be reviewed periodically to ensure that it continues to be relevant and to reflect the board's approach to managing risks.

Attachment: Proposed Risk Appetite Statement

Draft Risk Appetite v02 - RJAH

Proposed Risk category	Proposed Risk appetite	Proposed Risk tolerance - target score	Rationale
Quality	Cautious	6	The trust exists to provide optimal clinical care and treatment. Therefore, we take a **cautious** approach – we prefer to avoid risks which would adversely affect the quality of services but recognise that it is rarely possible to develop new services or change pathways without some degree of risk. We will pursue innovation in order to make improvements but when making significant decisions about clinical services, we will carefully assess any associated risks to patient safety, patient experience and clinical effectiveness, and put in place control measures to mitigate them. We continuously monitor the impact on quality, using both statistical data and feedback from patients and carers.
Finance	Open	9	We are an ambitious organisation which plans for the future. Many of our initiatives and innovations will generate additional income and efficiencies in the longer term but require financial investment to get started. We also recognise that the cheapest option is not always the most effective. We are therefore **open** to financial risk. This is dependent on financial forecasting which allows us to quantify the level of risk, and applying robust budgetary controls as set out in our standing financial instructions and scheme of delegation.
Workforce	Seek	12	We aim to provide a supportive workplace in which employees can thrive and which people choose as a great place to work. For these reasons, and to fulfil our ambitions of growing and transforming our services, we will pursue new ways of working. We **seek** risk in that we recognise that the prospect of change can be disruptive and unsettling but are willing to accept this risk where there are longer term gains, including improved recruitment and retention, and widening the skills and capabilities of staff.
Regulatory	Open	9	It is important for us to remain in good standing with regulatory bodies because this provides assurance over the quality of our services and reinforces public confidence in our trust. However, we recognise that regulators will closely scrutinise and challenge significant changes and innovations to our services. We are **open** to this risk in cases where we are confident that we are acting in the interests of patients and can demonstrate that our actions are consistent with relevant legislation and professional standards.
Reputational	Open	9	We are an outward-looking organisation which works in partnership with healthcare, educational and charitable organisations in Shropshire and further afield. Patient and community involvement is very important to us. We believe that stakeholders of all kinds recognise our commitment to maintaining good working relationships with them. We are, however, **open** to reputational risk in that we are prepared to take decisions which may attract scrutiny or opposition when we can clearly demonstrate that they will achieve better outcomes for patients.

Key to Risk Appetite Descriptors

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Chair's Assurance Report
Quality and Safety Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	10 January 2024
Executive Sponsor:	Paul Kavanagh Fields, Chief Nurse and Patient Safety Officer / Ruth Longfellow, Chief Medical Officer	**Paper written on:**	05 January 2024
Paper Reviewed by:	Lindsey Webb, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the Quality and Safety Committee. The Board is asked to consider the recommendations of the Quality and Safety Committee.

2. Context

2.1 Context

The Trust Board has established a Quality and Safety Committee. According to its terms of reference: *"The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes, and controls in place throughout the Trust to:*

- *Promote safety and excellence in patient care.*
- *Identify, prioritise, and manage risk arising from clinical care.*
- *Ensure efficient and effective use of resources through evidence based clinical practice".*

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Quality and Safety Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from Quality and Safety Committee

This report provides a summary of the items considered at the Quality and Safety Committee on 21 December 2023. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT – The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

Corporate Risk Register

The Committee reviewed and agreed the movement of the risks ahead of presentation at the Board meeting:

- 3105 | Insufficient clinical capacity to follow up patients with a Metal-on-Metal Implant in line with national guidance (which is a new addition to the risk register) – reduced the risk score from 16 to 9.
- 3056 | Non-compliance with Legislation/Guidance Relating to FFP3 Face Masks – remains a high risk. The Trust continue to identify options to mitigate the risk. The health and safety team are now seeking external support from a contractor.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Chief Nurse and Chef Medical Officer Update
The Committee were assured with the processes in place in relation to Operation Lazurite. The Trust have taken on a lead role for the quality and safety medical provision at Nesscliffe Army training camp. It was noted there has been a contract developed and SOP implemented.

Clinical Audit Forward Plan
The Committee received the revised plan which was noted to have improved. Concerns were raised in relation to the compliance rates of internal audits being completed in a timely fashion – this will be addressed via the unit governance meetings before onward reporting to the Clinical Effectiveness Meeting.

Quality Strategy
The Committee receive the Trusts Quality Strategy for consideration and comments. It was noted the revised strategy aligns to the national patient safety strategy. The committee requested additional content on clinical effectiveness and input from medical colleagues and therefore the strategy will be presented to the Board in due course. The Trusts aim is to apply for the accreditation programme for the pathway to excellence. The Committee asked for quarterly updates to be added to the workplan to gain assurance on the action plan.

3.3 Areas of assurance

ASSURE - The Quality and Safety Committee considered the following items and did not identify any issues that required escalation to the Board.

CQC Framework and Ward Accreditation
The Committee were assured with the proactive work being undertaken and embedded to ensure the collation of evidence is available via a dashboard. The Committee asked the Trust to ensure medical representation is gained at the CQC preparedness group and agreed for quarterly CQC updates to be added to the Committee workplan.

Performance Report
The Committee were assured with the report, the following performance indicators were acknowledged:

- A task and finish group continues to review delayed discharges.
- 1 case of klebsiella urosepsis was recorded – this has been deemed unavoidable.
- 4 SSIs have been reported in November – one together audits are underway to review.
- 36 medication errors were reported – 3 patients being deems as sustained low harm. A review will be completed and reported to the patient safety meeting in January. The Committee queried a link between agency staff and high reporting of medication incidents. It was noted this would be reported through the quarterly thematic review which is currently being completed.
- 1 expected death was reported.
- The cancer standard for 62-day cancer was not met due to a complex and shared pathway.
- Theatre cancellations are being reviewed as part of the pre-op and outpatient review. This is one of the operational interventions being undertaken to support the improvement of the delivery of activity.

PROMs Update
The Committee received an overview of the PROMS and discussed the reporting requirements for future meetings.

PSRIF and Patient Safety Improvement Plan
The Committee were assured with the processes in place in relation to PSIRF and improvement plan. It was noted that there have been no PSIs in November and actions are being monitored.

Staffing Reviews
A comprehensive review of staffing establishments has been completed and no fundamental changes have been noted. Assurance was provided that subacute beds would not influence staffing levels. It was noted that training is in place for all staff on the MCSI wards to meet the needs of the patients and provide safe care.

PLACE Review
The patient led review has recently been undertaken – excellent care was noted by the members of the panel. An action plan has been created following the recommendations of the review. Assurance was provided that some actions have already been addressed. The action plan will be overseen by the patient experience meeting with onward reporting to the QS Committee via a chairs report. The Committee suggested a mid-year review to ensure the actions implemented have been sustained.

Internal Audit Recommendations (Quality Spot Check Review and Planned Care Review)
The Committee were assured with the processes in place to embed the recommendations following the above reviews. It was noted that the quality spot check review is now completed and there is one action remaining on the planned care review. The Committee welcomed an update in February which aligns with the Audit and Risk Committee reporting.

The Committee endorsed the following policies:

- Safe Administration of blood and blood products and the management of transfused patients' policy
- Clinical photography code of practice policy
- Infection event and outbreak management policy
- IPC arrangements and responsibilities policy
- IPC principles in the management of invasive devices
- Notifications of infectious diseases

Chair Report – Health Inequalities Group
The Committee noted the report with no concerns to be escalated. A deep dive on health inequalities is expected to be presented to the Committee in February.

Chair Report – Clinical Effectiveness Meeting (inc. Terms of Reference)
The Committee were pleased to see how the review completed on the meeting would improve the assurance provided in future. The Trust are to confirm what outcome data is currently being collected and whether it is compared internationally. The Committee asked for amendments to be made to the terms of reference which included details on outcomes. The revised ToR will be presented at the next meeting for approval.

Chair Report – Patient Experience Meeting
The frequency of the meeting has been increased to bi-monthly to ensure sufficient oversight and therefore the committee asked to the Trust to circulate the terms of reference for the meeting. There were no areas to escalate.

Chair Report – Patient Safety Meeting
The Committee noted the report – there were no items of concern raised.

Chair Report – IPC Meeting
The Committee discussed the FFP3 masks risk in detail. It was noted this action has been recorded on the IPC improvement plan for several months. The Trust continue to identify options to mitigate the risk. The health and safety team are now seeking external support from a contractor.

System Update
The Committee asked for further information and assurance from the System relating to the diabetes programme being behind plan.

The following was shared with the Committee for information only:

- Committee workplan
- IPC policy alignment

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps.
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.

Trust Board - Quality & Safety
November 2023 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

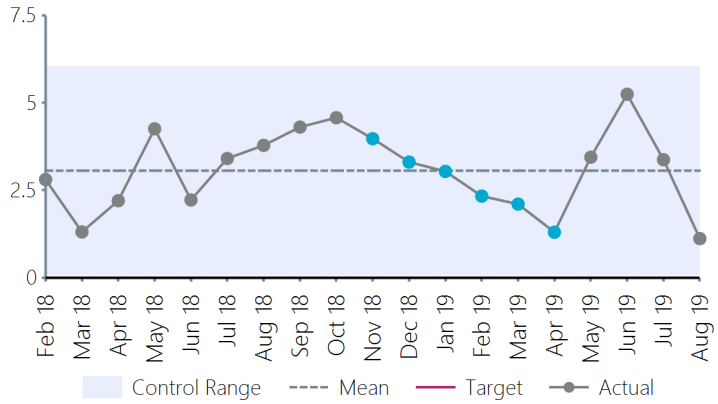
Some examples of these are shown in the images to the right:

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

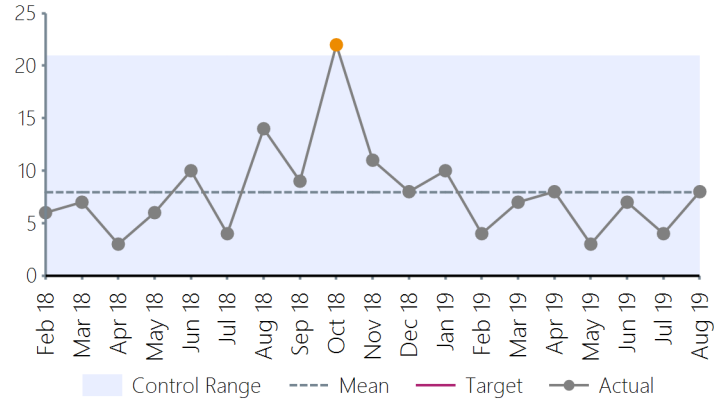
b) shows a point of concern sitting above the control range.

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

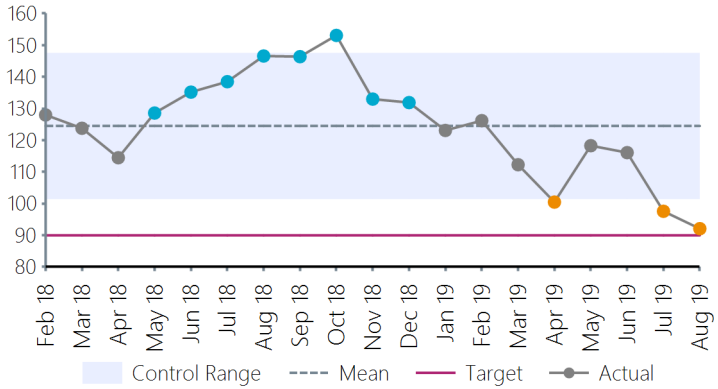
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	14			?		11/05/18
RJAH Acquired C.Difficile	0	0		N/A to SPC	?		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		
RJAH Acquired Klebsiella spp	0	1		N/A to SPC	?	+	
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	1			?	+	
Outbreaks	0	0		N/A to SPC	P		

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Number of Deteriorating Patients	5	4		N/A to SPC	?		
Total Deaths	0	1		N/A to SPC	F	+	12/09/23
WHO Quality Audit - % Compliance	100.00%	100.00%			P		

RJAH Acquired Klebsiella spp

RJAH Acquired Klebsiella spp 217635

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan

0

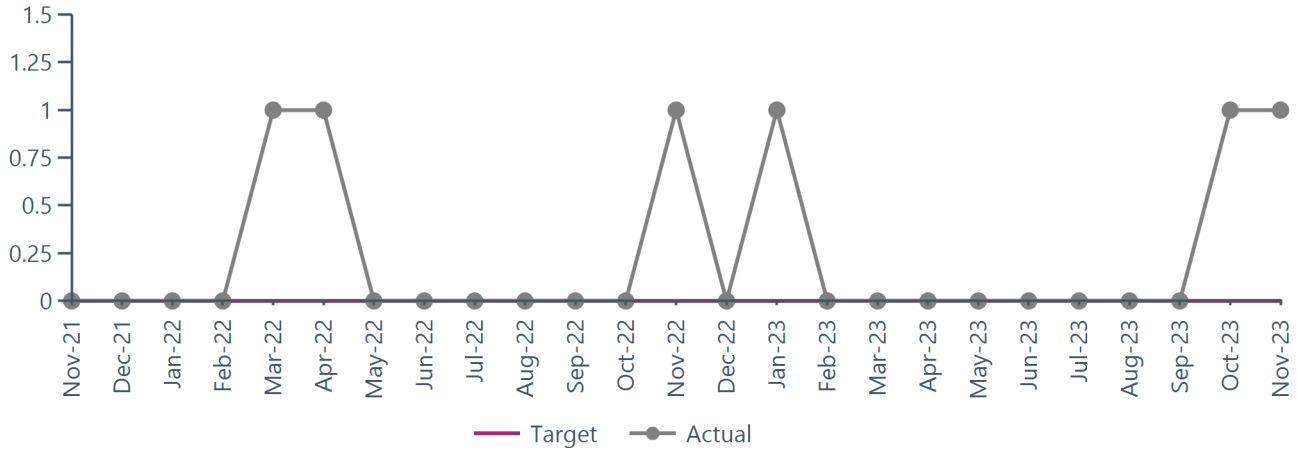
Latest Value

1

Variation

Assurance

Trajectory



What these graphs are telling us

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

Narrative

There was one case of RJAH Acquired Klebsiella spp reported in November. A post infection review has been conducted where it was deemed to be unavoidable due to non-compliance of treatment.

Actions

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
1	0	1	0	0	0	0	0	0	0	0	1	1

Surgical Site Infections

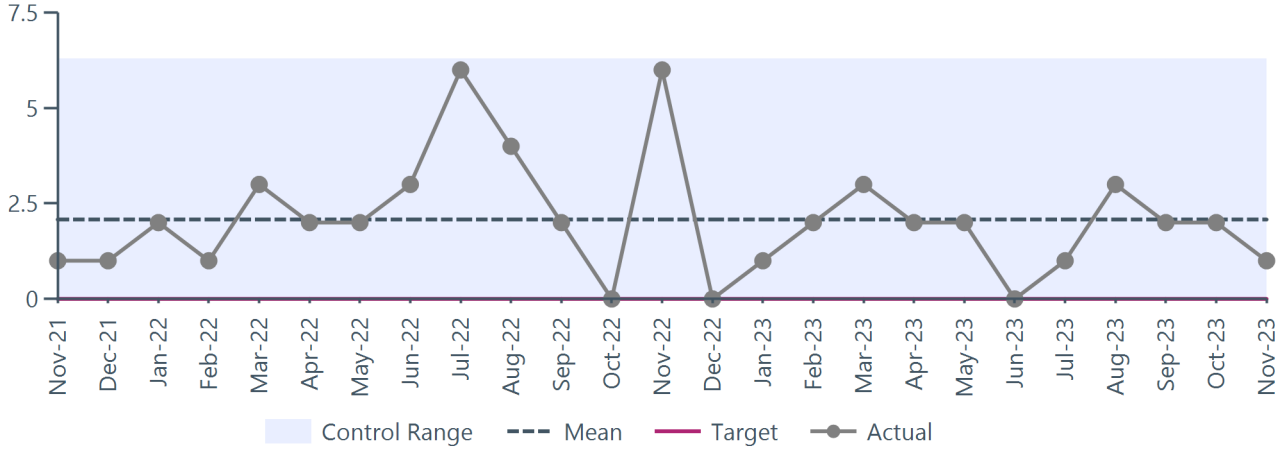
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	1		

Trajectory



What these graphs are telling us

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

Narrative

Surgical Site infections are monitored for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement. They are monitored for a period of 365 days following their procedure. The data represented in the SPC above shows any surgical site infections that have been confirmed. SSI rates are benchmarked against peer providers by the UKHSA, and Trusts are notified if the data identifies them as an outlier. At present, RJAH is identified as an outlier for Hips in the period of January-23 to March-23.

There were four additional infections confirmed in November, these related to procedures that took place in August (1), October (2) and November (1). The IPC Team carry out case reviews within 30 days and are compliant with this process.

Actions

The IPC Team have completed case reviews for all SSIs which shows compliance against the OneTogether assessment. These are then explored further at MDT, in line with PSIRF, and all actions will be added to the IPC Quality Improvement plan and actioned by the SSIPWG.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
6	0	1	2	3	2	2	0	1	3	2	2	1

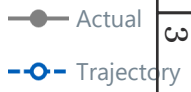
Total Deaths

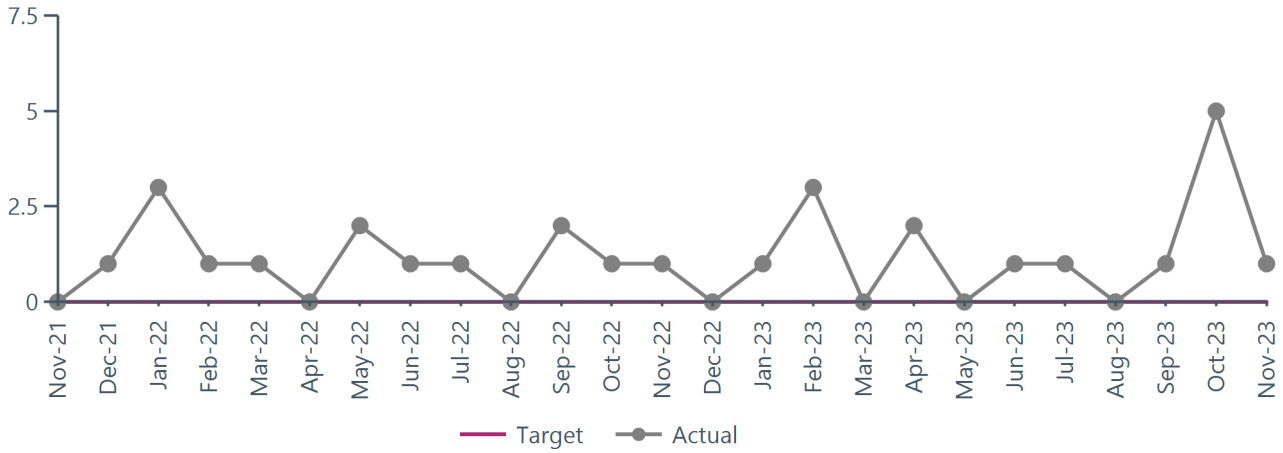
Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

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

Trajectory





What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently exceeding the tolerance.

Narrative

There were one death within the Trust throughout November that has been classified as an Expected Death.

Actions

The death has been referred to the medical examiners office and will undergo a Learning from Death review within the Trust.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
1	0	1	3	0	2	0	1	1	0	1	5	1

Health and Safety Annual Report 2022/2023

Committee / Group / Meeting, Date

Board of Directors, public Meeting – 10 January 2024

Author:

Name: Ian Gingell
Role/Title: Health and Safety Manager

Contributors:

Report sign-off:

Health and Safety Meeting – November 2023
Quality and Safety Committee November 2023

Is the report suitable for publication?:

Yes

Key issues and considerations:

This paper highlights the health and safety aspects of risk management undertaken within the Trust during the period April 1st 2022 to 31st March 2023.

The paper includes Premises Assurance Model data covering the 2022/23 financial year.

The report covers DATIX incident data on health and safety related incidents during 2022/23.

The Trust aims to comply with its statutory duties in relation to health and safety at work and to minimise its losses due to risks encountered during operational activities

Strategic objectives and associated risks:

As per the Board Assurance Framework 2023-24, the following will contribute towards the Trust's strategic objectives:

- Developing and Maintaining Safe Services
- Maintaining statutory and regulatory compliance

Operational Risks – Health and Safety (as outlined In the Trust Risk Management Policy):

- Risks which do not have the ability to directly affect individual patient care or harm the patient in a clinical or treatment focused way but may affect patients and others on site such as visitors, contractors and staff, e.g., fire, security, environmental and health and safety issues.

Recommendations:

The Board is asked to NOTE the content of the Health and Safety Annual Report

Report development and engagement history:

The paper was developed via the Health and Safety Working Group (September 2023) and was presented to the November 2023 Health and Safety Meeting.

Acronyms

CAS	Central Alerting System
HSE	Health and Safety Executive
PAM	Premises Assurance Model
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

1. Health and Safety Annual Report

1.1 Introduction

The Health & Safety Executive (HSE) has memoranda of understanding with other regulatory bodies including the Care Quality Commission, General Medical Council and the Nursing and Midwifery Council, which set out roles and responsibilities and clarifies which regulator is likely to act in the event of a patient or member of staff suffering serious harm/death.

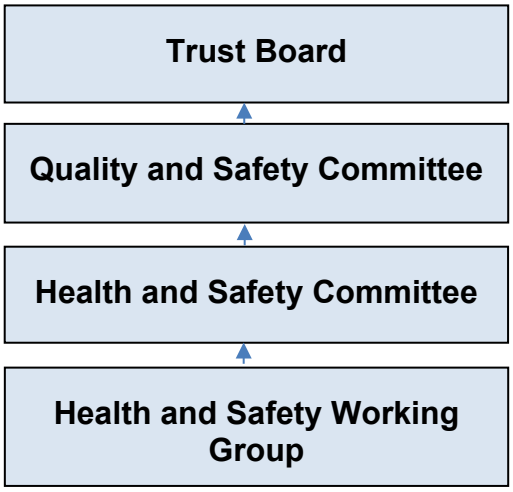
The HSE focus their investigations on systemic failure of management systems, which may include:

- Systemic failures to comply with statutory health and safety duties.
- The absence of or wholly inadequate arrangements for assessing risks to health and safety.
- Lack of suitable controls and inadequate monitoring and maintenance of the procedures or equipment needed to control the risks, resulting in serious harm or death.

The HSE may, dependant on the circumstances, investigate RIDDOR reportable incidents which include some needlestick injuries, work related injuries and serious injuries or ill-health caused by hazardous substances.

1.2 Health and Safety Arrangements

The Trust had a clearly defined structure for health and safety reporting:



The Chief Finance Officer retained Board-level responsibility for health, with the Director of Estates and Facilities nominated as Chair of the Health and Safety Committee.

The Trust employed a 0.4 WTE Health and Safety Manager to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

The resilience of the health and safety provision was improved from 1st July 2022 with an increase to a 0.5 WTE Health and Safety Manager supported by a 0.5 WTE Health and Safety Advisor.

A Service Level Agreement was entered into with Shropshire Community Health NHS Trust to provide them with an equivalent health and safety provision.

The Health and Safety Manager remit for RJAH also included the roles of Medical Device Safety Officer and Violence Prevention and Reduction Lead.

The Health and Safety Advisor remit for RJAH also included the role of Central Alerting System Liaison Officer, support for the Trust's Emergency Preparedness, Resilience and Response arrangements, and management of the Premises Assurance Model workstream.

1.3 Fee for Intervention (FFI)

A fee for intervention is charged if the HSE identify a material breach of health and safety law. A material breach is something which an inspector considers serious enough that they need to formally write to the Trust requiring action to be taken to rectify the breach. The fee is currently £163 an hour (increasing to £166 in 2023/24) and the total charge will include the costs covering the HSE inspector's time during inspections, preparing reports, obtaining specialist advice and any costs associated with formal enforcement or prosecutions.

The Trust did not incur any fee for intervention costs in 2022/23.

1.4 Health and Safety Management Systems

Organisations have a legal duty to put in place suitable arrangements to manage for health and safety.

The Health and Safety Executive provide a framework in the form of the document 'Managing for Health and Safety' (HSG65). This framework outlines the management arrangements and systems that organisations should have in place to manage their health and safety risks in a proactive manner. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

The limited health and safety resource led to a mostly reactive approach leading to challenges in adhering to the HSG65 'Plan, Do, Check, Act' model, however a summary of the activities related to the model are detailed below.

PLAN

The Health and Safety Committee met bi-monthly throughout the year, via Microsoft Teams, and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations,1977.

The Health and Safety Working Group, chaired by the Health and Safety Manager, also met bi-monthly and provided an invaluable forum for the management of operational level safety issues.

The Trust employed a 0.4 WTE Health and Safety Manager to undertake the role of Competent Person as required by the Management of Health and Safety Regulations 1999. The provision was increased to 0.5 WTE from July 2022 with the addition of a 0.5 WTE Health and Safety Advisor.

DO

The Health and Safety Committee met bi-monthly during 2022/23 and monitored health and safety incidents, RIDDOR reported incidents, safety alerts and legislation changes.

The overarching Health and Safety policy set out the organisational duties of Trust employees and detailed the arrangements required to comply with the Health and Safety at Work, etc Act and the Management of Health and Safety at Work Regulations.

Health and safety risk assessments were recorded in DATIX risk module and monitored in accordance with the Trust's Risk Management Strategy.

The Health and Safety Working Group led on resolving operational level health and safety issues.

CHECK

A programme of health and safety spot checks was introduced, with unannounced safety checks being carried out by the Trust's Health and Safety Manager and the Health and Safety Advisor.

The Trust had a comprehensive incident reporting system in operation. The DATIX database was utilised to record all staff, patient and visitor health and safety related incidents. Fire, security, and violence and aggression incidents were reported to the Health and Safety Committee via a Chair report from the Fire, Security and Electrical Services Group.

ACT

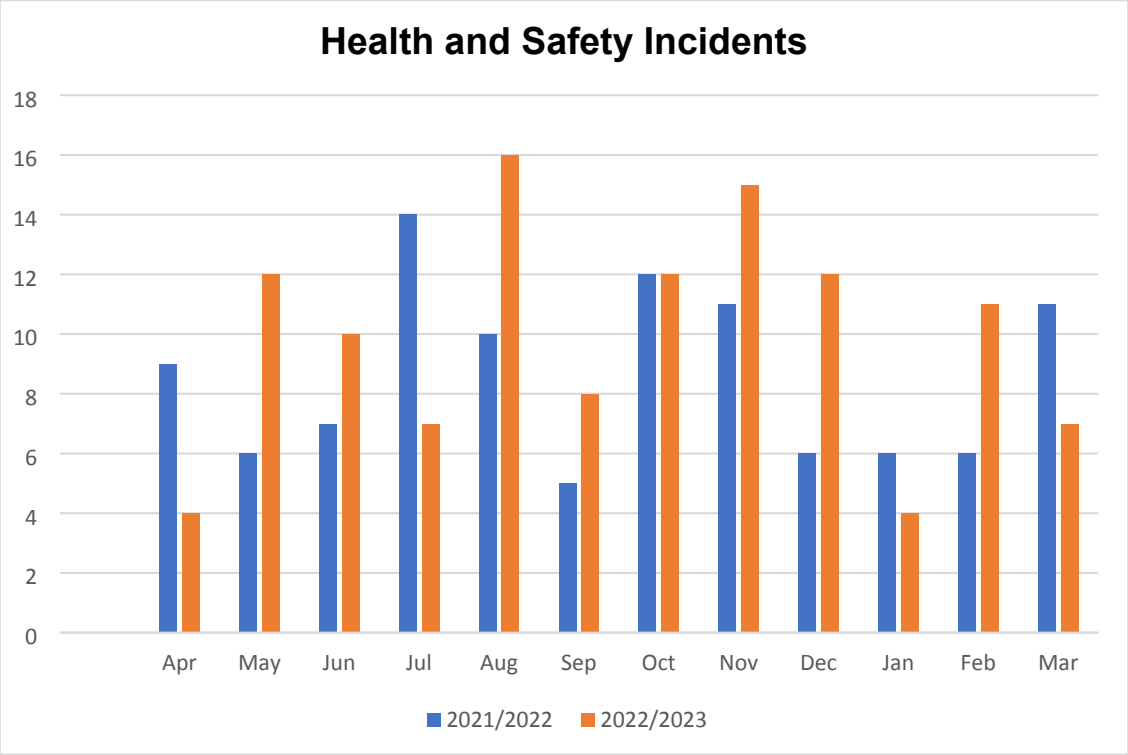
Any safety issues noted during unannounced safety spot checks were communicated to the relevant service manager. Immediate remedial actions were taken where appropriate, and a number of capital bids were developed to address concerns with aging equipment that did not comply with current safety standards.

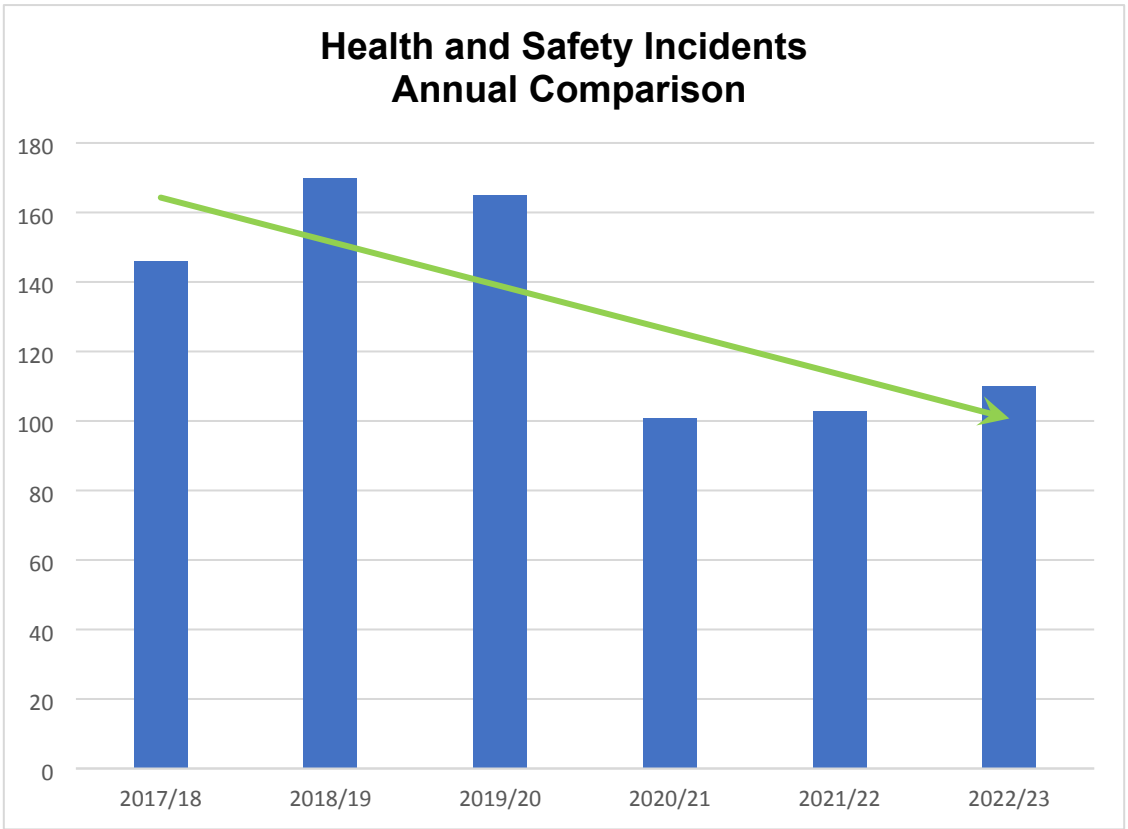
Incidents reported to the Health and Safety Executive as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) were jointly investigated by the Health and Safety Manager/Advisor and Staffside Union Safety Representatives.

Non-compliances relating to safer sharps were actively addressed by the Health and Safety Working Group.

1.5 DATIX Incident Reporting (Trends and Analysis)

A total of 110 health and safety incidents were reported during the 2022/23 financial year, a slight increase over the previous year's total of 103. This slight increase must be viewed in the context of increasing activity as the Trust started to return to a 'business as usual' position.

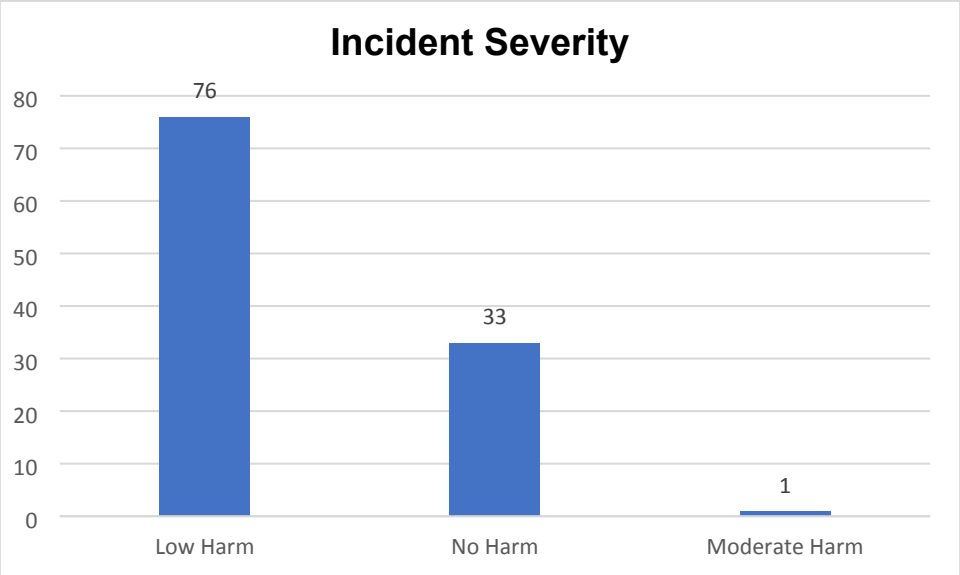

Health and Safety Incidents
18
16
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/2022
2022/2023


Health and Safety Incidents
Annual Comparison
180
160
140
120
100
80
60
40
20
0
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23

The top 5 sub-categories related to health and safety are shown in the table below:

Category	Number of Incidents
Manual handling of a patient	18
Near miss - safety	11
Staff fall on level ground	11
Struck by moving object	10
Staff slips	9

Severity of incidents



1.6 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

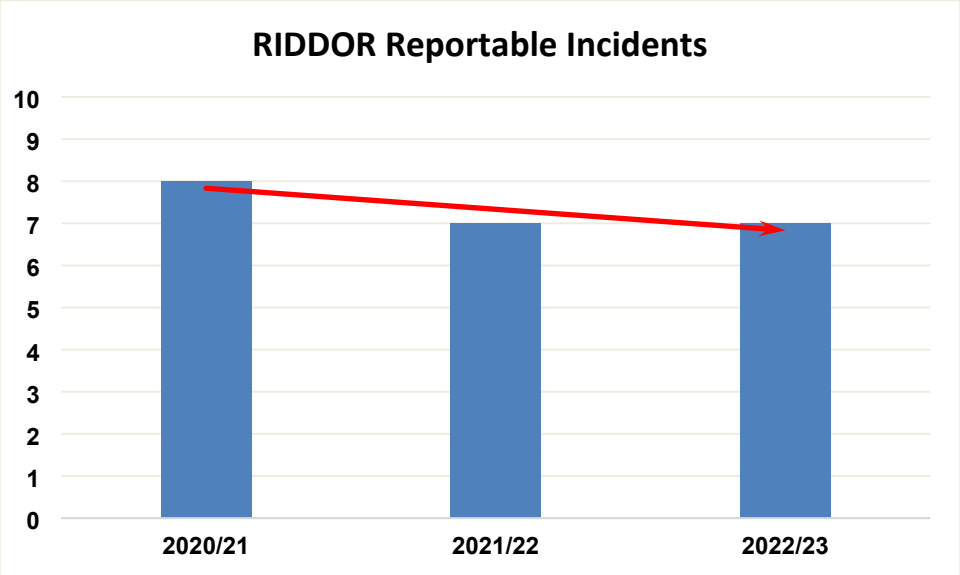
The Health and Safety Manager/Advisor ensured that any incident meeting the criteria of the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2015 (RIDDOR) was appropriately reported to the Health and Safety Executive (HSE).

During 2022-23 there were seven incidents reported to the HSE under the requirements of the RIDDOR regulations, compared with seven in 2021-22 and eight in 2020-21.

No regulatory action or sanction was received in respect of the reported incidents.

1.6.1 RIDDOR Trend Analysis

There remained a relatively low number of RIDDOR reportable incidents in the Trust, and there is an indication that an upward trend previously reported is flattening out.



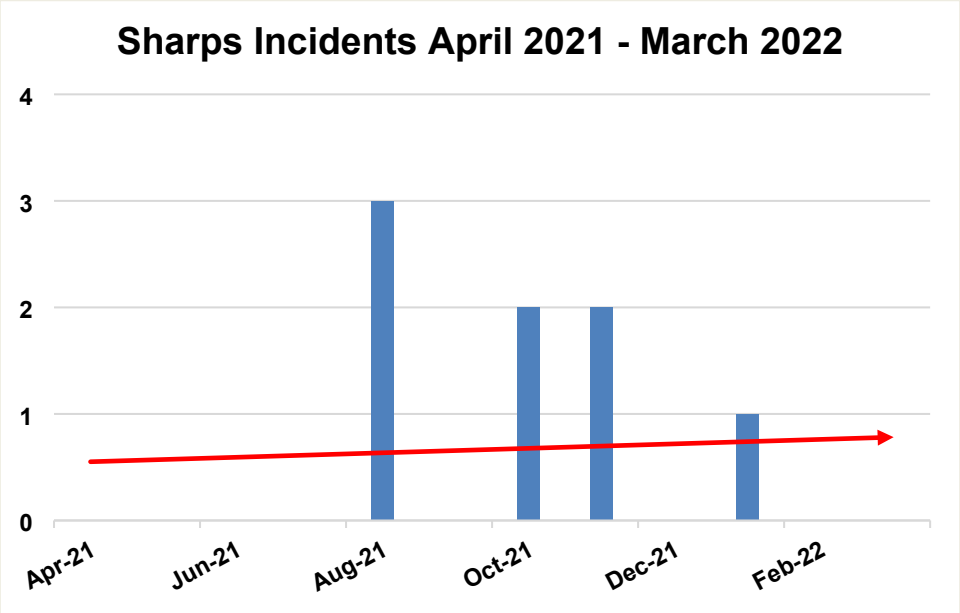
Slips, trips and falls accounted for 2 of the RIDDOR incidents, with the remaining 5 relating to lifting and handling activities.

All incidents have involved members of staff, no patients, visitors or other site users sustained reportable injuries. The incidents were recorded on DATIX and investigated by ward or department managers in accordance with Trust policy. The Health and Safety team ensured all RIDDOR reportable incidents were notified to Staffside Safety Representatives in accordance with the Safety Representatives and Safety Committees Regulations 1977.

1.7 Safer sharps

The Trust regained compliance with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013 following a workstream lead by the Health and Safety Manager.

Sharps (including needlestick) injuries remained at a low level and work is ongoing to ensure that safer sharps become the default devices of choice wherever reasonably practicable.



1.8 Health and Safety Committee

The Health and Safety Committee met bi-monthly and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations,1977.

The Terms of Reference were reviewed to better reflect the assurance and escalation purpose of the Committee. The Health and Safety Manager was removed from the role of Deputy Chair and replaced by the Head of Estates and Facilities to ensure transparency in policy approval in the absence of the Chair.

The Terms of Reference were further amended in October 2022 to temporarily suspend the quoracy requirement for staffside attendance. This was as a result of the staffside health and safety chair leaving the Trust and a delay in appointing a successor. The Trust continued to collaborate with staffside unions with regard to health and safety issues and the amendments were rescinded in February 2023 following the nomination of a new staffside lead.

Health and Safety Committee Attendance 2022/23						
	April 2022	June 2022	July 2022	Oct 2022	Dec 2022	Feb 2022
Chair	✓	✓	✓	X	✓	X
Head of Estates and Facilities (Deputy Chair)	✓	✓	✓	✓	X	✓
Health and Safety Manager / Advisor	✓	✓	✓	✓	✓	✓
Governance Representation	✓	✓	✓	✓	✓	✓

Clinical Representation	✓	✓	✓	✓	✓	✓
People Services /Training Business Partner	X	✓	✓	✓	✓	✓
Staffside Representation	✓	✓	X	X	✓	X
Manual Handling Coordinator	✓	✓	✓	X	x	✓
Occupational Health Representative	X	✓	✓	✓	✓	X
Quorate	✓	✓	X	✓	✓	✓

1.9 Central Alerting System Safety Alerts

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Alerts that are distributed include Estates Safety Alerts, Chief Medical Officer Messages, MHRA Drug Alerts, and Medical Device Alerts.

The Health and Safety Advisor undertook the role of CAS Liaison Officer within the 0.5 WTE provision and was responsible for overall management of the CAS process.

Progress towards completion of alert actions was monitored by relevant Committees and overall progress was monitored by the Health and Safety Committee. Executive approval was sought before the Health and Safety Advisor formally signed alerts off via the web portal.

The Trust received a total of 27 safety alerts through CAS in 2022/23, all of which were actioned within their respective deadlines.

A significant number of Field Safety Notices (FSN) and supply disruption alerts were also received. These were sent either directly to the Trust by manufacturers or suppliers or by NHS Supply Chain and were not captured through the CAS portal.

The Health and Safety Advisor managed the distribution of FSNs and monitored action completion. All required actions were taken, and confirmation returned to manufacturers where requested.

1.10 Estates Premises Assurance Model (PAM)

The NHS Constitution contains two pledges that relate to the premises in which healthcare is delivered:

- Services are provided in clean and safe environments that are fit for purpose, based on national best practice.
- Continuous improvement in the quality of services users receive, identifying and sharing best practice in quality of care and treatments.

The NHS Premises Assurance Model (PAM) identifies those areas of premises where the NHS Constitution needs to be considered, and where assurance is required.

The NHS PAM is a management tool, designed to provide a nationally consistent approach to evaluating NHS premises performance against a set of common indicators.

The annual independent PAM assessment assessed the Trust against the 2021/22 PAM model criteria. The 2022/23 PAM assessment results were evaluated against the 2021/22 baseline, enabling a more accurate analysis of scores to be assessed. The relaxation of Covid working practice and restrictions enabled a wider audit to be conducted against the PAM requirements.

The overall ratings per domain have not significantly changed, however some of the scores have changed as a direct result of post Covid restrictions being lifted, such as the reintroduction of Place assessments affecting the scoring for the patient experience element. The scores for this element now reflect more of a business-as-usual activity and some criteria has been downgraded to outline the requirement of trust AE personnel to physically attend site now the pandemic restrictions have been lifted. the PAM scores demonstrate a settling of activity to a more sustainable and recognisable status post Covid.

Some processes may take longer to implement than others, due to either financial constraints or newly introduced criteria requiring time to establish new processes and procedures from which to assess performance, which can be assessed at the next audit.

The Patient Experience domain scoring is predicated by the PLACE audit assessments, all Patient experience questions have now seen improvements within the criteria based on the reintroduction of the Place assessment.

The PAM Action Plan has been updated to reflect the latest Audit results and is included appended to this report. The Trust does not have any “Inadequate” scores and has reduced the number of actions that “Requires Moderate Improvement” since the previous PAM Assessment.

2.0 Conclusion

The Board is asked to NOTE the content of the annual report.

Trust Board - People & Workforce
November 2023 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

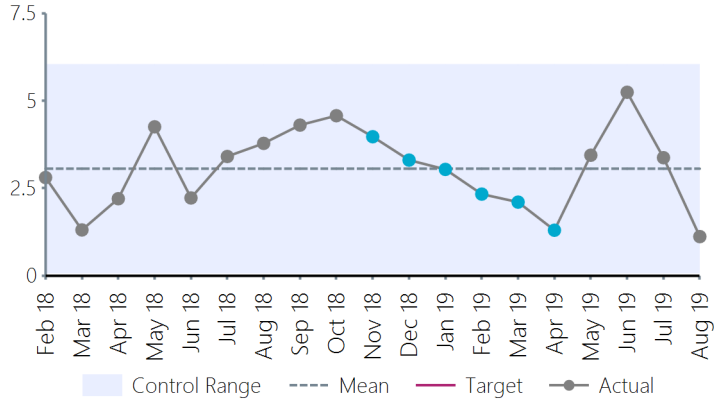
Some examples of these are shown in the images to the right:

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

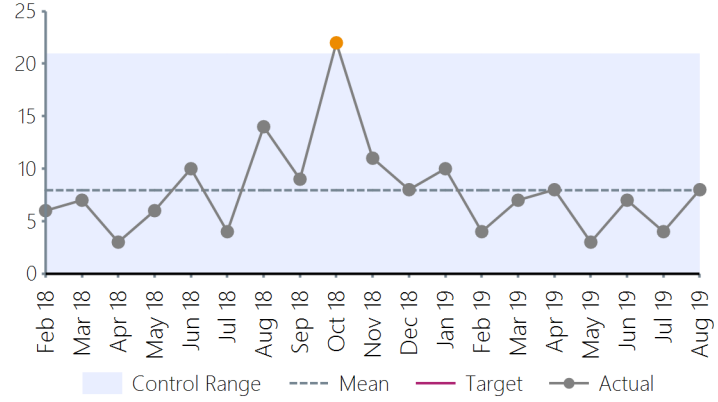
b) shows a point of concern sitting above the control range.

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

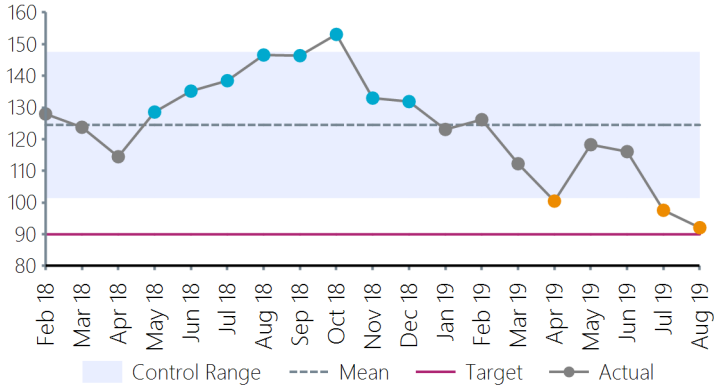
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.84%	4.67%			Moving Target	+	05/12/23
Staff Turnover - Headcount	11.00%	8.98%			Moving Target	+	
In Month Leavers	10	11			Moving Target	+	
Vacancy Rate	8.00%	5.23%				+	14/03/19

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Core - On Framework	258	199		N/A to SPC	Moving Target		
Agency Core - Off Framework	0	30		N/A to SPC	F	+	

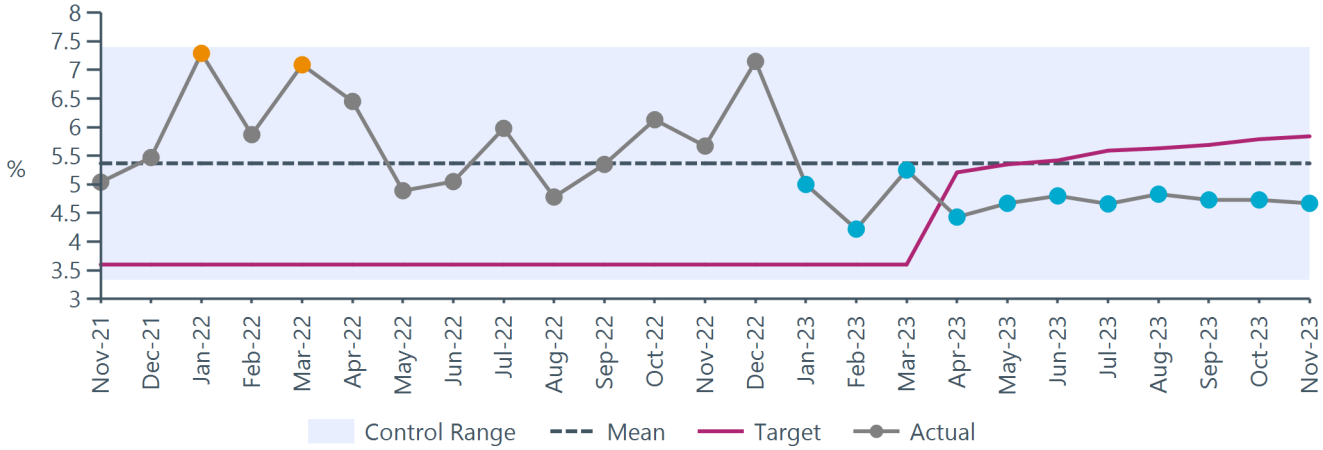
Sickness Absence

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

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
5.84%	4.67%	L	Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has had a target change from April-23.

Narrative

The sickness absence rate for November is reported at 4.67%. It is included as an IPR exception this month as the SPC graph indicates special cause variation of an improving nature with all data points since January consecutively below the mean.
The top three reasons for absence Trust-wide were:
* Anxiety/stress/depression/other psychiatric illnesses
* Other musculoskeletal problems
* Cold, Cough, Flu - Influenza

Actions

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
5.67%	7.15%	5.00%	4.22%	5.25%	4.43%	4.67%	4.80%	4.66%	4.83%	4.73%	4.73%	4.67%

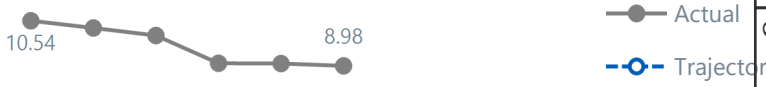
Staff Turnover - Headcount

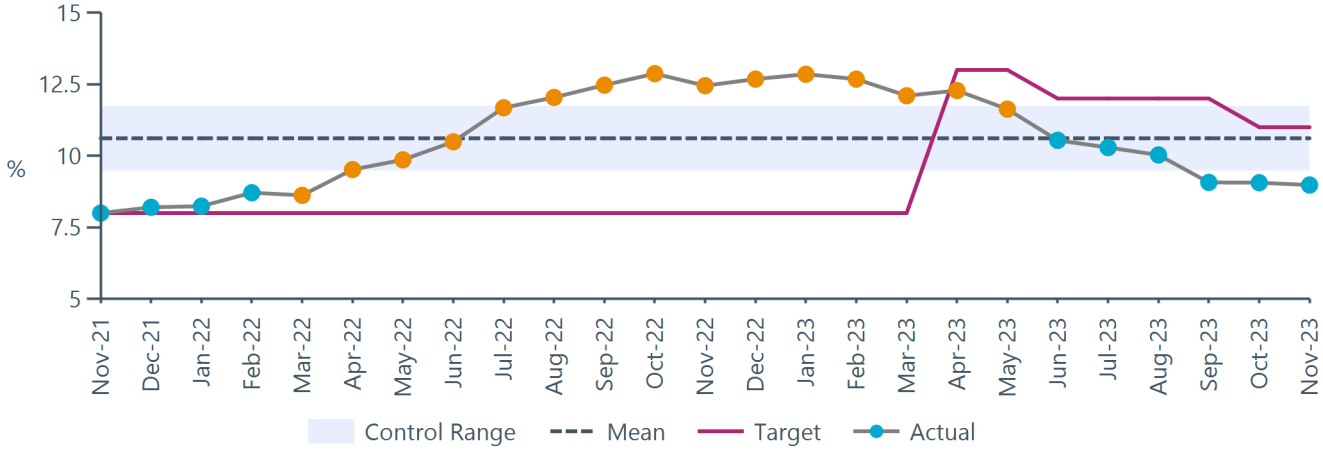
Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 217394

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
11.00%	8.98%	L	Moving Target

Trajectory





What these graphs are telling us

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

Narrative

Staff Turnover is reported at 8.98% for November and included as special cause variation due to the sustained improvement. This metric relates to the leavers over the past twelve months. For the period of December-22 to November-23 there have been 161 leavers as a proportion of the month end headcount of 1793.

Actions

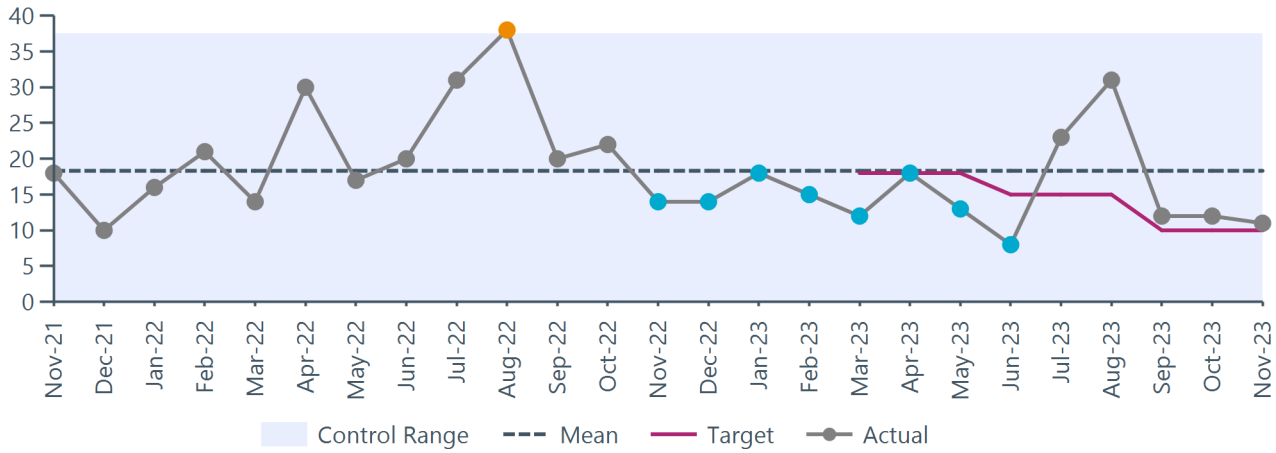
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
12.45%	12.68%	12.85%	12.68%	12.10%	12.28%	11.63%	10.54%	10.29%	10.03%	9.07%	9.06%	8.98%

In Month Leavers

Number of leavers in month 217809

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
10	11		Moving Target



Trajectory

What these graphs are telling us

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

Narrative

There were 11 staff that left the Trust in November. There has been a gradual target reduction on this metric, stabilising at ten per month from September; therefore, it is included as an exception this month as it is reported above the target.

The November leavers were from the following areas: MSK Unit (5), Specialist Unit (4) and Corporate Areas (2).

The reasons for leaving were:
* Flexi retirement (1)
* Retirement Age (1)
* Voluntary resignations - Other/Not Known (2), Promotion (2), Work Life Balance (2), Incompatible working relationships (1), To undertake further education or training (1), Lack of opportunities (1)

Actions

* Focussed effort on developing role competencies and career pathways for progression to agenda for change. Within Theatres, this launched in November and links to PDRs; eventually supporting the Learning & Development Team with what courses/education are required. Work ongoing within MCSI to progress.
* Trainee Nurse Associates; March-24 cohort compromised due to funding challenges. Revised Business Case to be formulated and presented with the view to support a September-24 cohort.
* System rotation for operating department practitioners is on hold due to the high volume of learners in the department and delays with system leading this work. Meeting to be scheduled with RJAH Workforce Team, Chief Operation Officer, Chief Nurse and ICS AHP Workforce Lead with a view to progress.
* Pathway of career progression for AHP HCSW with competencies for band 2,3,4 posts commenced. Job descriptions to be reviewed. The project has continued to develop, aligning NHSE/HEE HCSW roadmap framework. Plans to promote pushed back to quarter four.
* RJAH now delivering preceptorship programme independently, but still utilising springboard to align with system partners. Risk associated with preceptorship delivery due to training room availability within the Trust. This has been escalated to the Estates department.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
14	14	18	15	12	18	13	8	23	31	12	12	11

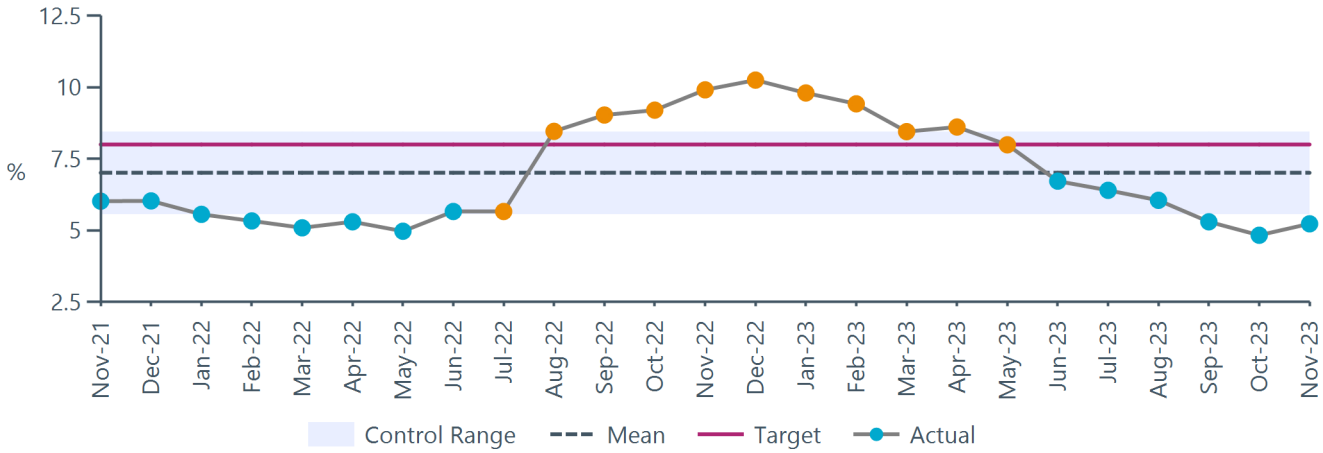
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	5.23%	L	?

Trajectory



What these graphs are telling us

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

Narrative

The Trust-wide vacancy rate for November month-end is reported at 5.23%. It is included as an IPR exception due to the graph displaying special cause variation of an improving nature. The increase in vacancy rate reported this month is partly attributable to establishment increase that has been transacted in November that relates to additional staff planned for Theatres.

Actions

* Emerging awareness of number of Admin & Clerical vacancies within MSK Unit that require support from Unit General Manager. Need to understand if related to SOOS/MUSST transition.

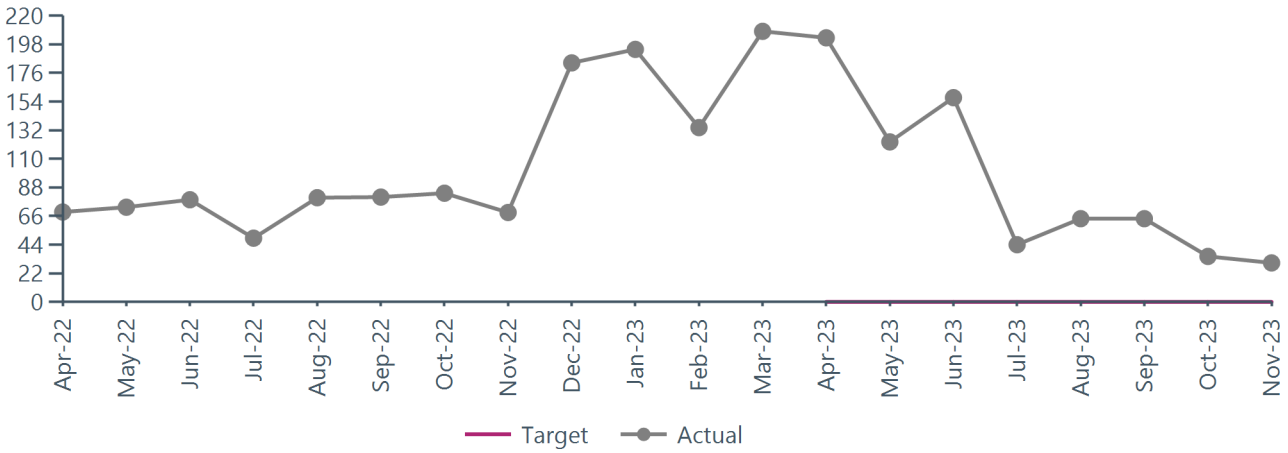
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
9.91%	10.25%	9.80%	9.42%	8.45%	8.61%	7.99%	6.72%	6.40%	6.05%	5.30%	4.83%	5.23%

Agency Core - Off Framework

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency Off Framework 217817

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
0	30	N/A to SPC	F



Trajectory

What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently failing the target.

Narrative

Off framework usage at 13%, in line with 14% in M7.

Actions

- Enhanced sign off arrangements for off framework agency shifts'.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
68	183	194	134	208	203	123	157	44	64	64	35	30

Chair's Assurance Report
People and Culture Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	10 January 2024
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	04 January 2024
Paper Reviewed by:	Martin Evans, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the People and Culture Committee. The Board is asked to consider the recommendations of the People and Culture Committee.

2. Context

2.1 Context

The Trust Board has established a People and Culture Committee. According to its terms of reference: *"The purpose of the People and Culture Committee is to assist the Board obtaining 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. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:*

- *Promote excellence in staff health and wellbeing;*
- *Identify, prioritise, and manage risks relating to staff;*
- *Ensure efficient and effective use of resources."*

In order to fulfil its responsibilities, the Committee has established sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The People and Culture Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from People and Culture Committee

This report provides a summary of the items considered at the People and Culture Committee on 21 December 2023. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The People and Culture Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

Corporate Risk Register

The Committee noted and agreed the corporate risk register ahead of presentation at the Board.

- **2993** | *Registered Nurse unavailability impacting safe staffing levels* – reduced from a score of 16 to 12.
- **3066** | *Consultant Anaesthetist vacancies and recruitment impacting on operational plan* – reduced from a score of 16 to 12.

- **3027** | *Variable Income Performance linked to Elective Activity Performance* – increased from a score of 16 to 20.
- **3132** | *Accommodation – international recruitment* – has recently been added to the register following a request from the Committee this will be reviewed through the usual risk management process.

Staffing Establishment Report
There have been no fundamental changes to the rota. The group took assurance from the report and the actions/oversight in place to monitor. The Committee supported the report being presented to the Board as suggested by internal audit and therefore has been added as an appendix to the Chairs Assurance Report.

ICS Workforce Metrix Reports
Concerns were raised regarding the discrepancies within the Systems workforce metrics report in comparison to the Trusts true position. There is a risk that a true reflection of the workforce performance isn't being received and therefore incorrect comparisons being made against the other Trusts. The ICS have been informed of the variances and the Committee highlighted the need for this to be addressed as a matter of urgency.
The Committee acknowledged that the System is currently recruiting a Chief People Officer which has previously been reported as a concern to Board by the Committee.

3.2 Areas of on-going monitoring with new developments

ADVISE - The People and Culture Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Workforce Performance Report
The Trust continues to report a positive position in relation to the following:

- KPI's continued to be maintained.
- Reduction in sickness from October to November and long-term sickness cases has improved.
- Fixed term contract information has been included in the turnover data.
- PDRs are currently at 92% - acknowledged the improvements made within the MSK Unit.

Further assurance was requested on the following:

- Time to hire – actions have been implemented to reduce the rate. The Committee have asked for a deep dive into the indicators to better understand and agree some realistic and meaningful improvement targets which is scheduled for February.
- Discussion was held in relation to the data quality issues aligned to the theatre vacancies. The committee were advised that following a review key issue such as double counting of staff and staff members withdrawing from the recruitment process had been identified. It was agreed that the committee would receive a more focused oversight of key vacancies within theatres so that progress on recruitment could be closely monitored. A risk to theatre activity is still noted following the review.

Powys Ward Action Plan
Although the Trust reassured the Committee that all actions have been implemented from the Powys Ward review, the Committee requested the final action plan to be presented in full at the next meeting.

3.3 Areas of assurance

ASSURE - The People and Culture Committee considered the following items and did not identify any issues that required escalation to the Board.

Agency Update
The Committee were assured with the actions implemented to support the reduction in agency usage. It was noted that off-framework agency continues a downward trend and MSCI staff have been realigned to on framework.

Nursing Safe Staffing Report
The Committee were assured that the Trust are compliant with the safe staffing levels. The Committee congratulated the team on being awarded the NHS Pastoral Care Quality Award, and for their continued hard work in improving agency rates, supporting international recruitment, and resolving issues flagged in a timely manner.

Core Training Compliance Report
The Committee noted the compliance rates and took assurance from the data provided which highlighted the ongoing actions implemented to improve the compliance position.

Internal Audit Recommendation Report (Medical Rota Review / Bank and Agency Review)
The Committee took assurance from the actions implemented to ensure the recommendations from internal audits have been completed. It was noted that although 3 actions remain outstanding for the Medical Rota Review, 97% of job plans have been signed off. The Committee noted the progress made and welcomed another update report next quarter.

e-Rostering and e-Planning Report
The Committee noted the progress that has been made and were pleased to note that the Trust was on target to achieve Level 4 as planned by the end of December 2023.

Chair Report Non-Medical Staff Group
The Committee noted the assurance report – no concerns were raised.

Chair Report LNC Meeting
The Committee noted the assurance report – no concerns were raised. The Committee discussed the junior doctor strikes and were assured of the processes in place to manage industrial action. The Trust expected more junior doctors to join the strikes which is likely to have an impact on activity levels.

Chair Report JCG Meeting
The Committee noted the assurance report – no concerns were raised.

The Committee considered and **endorsed** the following policies:

- Menopause Policy
- Domestic Abise and Sexual Safety Policy

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps,
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required,
3. NOTE the content of section 3.3.

Safe Staffing Review Summary November 2023

Committee / Group / Meeting, Date

Board of Directors, Public Meeting, 10 January 2024

Author:

Name: Paul Kavanagh-Fields
Role/Title: Chief Nurse and Patient Safety Officer

Contributors:

Report sign-off:

People and Culture Committee, 21st December 2023

Is the report suitable for publication?:

YES

Key issues and considerations:

- MSK Unit safe staffing review was carried out on 2nd November 2023 covering April to September 2023 data.
- Specialist Unit safe staffing review was carried out on 6th November 2023 covering April to September 2023 data.
- Both units have presented these reviews at unit board level where actions will be monitored.
- The next staff establishment reviews are planned for April 2024.

Strategic objectives and associated risks:

- Trust Strategic Objective: Developing and maintaining safe services.
- BAF 2: The workforce does not have the required capacity and capability.

Recommendations:

The Board is asked to note the contents of the safe staffing reviews.

Report development and engagement history:

The safe staffing reviews have been reviewed at Unit Board level.

Next steps:

The safe staffing reviews are planned to take place in April 2024.

Summary - MSK Unit Safe Staffing Review, November 2023

Committee / Group / Meeting, Date

MSK Unit Board - November

Author:

Ian MacLennan
Assistant Chief Nurse

Contributors:

Report sign-off:

NA

Is the report suitable for publication?

YES

Key issues and considerations:

- ✓ Successful recruitment across unit with names against all vacant posts in all areas
- ✓ Roster templates will be amended to accurately reflect requirement/budget going forward following success of the Enhanced Recovery Project
- ✓ Removal of agency usage for HCAs across unit has already been achieved.
- ✓ Removal of off fremwork agency usage across unit on the areas affected by this review has been achieved.
- ✓ On going monthly reduction in on framework agency usage is underway

Strategic objectives and associated risks:

The work of the Meeting relates primarily to delivery of the following Trust strategic objectives:

1) Developing and Maintaining Safe Services
2) Support MSK integration across the system
3) Optimise the potential of digital technologies to transform the care of patients and their outcomes.
4) Maintaining statutory and regulatory compliance

Recommendations:

The MSK Unit Board is asked to note the review and proposed actions contained within the embedded action plan.

Next steps:

Action plan has been completed and compliance monitored via MSK Unti Governance meeting

Acronyms

CHPPD	**Care Hours per Patient Day**
HCSW/HCA	**Health Care Support Worker/ Health Care Assistant**
MSK	**Musculoskeletal Unit**
NA	**Nursing associate**
OPD	**Outpatients Department**
OSCE	**Objective Structured Clinical Examination**
Q+S	**Quality and Safety**
TNA	**Trainee Nurse Associate**

Summary - MSK Unit Safe Staffing Review, November 2023

1. Background / context

Six to twelve monthly safe staffing reviews for all nurse led areas in MSK are carried out. This paper summarises the presentation and agreed actions following the review carried out on the 2nd of November 2023- covering the April to September 2023 data.

Data is triangulated between the ward rostering templates, safecare, Quality and Safety metrics, Human Resource metrics, and financial performance to ensure that our clinical areas are safely resourced.

On this occasion, the data was presented to the Chief Nurse and Chief Finance officer (HR and Finance colleagues were unavailable) by the Assistant Chief Nurse (IM), Matrons (RF and JB) and available ward manager (GL).

The areas included in the review were:

- Kenyon
- Clywd
- Ludlow
- Powys
- Baschurch
- HDU

2. Findings

2.1 **Kenyon** (including professional judgement)

2.1.1 Template

Kenyon is funded as a 22 bedded ward. Due to non-availability of staff and vacancy during the early part of the reporting period, as a proactive measure Kenyon reduced the maximum number of patients to 16 beds. This was a proactive approach to minimise agency spend and had no impact on activity given the increasing success of enhanced recovery.

2.1.2 SafeCare/rostering

There is nothing of concern to extract from the SafeCare Metrics. The skill mix of approximately 55%RN:45%HCA is such because of the ward running on 16 beds most of the time. This altered the ratio from the planned one of 66%:33%

2.1.3 Q&S Metrics

The reduction in incidents is impacted by the variability in activity (caused by intermittent ward closure). Additionally, the reduction in registered nurse vacancy levels is likely to have impacted on a reduction of incidents (for example there has been a sustained improvement in the number of medication errors). There has been a lot of work around learning through incidents. The ward is now fully staffed. Tendable Audit results are now displayed to inform staff and inform action plans to improve. These are relayed to all staff at every hand over via a Hot Topic report.

2.1.4 Finance

Kenyon's financial position has improved significantly, with a drop in agency spend from £21k in month 1 to £3k in month This is due to staff vacancies being filled and it should decrease further in upcoming months. RJAH have recently recruited increasing numbers of bank HCAs and nurses and their orientation supernumerary shifts on the wards are being charged to ward budgets.

2.1.5 People

The ward manager is managing her sickness absence well, despite the fact that sickness levels were intermittently higher when the ward temporarily closed due to reduced activity. Compliance with mandatory training and PDRs has significantly improved and are above Trust targets.

2.1.6 Recommendation (Kenyon)

Review of the structure of the ward has been commissioned as a result of the success of the enhanced recovery project. This review may have an impact on the required template, but currently no changes are requested. Should the review determine a reduction of beds (or working days) to be appropriate, the template will be altered accordingly and presented to Unit Board prior to onward approval if required. The Unit has just been made aware of a change in the Safer Nursing Care Tool which will also be embedded into practice in the forthcoming weeks. This will inform the skill requirements following any changes in structure. This is likely to require an increase in nurse-to-patient ratios with a smaller bed base (but not an overall increase in cost).

2.2 **Clwyd** (including professional judgement).

2.2.1 Template

Clwyd's bed requirement fluctuates between 10 to 22 patients due to the success of the enhanced recovery programme. The staffing template for 22 beds is appropriate but Clwyd are struggling with the reduced staffing template when only 16 beds are required to be open. The ward managers feels that an early coordinator shift is required, however when considering activity levels, it is apparent that the MSK wards get busier from 11am, with a peek between 5pm to 7pm. As such, it is proposed that the co-ordinator role should be in place between Mon – Sat, 11am to 7pm. It is also felt that on days with higher activity in relation to the ER pathway, the template should be altered to provide additional support due to the intensity of the care requirements. None of these changes require additional funding.

2.2.2 SafeCare/rostering:

We have started to capture in safe care the post operative patients returning to the ward by recording them for the 6 hours after return as 1A patients. This is because they require higher level nursing to keep them safe. Since we have done this SafeCare during the day feels like it represents ward activity appropriately. Safe care records overnight that there are around 10 to 15 excess hours, but we have used clinical judgement. The template is 2 nurses and 1 HCSW for 16 patients and 2 nurses and 2 HCSW for 22 patients. It is felt that this is correct for activity on the ward.

2.2.3. Q&S Metrics

In the reporting period, there has been a small rise in medication incidents. The patient safety team has completed an investigation into the systems at work around completing drug rounds and identified areas where incidents could occur as a result of current processes. Staff are producing more meaningful action plans utilising the tendable audits and all wards now have a tendable board to communicate to their teams what tendable is telling us and what we need to do. There is one vacancy for a part time nurse and vacancies have gone out to fill the HCA vacancies with an apprentice.

2.2.4 Finance

Clwyd has dropped from an agency spend of £15k in month to £2k in month 6. Bank spend remains high however this is due to new starters are only just joined the team and are currently just completing their supernumerary status. There has also been much tighter control into bank and agency bookings as staff now look across each other's areas and look at activity and pull staff to help on other wards where acuity is low, and staffing is high. This is enabling us to cancel between 1 to 3 bank shifts per day. RJAH have also successfully recruited bank HCAs and nurses. Currently these staff are being given supernumerary shifts on the wards and this is coming out of ward budgets.

2.2.5. People

The ward manager is managing her sickness absence well. Impacting on sickness levels are the higher rates of sickness reported when the wards temporarily close when activity is low. The average sickness rate though has dropped from 12.39% to 4%. Mandatory training has taken a dip because of the new starters but the ward managers are ensuring there are plans in place for the new starters to complete their training.

2.2.6. Recommendations (Clwyd)

Adjust the template when the ward reduces its bed base from 22-16 (matched to demand) to facilitate 3 RNs on the late shift. The additional late nurse is an 8-hour shift. Keep the number of nurses who work an early shift at 2 nurses. Continue to use staffing meeting to challenge managers to staff to activity and not to template. This will not have an adverse effect on budgets as will be within the current financial template.

2.3 **Summary – Ludlow** (including professional judgement).

2.3.1 Template

Ludlow has 16 side rooms. The staffing template for 16 beds is adequate for the activity and to manage the expectations of the client base on Ludlow. The template previously had allowed for preop patients.

2.3.2 **SafeCare/rostering**:

We have started to capture in safe care the post operative patients returning to the ward by recording them for the 6 hours after return as 1A patients. This is because they require higher level nursing to keep them safe. Since we have done this SafeCare during the day feels like it represents ward activity appropriately. Safe care records overnight that there are around 10 to 15 excess hours, but we have used clinical judgement. The template is 2 nurses and 1 CSW for 16 patients. Ludlow because most Private Patients come in on a weekend have additional staffing of a CSW all day Saturday and Sunday and an RN twilight on Saturday. It is felt that this is correct for activity on the ward.

2.3.3 Q&S Metrics

In the last 6 months there has been a small rise in May with tissue viability issues, but no themes and trends were identified. Staff are producing more meaningful action plans utilising the Tendable audits and all wards now have a Tendable board to communicate to their teams what Tendable is telling us and what we need to do.

2.3.4 Finance

Ludlow has reduced its agency expenditure from £7k in month 1 to £2k in month 6. Bank spend remains has increased from 14K M1 to 21K in M6. There has also been much tighter control into bank and agency bookings as staff now look across each other's areas and look at activity and pull staff to help on other wards where acuity is low, and staffing is high. This is enabling us to cancel around 1 to 3 bank shifts per day. RJAH have also recruited a lot of bank HCAs and nurses. Currently these staff are being given supernumerary shifts on the wards and this is coming out of ward budgets.

2.3.5 People

The ward manager is managing her sickness absence well. Impacting on sickness levels are the higher rates of sickness reported when the wards temporarily close when activity is low. The average sickness rate though has dropped from 8.37% to 4.49%. Mandatory training has taken a dip because of the new starters but the ward managers are ensuring there are plans in place for the new starters to complete their training. PDRs are 100%. There are vacancies on Ludlow of 63 hours RN this is out to advert and hours held for a TNA about to qualify. CSW vacancies are over recruited but one is a TNA about to qualify that will bring the over recruitment down.

2.3.6 Recommendations:

Continue to use staffing meeting to challenge managers to staff to activity and not to template. Ludlow ward supports the Outpatient clinics so we will be looking into how much nurse/ HCA is lost from the ward. Confirm arrangements for PP business management.

2.4 Summary – Powys (including professional judgement).

2.4.1 Template

Powys' bed requirement fluctuates between 10 to 22 patients due to the success of the enhanced recovery programme. The staffing template for 22 beds is appropriate but Clwyd are struggling with the reduced staffing template when only 16 beds are required to be open. The ward managers feels that an early coordinator shift is required, however when considering activity levels, it is apparent that the MSK wards get busier from 11am, with a peek between 5pm to 7pm. As such, it is proposed that the co-ordinator role should be in place between Mon – Sat, 11am to 7pm. This requires no additional funding to the budget for 22 beds.

2.4.2 SafeCare/rostering:

We have started to capture in safe care the post operative patients returning to the ward by recording them for the 6 hours after return as 1A patients. This is because they require higher level nursing to keep them safe. Since we have done this SafeCare during the day feels like it represents ward activity appropriately. Safe care records overnight that there are around 10 to 15 excess hours, but we have used clinical judgement. The template is 2 nurses and 1 HCSW for 16 patients and 2 nurses and 2 CSW for 22 patients. It is felt that this is correct for activity on the ward.

2.4.3. Q&S Metrics

In the last 6 months there has been an increase in medication incidents. The patient safety team has completed an investigation into the systems at work around completing drug rounds and identified areas where incidents could occur as a result of current processes. There has also been double the amount in slips trips and falls. Powys ward has reopened as it was closed for around a month. It also has a new ward manager in post. Staff are producing more meaningful action plans utilising the tendable audits and all wards now have a tendable board to communicate to their teams what tendable is telling us and what we need to do. Incidents have increased in reporting since the new ward manager. This could be due to the healthy culture of reporting incidents to learn from them being fostered on Powys ward.

2.4.4 Finance:

Powys has dropped from an agency spend of £46k in month to £10k in month 6. Bank spend remains high however this is due to new starters are only just joined the team and are currently just completing their supernumerary status. There has also been much tighter control into bank and agency bookings as staff now look across each other's areas and look at activity and pull staff to help on other wards where acuity is low, and staffing is high. This is enabling us to cancel around 1 to 3 bank shifts per day. RJAH have also recruited a lot of bank HCAs and nurses. Currently these staff are being given supernumerary shifts on the wards and this is coming out of ward budgets. Staff on secondment and maternity will soon be returning to the ward.

2.4.5 People

The ward manager is managing her sickness absence well. Impacting on sickness levels are the higher rates of sickness reported when the wards temporarily close when activity is low. The average sickness rate though has dropped from 12.31 to 8.62%. Mandatory training has taken a dip because of the new starters but the ward managers are ensuring there are plans in place for the new starters to complete their training. PDRs have been booked and they will shortly be at 100%.

2.4.6 Recommendations:

Increase the number of staff on the late shift to 3 nurses instead of 2 when staffed at 16 beds as this is when the majority of activity occurs. The additional late nurse is an 8-hour shift. Keep the number of nurses who work an early shift at 2 nurses. Continue to use staffing meeting to challenge managers to staff to activity and not to template. This will not have an adverse effect on budgets as will be within the current financial template.

2.5 Summary – Baschurch (including professional judgement).

2.5.1 Template

The Baschurch template is fit for purpose. However, activity varies significantly for Baschurch a long time after the rota is required to be produced. As such, there is significant flexibility of the Bascurch staff in order to meet demand, and this is always reflected in the rota that is locked down at the end of the worked month. An example of this would be reduced activity as a result of rolling half days or lists not taken up or increased activity due to changing balances of inpatients v day cases.

2.5.2 SafeCare/rostering

Bascurch do not undertake SafeCare (it is not applicable to day case units), but their rostering performance is reported to be good in terms of roster analyser.

2.5.3 Q&S Metrics

Incidents reported on Baschurch are almost solely related to on the day cancelations or the conversion of day cases to inpatients. A T+F group has been convened to increase the accuracy of this reporting as there are 2 reporting streams (outputs from theatres v outputs from datix). The theatre outputs are more accurate in terms of statistics, the datix outputs in terms of learning.

2.5.4 Finance

No escalations in terms of finance – the ward remains within budget. The slight increase in spend in M6 relates to non availability of an HCA

.

2.5.5 People

No escalations in terms of people. The temporary drop in PDR compliance was due to the ward manager undertaking a matron role on a secondment basis, but this was quickly resolved and PDRs are compliant.

2.5.6 Recommendation

No changes are recommended for Baschurch.

2.6 Summary – HDU (including professional judgement).

2.3.1 Template

The HDU template is fit for purpose and based on the required 1RN:2PT ratio for this clinical area.

2.6.2 SafeCare/rostering

There is significant variation in CHPPD required due to the variation in HDU activity, this is to be expected. Nurses are transferred to work elsewhere when they are not required on the unit – and on these occasions the base shifts are cancelled.

2.6.3 Q&S Metrics

Incidents reported on HDU are almost solely related to unexpected admissions, and not issues that have occurred on HDU. There are no areas of for escalation.

2.6.4 Finance

In Q1, there was a vacancy/non availability factor within outreach that influenced an overspend. (Outreach is included as a separate team on the HDU rota, and this is where the majority of the overspend was originated from). The new 2 new outreach practitioners have commenced a level 7 Apprenticeship as a route to achieving competence – and this has had an adverse impact on temporary staffing usage. Improved performance is currently noted in M7.

2.6.5 People

No escalations in terms of people. Vacancy rate has improved in the reporting period, as has non availability.

2.6.6 Recommendation

No changes are recommended for HDU.

3. Proposed next steps/ action plan

Action Title	Action Owner	Target Date	Update/RAG rating
IM to link in with Victoria Brownrigg to gain clarification as to the reasons why supernumerary TNAs are allocated to rotas, even when they are not working on the wards.	IM	31/12/23	
Plan for Qualified Nursing associates where applicable to be added onto the rota once qualified.	Matrons, MSK	31/12/2023	

Action Title	Action Owner	Target Date	Update/RAG rating
IM to work with finance colleagues to display how intermittent reduced beds affects pay expenditure in MSK (including when substantive staff are moved outside MSK).	IM, MO	30/12/2023	
Ensure HR and finance colleagues are at the next Safe staffing review.	IM	Next review	
IM to determine if the reduced bed base requirement as a result of the ER programme affects commissioner finance arrangements.	IM/MO	31/12/2023	
Adjust ward templates on the basis of activity changes in relation to enhanced recovery.	JB	31/01/2023	
IM to complete the review of the bed configuration in relation to the operational plan and the impact of enhanced recovery – to include consideration of a 5.5 day facility on Kenyon and focussing specialties onto wards.	IM/RF/JB	30/01/2024	
Confirmation required of the PP business management structure– it was part of the agreement to fund the Unit General Manager post.	Mark Lowe	31/12/2023	
CM to speak to Nia Jones to get an update regarding the application of ER to the PP cohort.	CM	31/12/2023	

CM to speak to Nia Jones to get an update regarding the application of ER to the PP cohort.

4. Recommendation

The MSK Unit board is asked to note the review and proposed actions.

Specialist Unit Safe Staffing Review 6th November 2023

Committee / Group / Meeting, Date

Specialist Unit Board- November

Author:

Lisa Newton
Assistant Chief Nurse

Contributors:

Report sign-off:

NA

Is the report suitable for publication?

YES

Key issues and considerations:

- ✓ Successful recruitment across unit with names against all vacant posts in MCSI, Sheldon and Main OPD
- ✓ Roster templates will accurately reflect requirement/budget going forward following merge of Gladstone and Wrekin rosters and uplift in Sheldon roster template due to opening of 2 additional MCSI beds.
- ✓ Removal of agency usage for HCAs across unit
- ✓ Cease off-framework agency usage across unit from November.
- ✓ On going monthly reduction of on-framework agency usage in unit, with trajectory to move to zero agency by Q1 2024 for Sheldon ward and Q2 for MCSI

- Review of mattress costs to identify any scope to reduce expenditure.
- Scope dental SLA on Alice for further work/expansion.
- Include Alice bed utilisation in future safe staffing reports.
- Review OH delays to ensure efficiency in service provided.
- Oswald to recruit into vacant posts.
- Review of agency changes when staff redeployed.
- Review plans to convert nurse funding into OT post and whether this should be funded from therapy funding stream.
- Review Saturday lists on OPD and whether this is included in budgets.
- Complete outstanding job plan for Montgomery staff member.
- Review funding stream for transition nurse on Alice ward

Strategic objectives and associated risks:

The work of the Meeting relates primarily to delivery of the following Trust strategic objectives:

1) Developing and Maintaining Safe Services
2) Support MSK integration across the system
3) Optimise the potential of digital technologies to transform the care of patients and their outcomes.
4) Maintaining statutory and regulatory compliance

Recommendations:

The Specialist Unit Board is asked to note the review and proposed actions.

Next steps:

Action plan to be completed and compliance monitored via Specialist Unit Governance meeting.

Acronyms

AHP	Allied Health Professional
CHPPD	Care Hours per Patient Day
CNS	Clinical Nurse Specialist
HCA	Health Care assistant
MCSI	Midlands Centre for Spinal Cord Injury
MSK	Musculoskeletal
NA	Nursing associate
OJP	Out of Job Plan
OPD	Outpatients Department
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapist
RSCN	Registered Sick Childrens Nurse
TNA	Trainee Nurse Associate

Specialist Unit Safe Staffing Review 6th November 2023

1. Background / context

The Trust undertake six monthly safe staffing reviews for all nurse led areas across the Specialist Unit. This paper summarises the presentation and agreed actions following the review carried out on the 6th November 2023 which covered the April to September 2023 data.

Several data sources are triangulated when setting are nursing staff rostering templates, these include, safe care, red flag data, Quality and Safety metrics, Human Resources metrics, and financial performance to ensure that our clinical areas are safely resourced.

This data is then presented to our Chief Nurse, Chief Finance officer, People Services Business Partner and Finance Business Partner. The data was presented by the department managers from each area supported by the matron and Assistant Chief Nurse.

The areas reviewed were:

- Sheldon Ward
- Alice ward
- Oswald Ward
- Montgomery Unit
- Main Outpatients Unit
- MCSI unit – including both Gladstone and Wrekin Wards

2. Findings

2.1 ***Sheldon Ward***

Sheldon ward was presented by Ward Manager- Lorna Edwards and Matron Zoe Day. It was noted that the staffing template on Sheldon ward was increased in October 2023 due to the opening of 2 MSCI beds on the unit and therefore the metrics presented no longer represent the current picture.

Even with the uplift Lorna has worked tirelessly to recruit to all vacancies and now has a name against every vacant post, it is hoped that in the new year when these staff arrive that this will translate into 0 vacancies.

11 red flags were raised during the six-month period; however, all were noted to have been resolved or raised in error. A red flag SOP was devised and has been shared with the team as a quick reference guide to red flag alert usage.

The shortfalls in Care Hours per patient day (CHPPD) demonstrated in the safe care data have been addressed by the uplift in staffing template and going forward Lorna believes that this will be resolved.

Unify data demonstrated the additional shifts entered to support both bay watch patients and the 2 additional beds funded by MCSI, however the roster template was only amended from October 2023 so up to this point these showed as additional shifts.

Quality and Safety metrics did not identify any correlation between staffing levels and patient safety.

Both long term and short-term sickness have been high over the last 6 months, however there are robust plans in place to manage this and current sickness is expected to be resolved in the coming months.

Finances are in deficit which is driven predominantly by staffing, due to agency and bank costs, and non-pay costs associated with mattress hires.

In summary all vacancies have been recruited to, long term sickness is being managed and the activity co-ordinator and discharge co-ordinator roles have released nursing time. The new uplifted staffing template should negate the need for additional shifts going forward.

2.2 *Alice Ward*

Alice Ward was presented by Ward Manager Suzanne Marsden and Matron Zoe Day. It was noted that the staffing template for Alice ward also includes children's outpatients, and outreach clinics, dental lists and OJP clinics.

0 red flags were reported in last 6 months and it was acknowledged that Safe care and CHPPD data cannot be applied to Alice ward in the same way as adult wards due to their low numbers of patients and the minimum staffing requirement of 2 RSCN's per shift.

Quality and Safety metrics did not identify any correlation between staffing levels and patient safety.

Sickness is well managed and long-term sickness has been addressed and managed in line with policy.

Due to low activity finances are favourable and in the green.

In Summary Paediatric nurse recruitment is becoming a national challenge and recruitment remains difficult at present, Suzanne has joined the regional rotation programme for newly qualified nurses and worked with communications to support recruitment into her vacancies.

2.3 *Oswald Ward*

Oswald ward was presented by Ward Manager Sarah Kaye and AHP lead Geraint Davies. It was noted that the staffing template accurately reflects the current requirements.

1 red flag was reported however assurances were given that this had been resolved at the beginning of the shift, however it was noted that this had not been updated on safe care. As with Alice ward the Safe care and CHPPD data cannot be utilised in the same manner as other wards as there are only 10 beds on the unit which appear to be overstaffed when using safe care.

Quality and Safety metrics did not identify any correlation between staffing levels and patient safety.

1 staff member on long term sick, being supported by HR to manage, 1 vacancy identified however plan to fill with current band 6 on secondment. No training gaps identified.

Finances favourable, however note small overspend on pay, due to sickness absence, maternity leave and agency redeployed from another clinical area and charged to ward in error.

Unify fill rates are within target ranging from 97% to 102%.

In summary Sarah agreed to do some education with her team regarding red flags and recording actions taken. She also received authorisation to recruit into outstanding vacant posts with slight over recruitment.

2.4 *Montgomery Unit*

Montgomery Unit was presented by Geraint Davies, AHP lead. The roster templates gave a breakdown of all of the clinics covered by the team, and these have now been aligned to agreed job plans for the team.

Quality and Safety data did not identify any issues however it was noted due to size of area and low numbers of incidents it is hard to make any informed conclusions from this small data set.

Long term sickness on the unit is ongoing with 1 CNS currently off, this has RAG rated the unit red for sickness compliance however it was acknowledged that with such a small team it only took 1 person to push the unit into the red.

In relation to training, Geraint explained that some of the administrative staff and non-clinical staff sit within his figures which is bringing the percentage compliance down. We are working with the training team to separate these staff groups from their data.

In the finance section the non-pay spend was noted to be higher than budgeted and Geraint explained that this was due to the increasing high usage of vac dressings within the unit. This will need to be included/considered when budget setting if this continues.

In Summary Montgomery unit is fully recruited to and the roster templates and job plans reflect the activity delivered. Currently an options appraisal is being considered in relation to converting the remaining band 6 nurse funding into OT hours. Montgomery has an HCA that has commenced their TNA course and Geraint plans to look at whether there is a role for a NA on the unit when they qualify.

2.5 Main Outpatients Unit

Outpatients was presented by Sister Liz Reece and AHP lead Geraint Davies. It was noted by Liz that the roster template included Saturday clinic cover however it is unclear whether the department is funded for this or whether this is an ongoing cost pressure.

Quality and Safety metrics indicated that a large number of incidents in the department relate to MSK patients and do not relate to safe staffing.

Finances highlighted an overspend on non-pay and this is believed to be related to the exogen bone stimulators as income from this service does not go into the OPD budget however the costs do. Whilst this should be acknowledged by the finance team again when budget setting going forward these costs need to be accounted for.

Liz gave assurances of how she was managing the multiple cases of long-term sickness within the department and has recruited to all of her vacant posts. She was also able to demonstrate compliance with all the mandatory training metrics.

In Summary Liz is keen to integrate the Band 4 Nurse Associate role into OPD, keen to ascertain if Saturday work is funded within the budget, highlighted that if the Headley Court day case facility utilisation increases we would need to review and increase staffing levels accordingly and finally highlighted the challenges with having the 16yr old apprentices in the department due to restrictions in their practice and the challenges this presented for the unit.

2.6 MCSI

MCSI unit was presented by Ward Managers Jess Sheil and Katy Coulson and were supported by Matron Kirsty Ditcher. It was noted that the roster templates for Gladstone and Wrekin wards will merge on the 4th December 2023 and whilst this will not change the staffing numbers in total it will mean the nursing staff can be allocated in a more equitable way to meet the needs of the patients and even out the safe care data which is currently showing as an over fill on Wrekin and underfill on Gladstone, due to the staff being reallocated across the 2 wards.

1 red flag was recorded as resolved on Gladstone by the Ward Manager stepping into the numbers to cover the shortfall.

Quality and safety metric highlight a high prevalence of medication errors and it was felt that the high vacancies and use of bank and agency had contributed to this.

A huge amount of wark is ongoing on MCSI to address these errors, including introduction of induction process for all new agency/bank staff/ review of drug charts and removal of ‘long stay charts’, Observation of work as done by senior nursing team and subsequent action plan.

Sickness absence is noted to be improving and MCSI senior nurse governance meetings have been introduced to monitor compliance against training and PDR targets.

Vacancies have been a real issue on MCSI for a number of years, however the ward managers should be commended as they have now recruited to every vacancy, and it is hoped that this will translate to 0 vacancies in quarter 4. Jess highlighted the challenges of International Recruits being added to the roster on arrival in the country but not being ready to work on the ward for 4 months following completion of 12-week training programme, OSCE exams and PIN number acquisition.

This has added to the already Signiant staffing overspend for MCSI, however it was acknowledged that the team again have worked to reduce off-framework agency usage for the last 4 consecutive months with a plan to stop off-framework usage from the beginning of November. Alongside this there has been some success attracting agency staff to join the nurse bank and to take up substantive roles.

Unify fill rates demonstrate staffing numbers within expected ranges however the skill mix and lack of continuity needs to be acknowledged. In other words, whilst we have the correct numbers of staff, they do not all have the skills and knowledge required to meet the needs of the patients.

In Summary recruitment to date has been successful and assuming these translate into posts MCSI will be in the strongest staffing position they have been in for many years. International recruits will however continue to create a cost pressure due to the protracted supernumerary status.

3. Proposed next steps/ action plan

Area	Issue	Proposed action	Responsible person	Completion date/ evidence
Sheldon and MCSI	Mattress hire costs high in these areas	Review mattress rental costs against costs of purchasing own mattresses to reduce costs. If continue to rent negotiate reduced costs with rental companies.	Sheldon- Zoe Day and Lorna Edwards MCSI- Kirsty Ditcher, Jess Sheil, Katy Coulson	31.12.2023
Alice	Bed utilisation data not included in safe staffing review	Bed utilisation data to be included in next safe staffing review	Zoe Day / Suzanne Marsden	01.05.2024
Alice	Additional capacity available for dental SLA	Dental SLA to be reviewed to see if we can increase provision	Victoria Brownrigg	01.12.2023
Alice	Funding for transition post unclear	To ascertain funding stream for transition nurse to remove cost pressure from Alice budget	Victoria Brownrigg	01.12.2023

Oswald	1 member of staff on long-term sick had OH delays of 6 months	To review staff members OH journey and identify areas to expedite process	Juliette	31.12.2023
Oswald	1 RN vacancy and HCA vacancy	To overrecruit with RN by offering seconded staff member a permanent post, and recruit HCA via generic advert already placed	Sarah Kaye	01.12.2023
Oswald	Potential agency costs incurred incorrectly to Oswald ward if staff redeployed	Review of agency costs and whether they are truly attributable to Oswald ward if staff redeployed	Victoria Brownrigg	01.12.2023
Montgomery	Proposal to convert nursing budget into OT post	Review whether funding for this should be provided by therapy department	Geraint Davies	31.12.2023
Montgomery	1 outstanding job plan	Outstanding job plan to be completed	Geraint Davies	01.12.2023
Main OPD	Saturday clinics believed to be funded outside of budget	Review of Saturday funding for OJP clinics	Victoria Brownrigg	01.12.2023

4. Recommendation

The Specialist Unit board is asked to note the review of nurse staffing establishments and commit to monitoring the proposed actions via Unit Board.

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 10 Jaaury 2024

Author: Contributors:

Name: Elizabeth Hammond
Role/Title: Freedom to Speak Up Guardian

Report sign-off:

Paul Kavanagh-Fields, Chief Nurse and Patient Safety Officer
People and Culture Committee, 19th October 2023

Is the report suitable for publication?

Yes

Key issues and considerations:

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q2 July-September 2023. The committee is asked to note the content and agree any subsequent recommendations / actions.

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

Key Points:

This quarter FTSU has received a total of 13 concerns.

- Four were anonymous concerns, one of the anonymous concerns related to bullying and harassment.
- There were four patient safety, one worker safety, three with an element of bullying and harassment and one an element of attitude or behaviours.
- Out of these concerns, six of the people who raised their concerns with the Guardian, required advice. When advice is given, rather than recording as a 'concern raised' it is recorded as 'other' on the National Guardian Office (NGO) data base.

It is important to note that some cases can fit several categories. For example, one case may have elements of patient safety as well as attitudes and behaviour, therefore, the concern should be recorded in both categories as per NGO guidance.

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

Sub-Scores

The NGO has released the sub-scores for FTSU (Raising Concerns sub-score in NHS Staff Survey reports). The sub-score has been calculated for both the 2021 and 2022 surveys and can be used as a benchmark. This is the first-time sub-scores have been produced.

RJAH has a sub-score of 6.4 The national mean sub-score fell this year to 6.4 from 6.5. Detailed report on sub-score is contained within this paper.

Assessment of cases

The number of cases raised this quarter was 13. Graph 1 shows concerns raised by Professional group, as required by the NGO. The graph also draws a comparison with the last quarter.

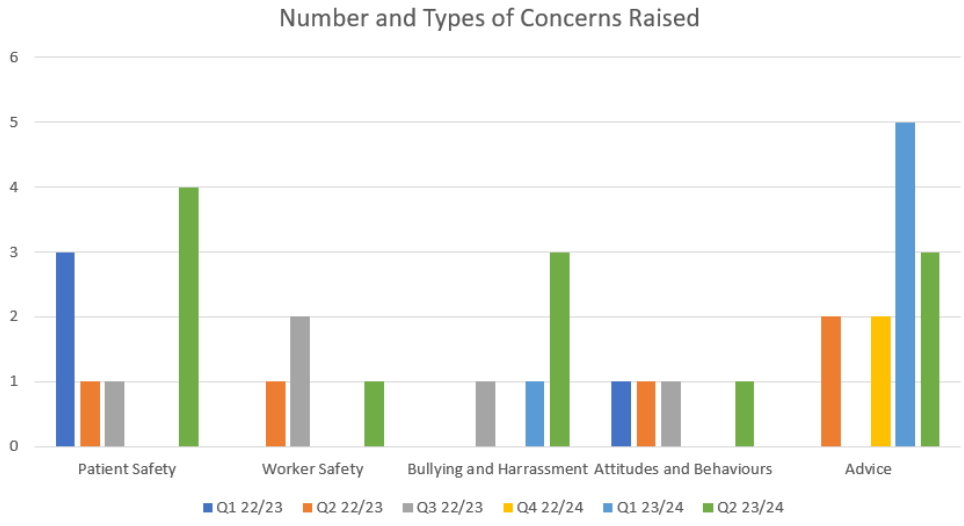
Graph 1

There has been an increase by five of anonymous concerns raised this quarter in comparison to last quarter. The FTSU post box is now in use. All anonymous concerns were received via the post box. Previously, staff could only raise anonymous concerns by writing a letter and delivering it to the office or by making an anonymous e-mail address. The letter box is situated above the Royal mailbox so that no-one notices if they are putting a letter into the FTSU box. This has contributed to a raise in anonymous concerns.

The increase of anonymous concerns is viewed as a positive, demonstrating that the mechanism to raise a concern anonymously has enable more staff to raise a concern.

Graph 2 shows the types of concerns raised and shows the comparison with the last quarter and the previous year.

Graph 2

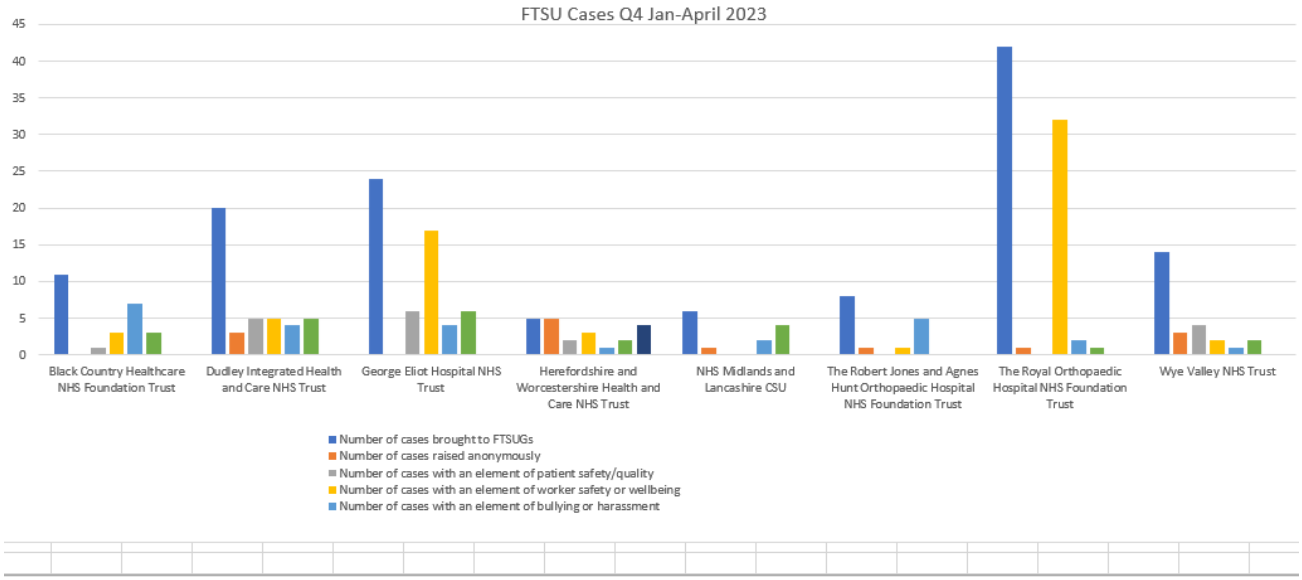


There has been an increase in total number of concerns raised this quarter. There are several contributing factors. These include:

- a FTSU office.
- an extra 7.5 hours.
- FTSU Champions.
- the role is no longer compromised by having two job roles in the Trust and therefore is viewed without any conflict of interests.
- a raised awareness of FTSU via the Comms Team.

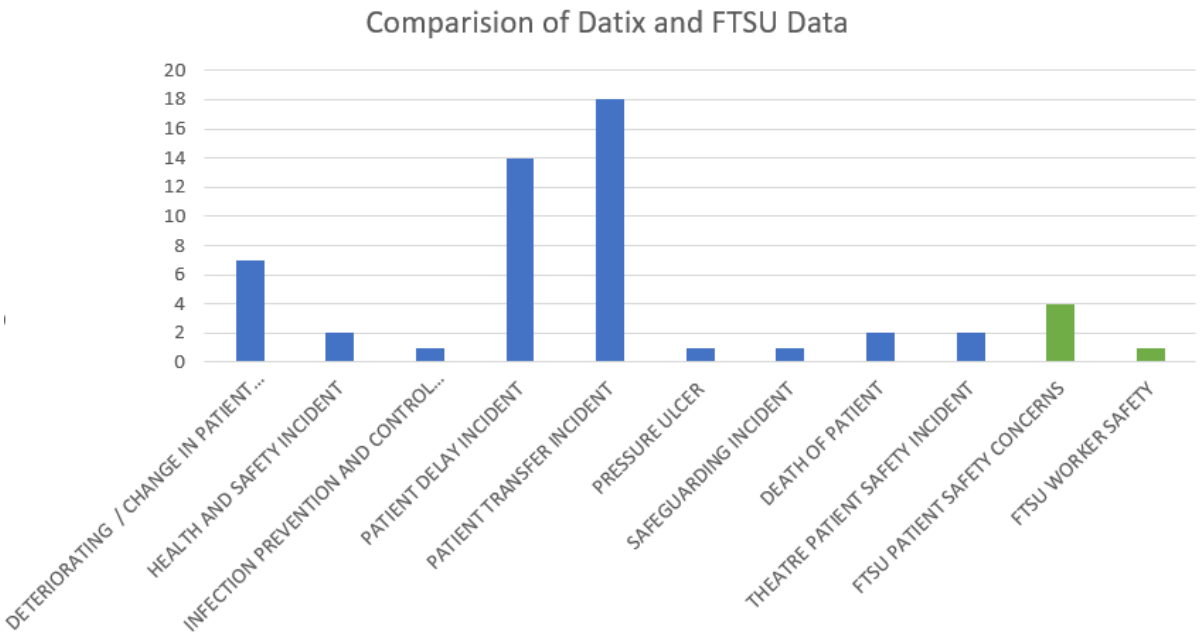
Graph 3 compares all NHS Foundation Trust in the Midlands who are in the small (5,000 and below) category. Please note that the RJAH main comparator for size and acute specialism is The Royal Orthopaedic Hospital in Birmingham. This data is compiled with the latest NGO data available which is Quarter 1st April- 30th June 2023.

Graph 3



Graph 4 compares the moderate to severe Datix incidents against the number of concerns raised to FTSU. Quarterly Datix figures are obtained from Clinical Governance.

Graph 4



Equality, Diversity, and Inclusion (EDI) triangulation data is available yearly. FTSU data is triangulated with WRES and DES data.

The FTSU Guardian is an integral member of the Equality, Diversity, and Inclusion monthly meeting. A monthly one to one meeting has been arranged with the Lead for EDI to compare soft intelligence and discuss what and how we can improve cultural behaviours and attitudes.

FTSU Sub-Score

A Freedom to Speak Up sub-score (Raising Concerns sub-score in NHS Staff Survey reports) has been calculated for both the 2021 and 2022 surveys and can be used as a benchmark.

The sub-score is calculated as the mean where at least three of the four questions, 19a, 19b, 23e, 23f in the staff survey have been answered. A higher score indicates a more favourable result.

The national picture which the Staff Survey results paints is that the confidence workers feel to speak up has declined for the second year in a row. The four questions which make up the Freedom to Speak Up sub-score can be mapped against two key barriers to speaking up:

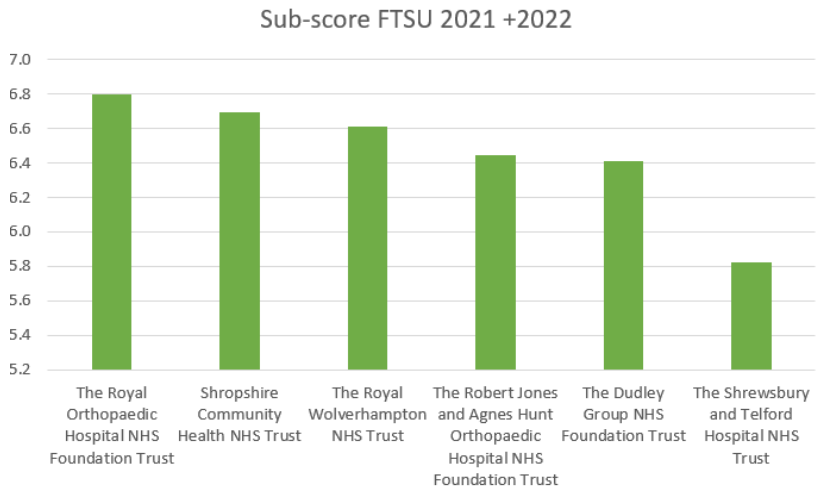
1. the fear of detriment, that speaking up is a risky thing to do (questions 19a and 23e).
2. the belief that speaking up is futile – that nothing will happen as a result (questions 19b and 23f).

RJAH have a Sub-score of 6.4.

Sector	Lowest sub-score	Highest sub-score	Mean sub-score
All Trusts	5.3	7.6	6.5
Acute specialist	6.4	7.3	6.8
Acute and Acute Community	5.7	7.1	6.4
Ambulance	5.3	6.9	5.9
Community	6.5	7.6	7.0
Mental Health & Learning Disabilities and Mental Health, Learning Disabilities & Community	5.7	7.4	6.7

Although RJAH has the lowest Sub-score for the acute specialist hospital nationally the mean sub-score for all NHS Trusts was 6.4.

The National Guardianship encourages leaders to be curious about your results and benchmark our organisation's culture against the Freedom to Speak Up sub-score.
The table below has compared our sub-scores against our main comparator, The Royal Orthopaedic hospital and other similar NHS hospitals in the Midlands and Shropshire.



Learning and Improvement

FTSU has utilised Comms to address an anonymous concern raised by highlighting Trust Policies.

A bespoke Speaking Up and Listening Up presentation has been developed for managers. The presentation looks at the barriers to speaking up and the pitfalls when listening up. It also discusses the tools to use when listening up and how to encourage staff to speak up.

The Health Education England FTSU training package and is now a mandatory requirement which has been incorporated into the learning and training package at RJAH. This is a one-off training. There are three different levels:

- Speaking up- core training for workers.
- Listen Up- training for managers (Band 7 and above, if other managers, of different grades, require this training we will add as required).
- Follow Up- training for senior managers (MD's and executives).

This will mean that senior managers will have to complete all three modules, Band 7 and above managers will need to complete the first two modules and Band 6 and below will need to complete the core training module.

This gives the Trust assurance that all staff have completed the Health Education FTSU Modules and understand why we have FTSU and how to speak up.

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

FTSU face-to -face induction training has resumed since April 2023.

Feedback

The FTSUG contacts the person who raised the concern to check on how they are and to give feedback about their specific concern at regular, pre-arranged intervals.

If a manager is dealing with the concern and they have been the person designated to give feedback to the person who raised the concern the FTSUG will check that the person has received feedback or requires additional updates.

Correspondence is sent to the person dealing (manager) with the concern, to ask for an update, feedback given to a staff member, actions, and learning achieved, to the FTSUG. This gives assurance that Speaking Up, results in learning and improvement.

Actions

Promotion and walk-about for FTSU October Month. This year's theme is 'Barriers to Speaking Up'. The FTSU Guardian and Champions are asking staff to share reasons what would stop them from speaking up and how can we as a Trust reduce the barriers which would prevent them from speaking up.

Collate data from walk about and report trends and actions required.

Completion of the NGO reflection and planning tool by January 2024.

Completion of self-assessment.

Ring fenced time for Champions. Although managers supported the Champions to attend bi-monthly meetings and FTSU Promotion days the Champions are finding that they can not attend due to service needs.

Acronyms

EDI - Equality, Diversity, and Inclusion
FTSU - Freedom to Speak Up
FTSUG - Freedom to Speak Up Guardian
NGO - National Guardian Office
NHS - National Health Service

GIRFT Elective Surgical Hub Accreditation: - Adults and Paediatrics

Committee / Group / Meeting, Date

Public Trust Board, 10 January 2024

Author: Contributors:

Name: Stephanie Wilson
Role/Title: Performance Insight and Improvement Manager

Report sign-off:

Mike Carr, Chief Operating Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

The Trust has been part of Cohort 3 of the national Getting It Right First Time (GIRFT) programme to become an accredited Elective Surgical Hub for both adults and paediatrics.

The Trust has successfully achieved this accreditation following submission of evidence, and a site visit by the GIRFT team on the 24th November 2023. This recognised our clinical and operational excellence for both paediatrics and adult elective pathways. This process reviewed our Trust elective pathways of care. The paper will cover:

- Background
- Benefits
- Site Visit
- Outcome
- Summary and Next Steps

Strategic objectives and associated risks:

This work supports the following Trust objectives in particular:

- Integrate the MSK pathway within and across STW and our aim to 'work towards Elective Hub accreditation'. The Elective Hub accreditation has now been achieved.

It also supports with:

- 'Deliver high quality clinical services' by ensuring we deliver Elective Hub efficiency standards.

Recommendations:

The committee is asked to note that the Trust has successfully been accredited as an Elective Surgical Hub for both adults and paediatrics. This is a significant achievement and supports delivery of strategic objectives. The Trust will progress with next steps following this accreditation.

Report development and engagement history:

This report has been collated and produced by the Performance Insight and Improvement Manager.

Acronyms

STW	Shropshire, Telford and Wrekin
HOP	Hub Optimisation Plan
MSK	Musculoskeletal
GIRFT	Getting It Right First Time

GIRFT Elective Surgical Hub Accreditation: - Adults and Paediatrics

Background

During September 2023 the Trust was successfully accepted on to cohort 3 of the NHS England's Getting It Right First Time (GIRFT) Elective Surgical Hub Accreditation programme.

The programme, in collaboration with the Royal College of Surgeons of England, and supported by the Royal College of Anaesthetists, assesses elective surgical hubs against a framework of standards, this is to give elective hubs protected status to allow them to continue to undertake surgical activity, which includes elective orthopaedics, even when the wider NHS is experiencing pressure on their emergency activity e.g., what is frequently seen during the winter. Importantly it also seeks to assure patients about the high standards of clinical care provided by the hubs.

Cohort 3 was the first cohort to also be part of the GIRFT Paediatric Hub Accreditation programme.

It's a thorough and full assessment of the complete patient pathway – looking at everything we do from welcoming the patient into outpatients, to their journey through pre-operative assessment and into Theatres, and then onto the ward and how we manage their discharge. To achieve the accreditation, the Trust was assessed against a defined list of criteria and clinical and operational standards across the following domains:

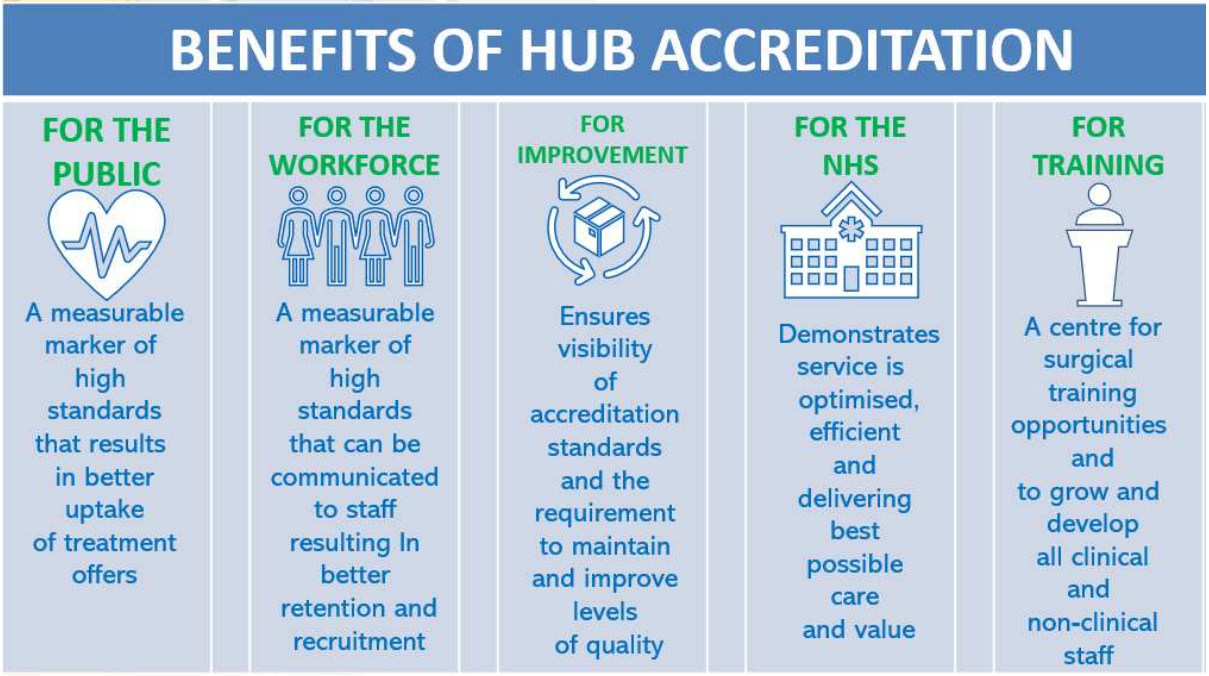
- Domain 1: Patient Pathway
- Domain 2: Staff and Training
- Domain 3: Clinical Governance and Outcomes
- Domain 4: Utilisation and Productivity
- Domain 5: Facilities and Ring-Fencing

Each domain covers many criteria elements. The amount of evidence to be submitted and time required to plan for the day was significant. Staff from across the Trust supported the process, providing the required documentation and were involved in the site visit too. It was seen as an opportunity to showcase and be proud of all that we do for our patients and staff.

Benefits

There are multiple benefits to being accredited which is shown in the GIRFT illustration below:

Image 1: - Benefits of Hub Accreditation



GIRFT Elective Surgical Hub Accreditation: - Adults and Paediatrics

Site Visit

In addition to the evidence submitted for each domain the Trust had a site visit from the GIRFT team as part of the accreditation process on the 24th November 2023.

The Trust hosted a delegation of seven people – led by orthopaedic surgeon Mr Andrew Dunn – from Getting It Right First Time (GIRFT).

- The site visit involved an overview of RJAH, a site tour, group sessions and a feedback session.
    - The site tour involved specific visits to Baschurch, Theatres, an elective ward and our childrens unit.
    - The group sessions were on the 'Patient Pathway' and 'A Focus on Workforce'. These group discussions were attended by staff from across our organisation (clinical and non-clinical) and included patient involvement for the 'Patient Pathway' group.

Outcome

At the end of the site visit on the 24th November 2023, the GIRFT team gave feedback which was extremely encouraging. They highlighted:

- how welcome they had been made to feel, and the honesty and inclusivity they got from our staff.
- how evident it had been that we work across teams to deliver outstanding patient outcomes.
- that they saw clear evidence of a culture of continuous improvement.

Following the site visit on the 24th November the evidence and observations from the day were further assessed. On the 19th December 2023 national clinical leads involved in the GIRFT accreditation programme of work met to agree the outcome.

- The Trust was notified on the 19th December 2023 that we had been successful in achieving accreditation as a Elective Surgical Hub for both adults and paediatrics.
    - The confirmation letter further iterated that the GIRFT visiting team were impressed with the professionalism and enthusiasm of our staff.

Being accredited as an Elective Surgical Hub for both adults and paediatrics is a visible marker of high standards and excellent quality. We know that we already deliver outstanding patient care – this is another positive confirmation. It is endorsed by the Royal College of Surgeons, which is another marker of its value and importance.

We will now hold this accreditation for the next three years, at which point we will be re-assessed to check that we are still meeting standards.

In addition to confirmation of the accreditation the Trust will continue to be supported by the GIRFT team. A hub optimisation plan template has been received with areas where further opportunity was identified. The 5 recommendations include:

- Domain 1: - Patient Pathway – A plan and review of clinical pathways that will support the Trust ambition to increase day case rates.
- Domain 1: - Patient Pathway - Review the use of hip precautions to ensure that good practice clinical pathways are embedded as standard.
- Domain 4: - Utilisation and Productivity – Root Cause Analysis of cancellations to identify themes and share findings with the GIRFT team.
- Domain 4: - Utilisation and Productivity - Develop a plan for implementing early screening, risk assessment and optimisation programmes to maximise productivity through the reduction of cancellations.
- Domain 4: - Utilisation and Productivity - Develop a process to ensure that standby patients are identified and ready to fill cancelled places on theatre lists.

It is worth noting that these recommendations are already part of continuous improvement programmes of work within the Trust. The Trust will continue to progress these recommendations with the support from the GIRFT team.

GIRFT Elective Surgical Hub Accreditation: - Adults and Paediatrics

Summary and Next Steps

The Trust is proud to have achieved accreditation as an Elective Surgical Hub for both adults and paediatrics. The Trust is part of the first cohort to go through this process for paediatrics and achieve the accreditation. Next steps the Trust will be taking include but not limited to:

- Celebration of the achievement of the accreditation as an Elective Surgical Hub for both adults and paediatrics.
- Follow-up meetings with the GIRFT team. This is to include development of the Hub Optimisation Plan (HOP) aligned to GIRFT recommendations. An initial action plan using the HOP template to be completed by 2nd February 2024
- Opportunity for staff to be a part of future GIRFT accreditation reviews at other providers as a "visiting assessor". Operational and clinical colleagues have already expressed interest.
- Opportunity for growth and to support other providers following affirmation of the high standards of clinical care being achieved.
- Continued working relationships with the GIRFT team. The GIRFT team will continue to offer support where required.

Overall, the accreditation process has been a cathartic experience; it has recognised the high standards we are achieving during the current pressures seen within the NHS. There is evidence across the domains of the continuous improvement approaches within our organisation. It has brought together and flagged the results and achievements we should be very proud of.

Trust Board is asked to note that the Trust has successfully been accredited as an Elective Surgical Hub for both adults and paediatrics. This will be celebrated and further communicated externally during January 2024.

Trust Board - Performance
November 2023 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

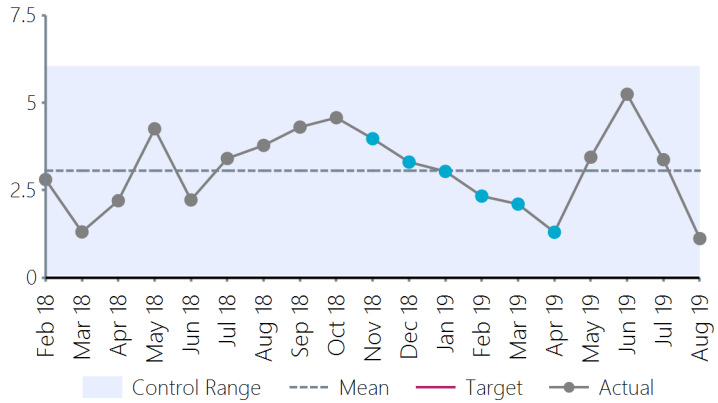
Some examples of these are shown in the images to the right:

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

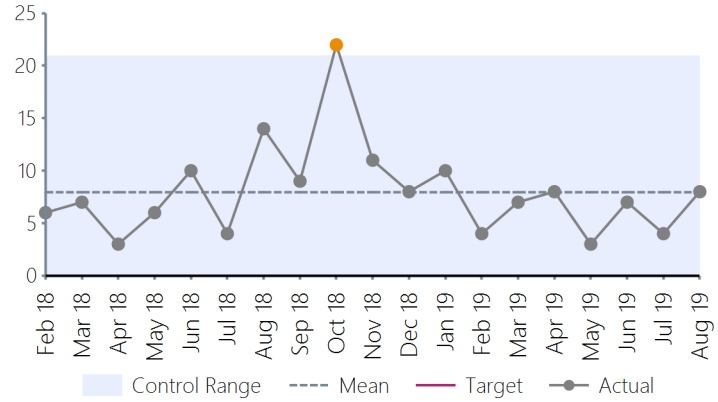
b) shows a point of concern sitting above the control range.

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

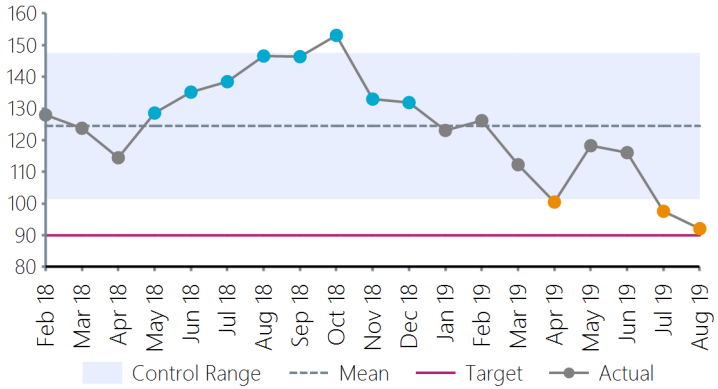
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%			P		
62 Day General Standard*	85.00%	60.00%			?	+	
28 Day Faster Diagnosis Standard*	75.00%	92.68%			?		12/09/23
18 Weeks RTT Open Pathways	92.00%	48.43%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,193	1,091	L	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,058			No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	10	0	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		253			No Target	+	
Patients Waiting Over 104 Weeks - English	0	0		L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		66			No Target	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Overdue Follow Up Backlog	5,000	10,522				+	
6 Week Wait for Diagnostics - English Patients	85.00%	77.80%				+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	86.18%				+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,182	1,106			Moving Target	+	24/06/21
Overall BADS %	85.00%	84.29%				+	
Total Outpatient Activity against Plan (volumes)	17,045	13,642			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	5.00%	4.37%			Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,545	2,685			Moving Target		

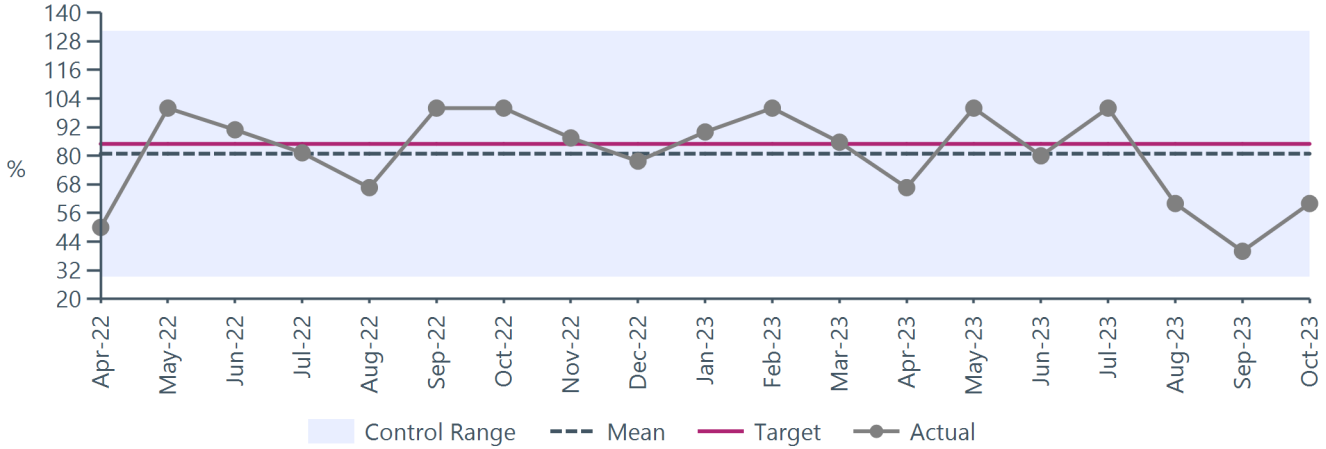
62 Day General Standard*

From receipt of an urgent GP referral for urgent suspected cancer, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer 217831

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	60.00%		

Trajectory



What these graphs are telling us

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

Narrative

The Cancer 62 Day General Standard was not met in October; this measure is reported in arrears. The October performance is reported at 60% against the 85% target. A breakdown of the October performance is:
* 3 shared pathways all within target
* 1 x shared pathway that breached due to the complexity of the pathway that required multiple diagnostics
* 1 x breach shared pathway that has been allocated to RJAH in error - another Provider has selected the wrong site code so this has been raised with the national help desk

Actions

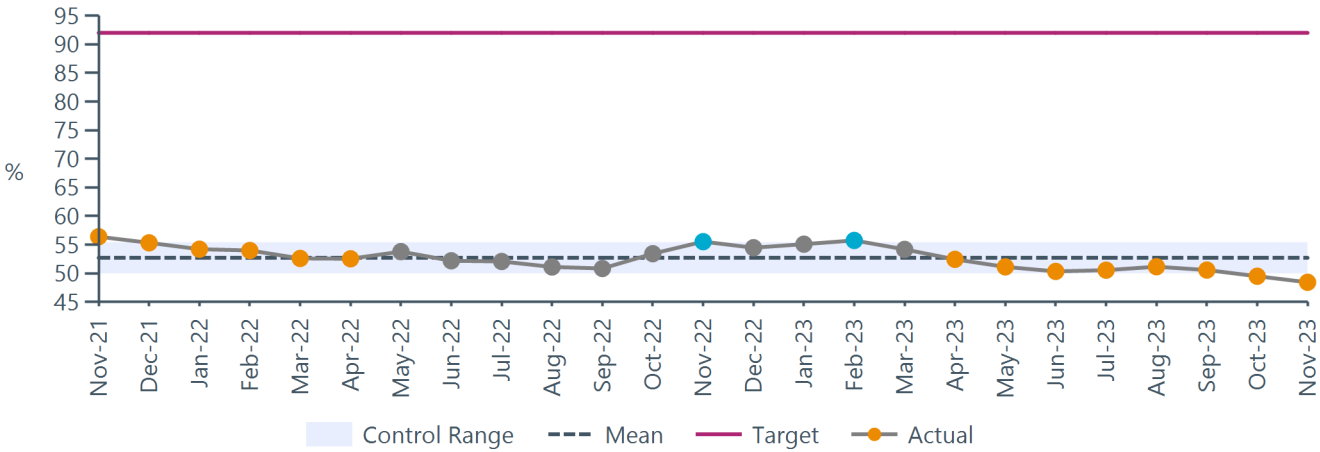
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
87.50%	77.78%	90.00%	100.00%	85.71%	66.67%	100.00%	80.00%	100.00%	60.00%	40.00%	60.00%	

18 Weeks RTT Open Pathways

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	48.43%	L	F



Trajectory

What these graphs are telling us

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

Narrative

Our November performance was 48.43% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows:
* MS1 – 8094 patients waiting of which 2871 are breaches
* MS2 - 1454 patients waiting of which 967 are breaches
* MS3 - 5524 patients waiting of which 3934 are breaches

Following the system transition to MUSST service, we expect to see a 4% negative impact on this measure.

2023/24 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025
The Trust continues to address patients who continue to wait greater than 78 weeks with a route to zero planned by end of quarter one.

Actions

Planning assumptions for 2023/24 include increases in capacity throughout the year aligned to productivity, workforce and estates programmes of work. Transformation, alongside increases in capacity, will continue to be assessed against the impact to overall list size. Planning for 2024/25 has begun, this includes demand and capacity assessments of our services. The Trust will also be taking actions during 2023/24 to assess waiting lists alongside health inequalities assessments.

The Trust has been focusing on treatment of its longest waits. Agreements made for mutual aid support continue to be reviewed. A continuous validation programme is in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. The Trust has put in place a digital solution to support with validation; expected to go in live in December. For patient initiated digital mutual aid, external deadlines have been met and patients have been contacted where applicable.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods.

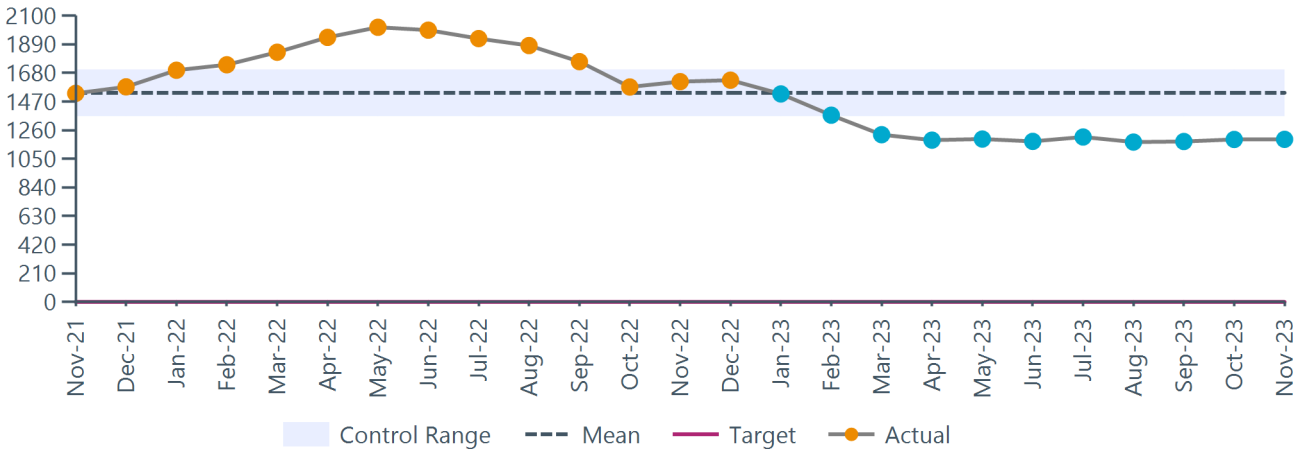
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
55.53%	54.47%	55.09%	55.74%	54.18%	52.44%	51.12%	50.33%	50.55%	51.15%	50.57%	49.49%	48.43%

Patients Waiting Over 52 Weeks – English

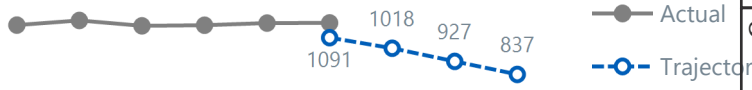
Number of English RTT patients waiting 52 weeks or more at month end 211139

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,193	L	F



Trajectory



What these graphs are telling us

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

Narrative

At the end of November there were 1193 English patients waiting over 52 weeks; above our trajectory figure of 1091 by 102. The patients are under the care of these sub-specialities; Arthroplasty (516), Spinal Disorders (174), Upper Limb (169), Knee & Sports Injuries (163), Foot & Ankle (135), Paediatric Orthopaedics (11), Metabolic Medicine (8), Tumour (5), Neurology (4), ORLAU (3), SOOS GPSI (2), Paediatric Medicine (1), Spinal Injuries (1) and Physiotherapy (1).
Patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 1183 patients
* >78 to <=95 weeks - 9 patients
* >95 to <=104 weeks - 1 patient

Actions

The national planning requirements for 2023/24 stipulate that Trusts should eliminate waits of over 65 weeks for elective care, by March-24 (except where patients choose to wait longer or in specific specialties). To support achievement of this the Trust has ensured all patients, where possible, are waiting for a 1st Outpatient appointment have been dated before the end of December-2023. The Trust has revised its submitted plan to NHSE that originally forecast zero 65+ weeks waits by March-24; the revised plan now reflects known capacity issues expected in quarter four.

A continuous validation programme is in place whilst patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. The Trust has put in place a digital solution to support with validation that went live in early December. For patient initiated digital mutual aid, external deadlines have been met and patients have been contacted where applicable.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
1616	1627	1526	1370	1227	1187	1195	1178	1210	1173	1177	1192	1193

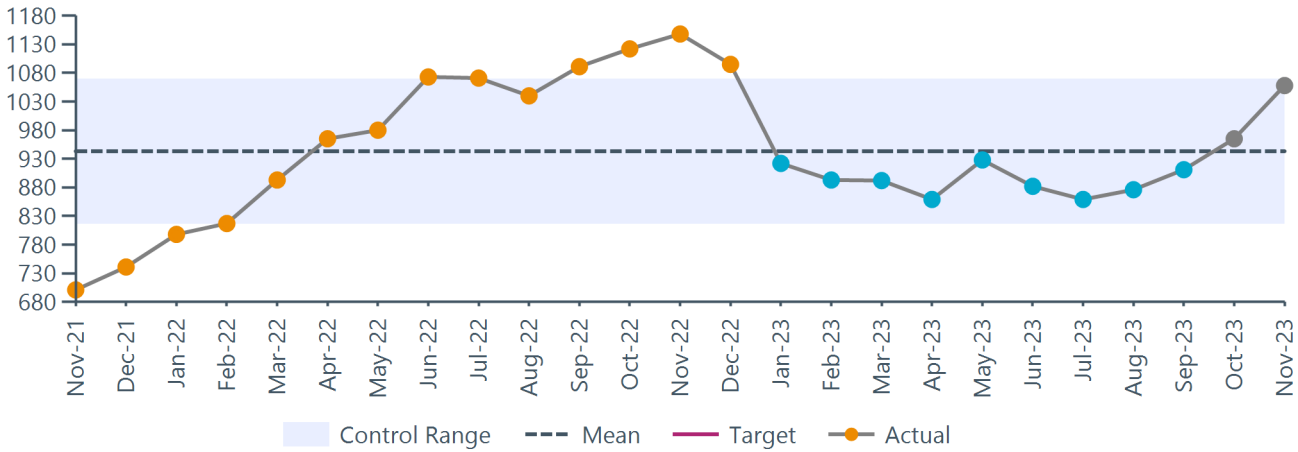
Patients Waiting Over 52 Weeks - Welsh (Total)

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	1,058		No Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of November there were 1058 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (445), Arthroplasty (236), Knee & Sports Injuries (162), Upper Limb (100), Foot & Ankle (76), Veterans (19), Paediatric Orthopaedics (12), Metabolic Medicine (3),Tumour (2), Physiotherapy (2), Neurology (1).

Patients are under the care of the following commissioners: BCU (575), Powys (454), Hywel Dda (25), Aneurin Bevan (2), Cwm Taf (1) and Abertawe Bro Morgannwg (1). The number of patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 805 patients
* >78 to <=95 weeks - 153 patients
* >95 to <=104 weeks - 34 patients
* >104 weeks - 66 patients

Actions

The Welsh guidance differs from NHS England guidance. The Trust continues to monitor equity across our commissioners whilst recognising guidance and differences in pathway monitoring. The Trust has now received confirmation (w/c 16th October) from BCU & Powys that RJAH can utilise mutual aid for their patients. Mutual aid discussions progressing with commissioners; further discussions re pathway requirements are taking place.

A continuous validation programme is in place whilst patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. The Trust has put in place a digital solution to support with validation that went live in early December.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods.

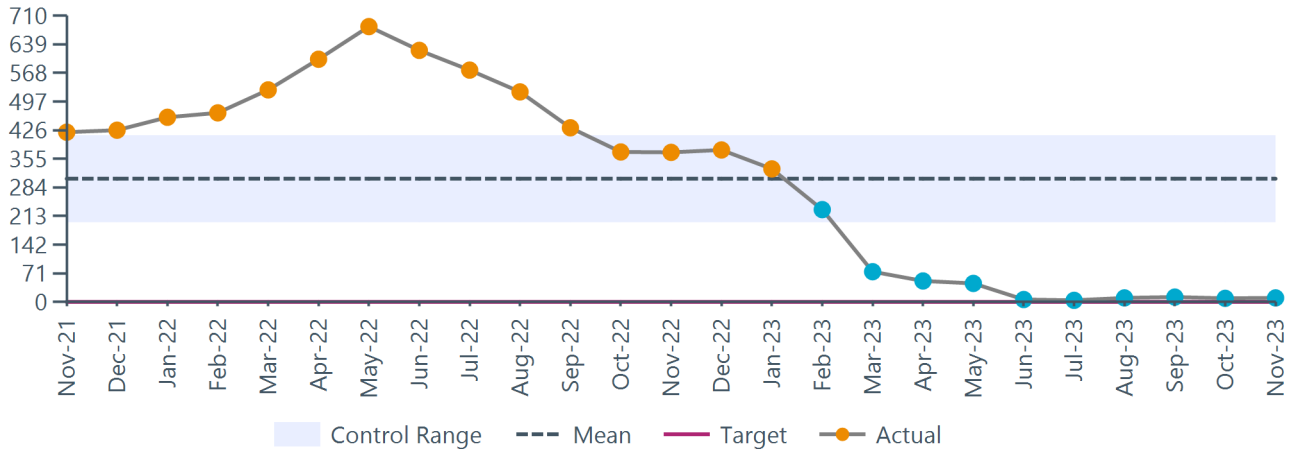
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
1148	1095	922	893	892	859	928	882	859	876	911	965	1058

Patients Waiting Over 78 Weeks - English

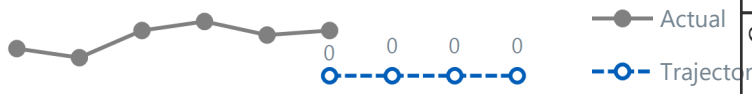
Number of English RTT patients waiting 78 weeks or more at month end 217774

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	10	L	F



Trajectory



What these graphs are telling us

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

Narrative

At the end of November there were 10 English patients waiting over 78 weeks; above our trajectory of 0. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Arthroplasty (3), Spinal Disorders (3), Upper Limb (2) and Foot & Ankle (2).

32 patients declined the offer of mutual aid leading to non-admitted clock stops.

2023/24 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025 .
Discussions continue with our Welsh Commissioners to ensure we are aligned to their ambitions too.
The Trust continues to address patients who continue to wait greater than 78 weeks with a route to zero planned by end of quarter one.

Actions

The Trust is now reporting against this standard by exception with the Trust making significant improvements against this standard in quarter one. In line with national planning expectations the Trust aims to further reduce long waits to less than 65 weeks by March-24. Forecasts are being revisited to assess the achievability of this.

A mutual aid co-ordinator and validation resource are in place. The Trust has put in place a digital solution to support with validation that went live in early December. For patient initiated digital mutual aid, external deadlines have been met and patients have been contacted where applicable.

Internal Operational meeting are in place to further monitor progress.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible during the periods.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
371	377	330	229	75	52	46	6	4	10	12	9	10

Patients Waiting Over 78 Weeks - Welsh (Total)

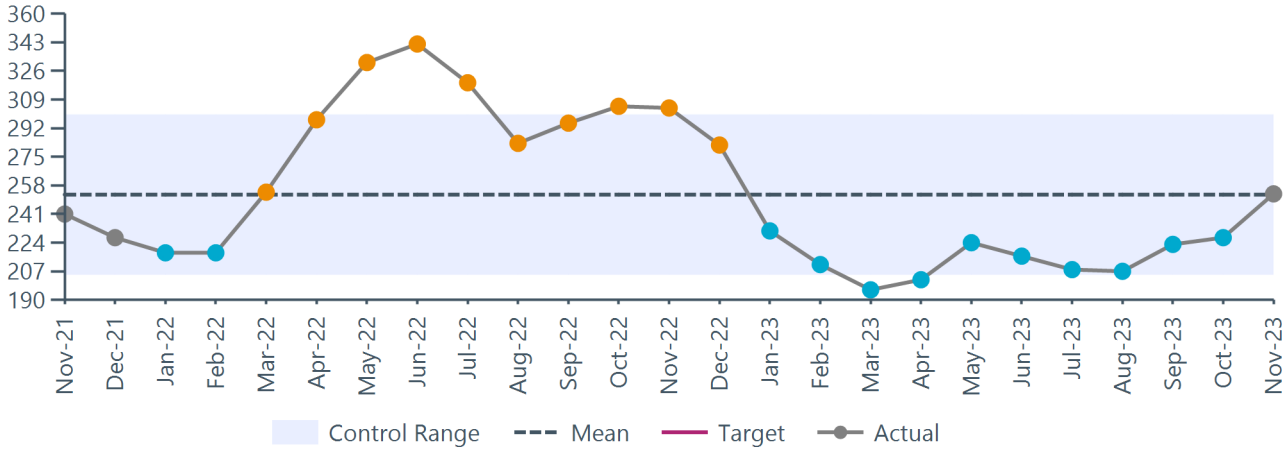
Number of Welsh RTT patients waiting 78 weeks or more at month end 217802

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	253		No Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of November there were 253 Welsh patients waiting over 78 weeks.

The patients are under the following sub-specialties; Spinal Disorders (121), Knee & Sports Injuries (59), Arthroplasty (35), Foot & Ankle (18), Upper Limb (14), Veterans (3), Metabolic Medicine (1), Neurology (1) and Paediatric Orthopaedics (1).

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients. The Trust continues to treat Welsh patients alongside English patients, balancing both long waits and clinical urgency. The Trust has now received confirmation (w/c 16th October) from BCU & Powys that RJAH can utilise mutual aid for their patients. Mutual aid discussions progressing with commissioners; further discussions re pathway requirements are taking place.

The Trust has put in place a digital solution to support with validation that went live in early December.

Internal pooling is underway to further support progressing our longest waits.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
304	282	231	211	196	202	224	216	208	207	223	227	253

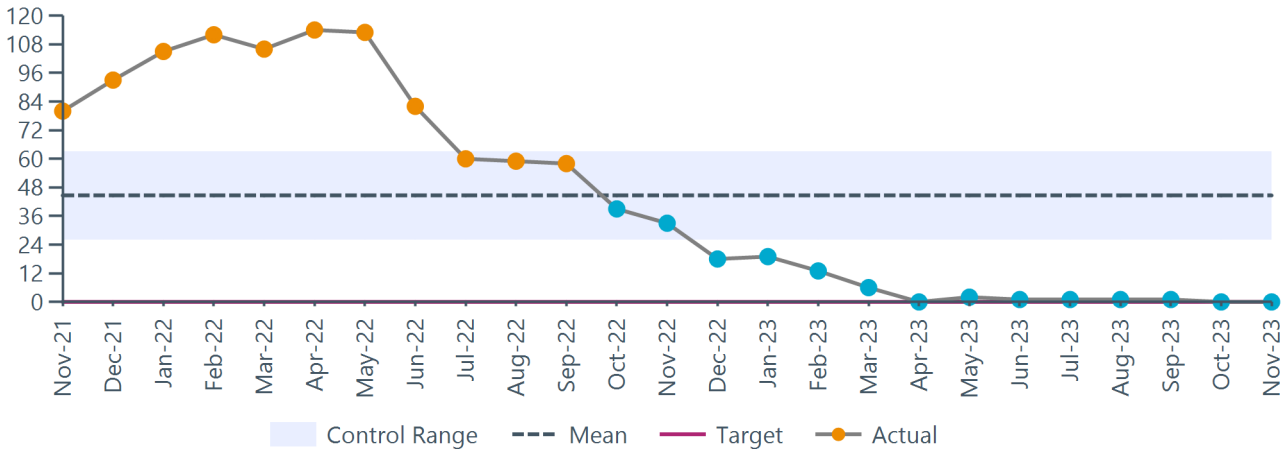
Patients Waiting Over 104 Weeks - English

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	0	L	F

Trajectory



What these graphs are telling us

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

Narrative

At the end of November there were 0 (zero) English patients waiting over 104 weeks.

The Trust is forecasting 0 breaches for the end of December.

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
33	18	19	13	6	0	2	1	1	1	1	0	0

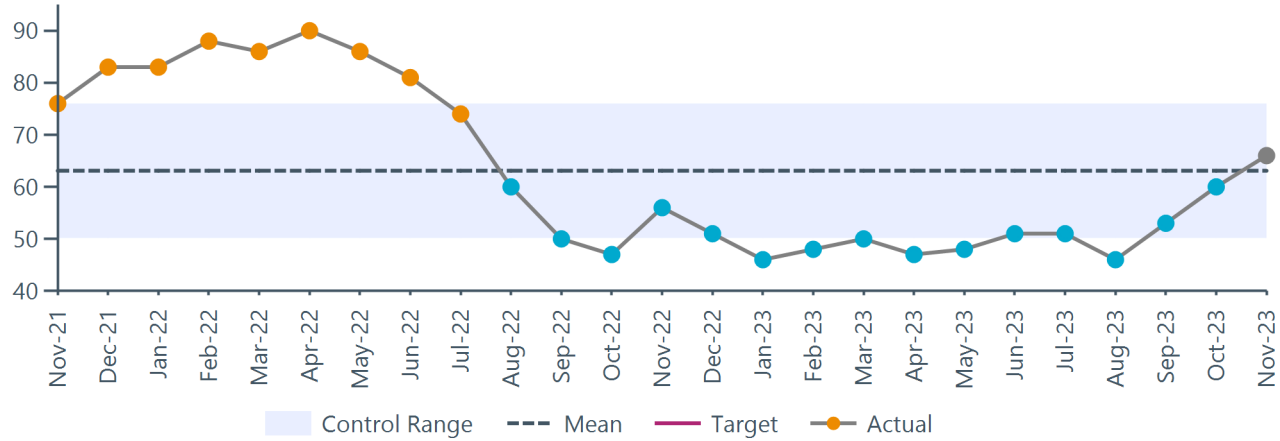
Patients Waiting Over 104 Weeks - Welsh (Total)

Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	66		No Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of November there were 66 Welsh patients waiting over 104 weeks.

The patients are under the care of the following subspecialties:
* Spinal Disorders (58)
* Knee & Sports Injuries (5)
* Foot & Ankle (1)
* Metabolic Medicine (1)
* Neurology (1)

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward. The majority of breaches are now attributable to our most challenged sub-specialty. The Trust has now received confirmation (w/c 16th October) from BCU & Powys that RJAH can utilise mutual aid for their patients. Mutual aid discussions progressing with commissioners; further discussions re pathway requirements are taking place.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
56	51	46	48	50	47	48	51	51	46	53	60	66

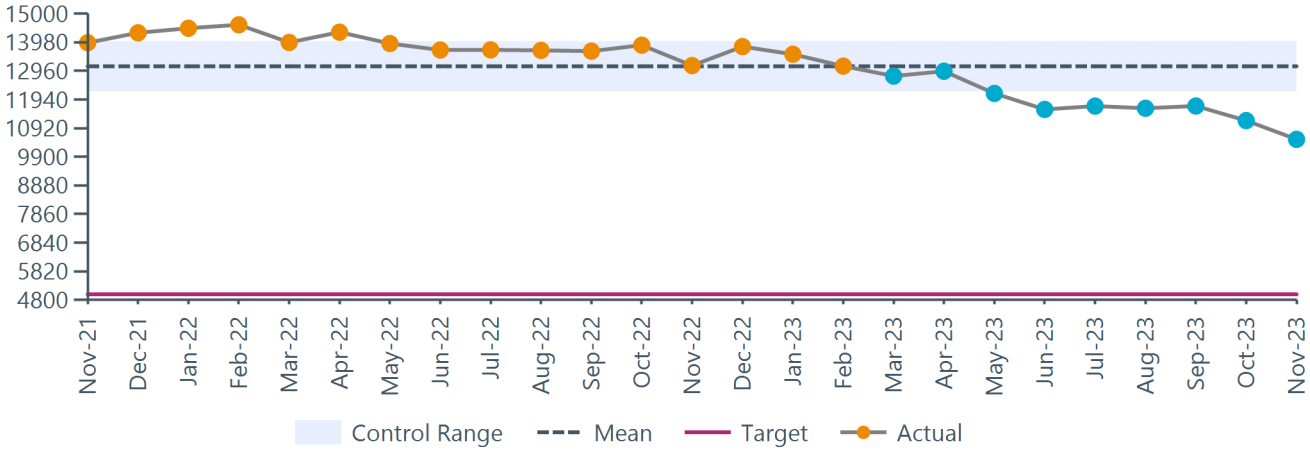
Overdue Follow Up Backlog

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	10,522	L	F

Trajectory



What these graphs are telling us

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

Narrative

At the end of November, there were 10522 patients overdue their follow up appointment. This is broken down by:

- Priority 1 - 6765 with 1064 dated (15%) (priority 1 is our more overdue follow-up cohort)
- Priority 2 - 3757 with 1123 dated (27%);

* The backlog decreased by 668 from last month, of which, 302 are Rheumatology. The priority 1 backlog reduced by 25.
* Of the 10522 patients overdue, 36% are diagnostic follow ups.
* Of all the patients on a non diagnostic follow up, 18% are overdue.
* Of all the patients on a diagnostic follow up, 55% are overdue.
* The sub-specialities with the highest proportion of overdue follow ups are: Spinal Injuries - 52%; Neurology - 52%; Muscle - 43%; (% of their total follow up waiting list which are overdue)
* The main focus within the Trust has been on long waiters, with a specific focus on the NHSE ask to meet the 65 week milestone 1 target.

Actions

Meeting to be held with the clinical leads/clinical chairs to review how we urgently reduce the overdue follow up backlog.
* Review of current processes for technical validation has started.
* Further validation of diagnostic follow ups is required.
* Clinical meetings are planned in December to look at further opportunities.
* Assessment of utilising PIFU pathways.
* Planning expectations for 2022/23 were to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023, however, our plans do not meet this aspiration. One of the factors to non-achievement is recognition that the Trust continues to address its overdue follow-up backlog.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
13151	13828	13554	13132	12777	12949	12158	11589	11707	11630	11710	11190	10522

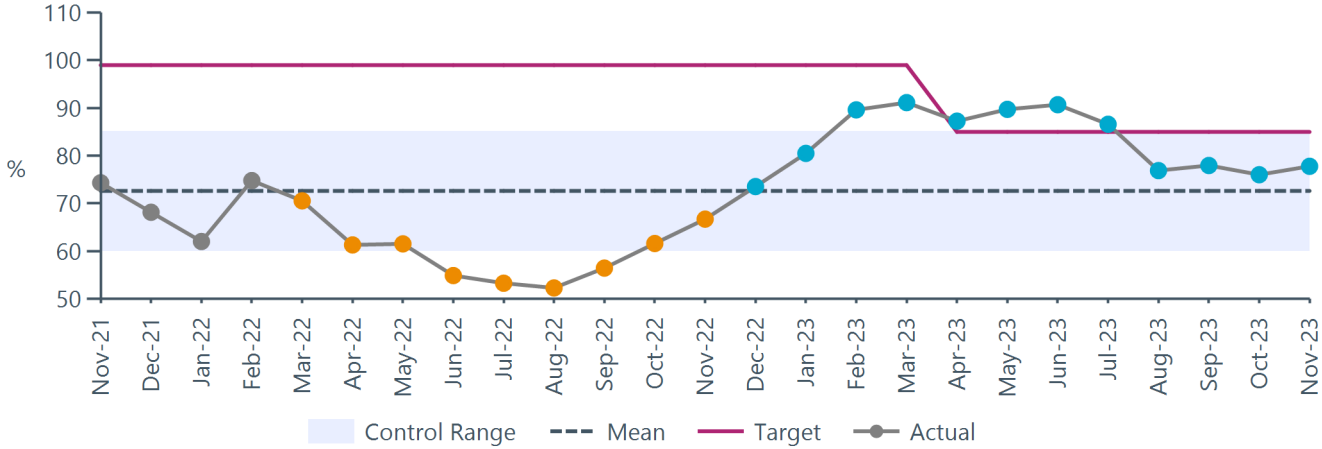
6 Week Wait for Diagnostics - English Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	77.80%	H	Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Due to target change, this shows as a moving target.

Narrative

The November position is reported at 77.80%; below the 85% target. Reported performance equates to 206 patients who waited beyond 6 weeks. Of the 6-week breaches; 58 are over 13 weeks (Ultrasound). Breakdown below outlines performance and breaches by modality:

* MRI – 99.36% - D4 (Routine - 6-12 weeks) - 2 dated
* CT – 100%
* Ultrasound – 60.99% - D2 (Urgent - 0-2 weeks) - 1 dated, D3 (Routine - 4-6 weeks) – 2 with 1 undated, D4 (Routine - 6-12 weeks) - 201 with 63 dated
* DEXA Scans - 100%

Although there is only a slight increase in performance since last month, there has been both a reduction in the number of patients waiting over 6 and 13 weeks and in the waiting list. In order to support the percentage of patients receiving a diagnostic test within 6 weeks, NHSE are increasing focus on >13 weeks. National expectations to have no 13 weeks by end of June 2023 and by March 2024 the ambition is to achieve 85% against the 6-week standard within all modalities. It must be noted that both MRI and CT are already achieving the 6-week standard. The trust continues to treat by clinical priority. Both Ultrasound and MRI activity plans were met in November.

Actions

* Currently training additional people within Radiology to shift validation from monthly to weekly.
* Business case for additional Radiologists to be completed by Clinical Director is still in progress and due to be completed before end of December. Focus is on offsetting OJP and high tariff procedure lists.
* 'Case of Need' for bank/locum Radiologist to run Ultrasound diagnostic all day Saturday lists has been agreed and clinics will start in January '24.
* Additional ultrasound clinics still in place, although there is limited uptake there has been some improvement within ultrasound performance in November.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
66.73%	73.55%	80.51%	89.63%	91.15%	87.27%	89.74%	90.71%	86.61%	76.91%	77.97%	76.04%	77.80%

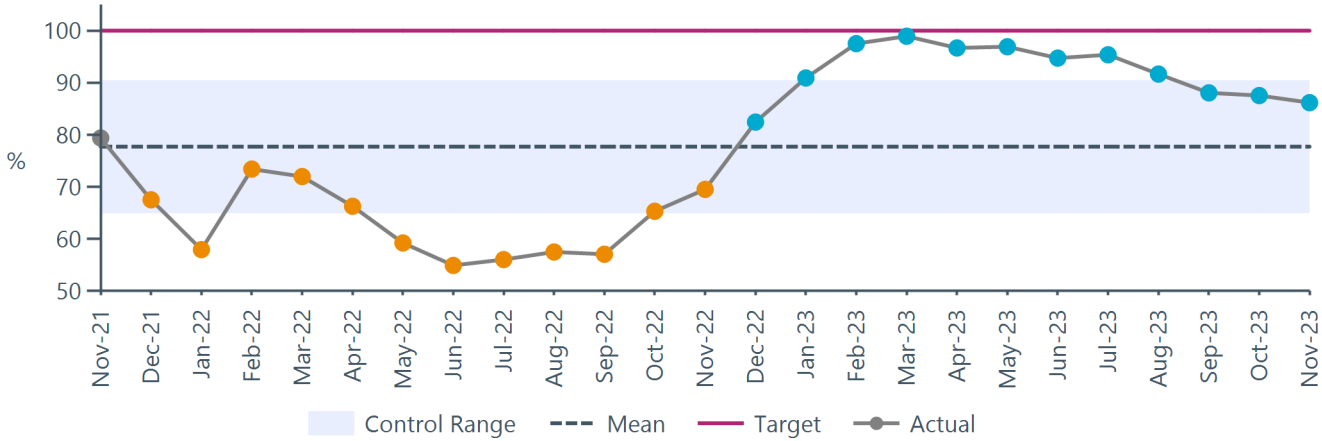
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	86.18%	H	F

Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics was not achieved this month and is reported at 86.18%. Reported performance equates to 34 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
* MRI – 100%
* CT - 100%
* Ultrasound – 68.52% - (D4 (Routine - 6-12 weeks) - 34 with 13 dated
* DEXA Scans - 100%
The trust continues to treat by clinical priority. Both Ultrasound and MRI activity plans were met in November.

Actions

* Currently training additional people within Radiology to shift validation from monthly to weekly.
* Business case for additional Radiologists to be completed by Clinical Director is still in progress and due to be completed before end of December. Focus is on offsetting OJP and high tariff procedure lists.
* 'Case of Need' for bank/locum Radiologist to run Ultrasound diagnostic all day Saturday lists has been agreed and clinics will start in January '24.
* Additional ultrasound clinics still in place, although there is limited uptake there has been some improvement within ultrasound performance in November.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
69.52%	82.44%	90.92%	97.52%	98.94%	96.69%	96.92%	94.74%	95.38%	91.67%	88.06%	87.54%	86.18%

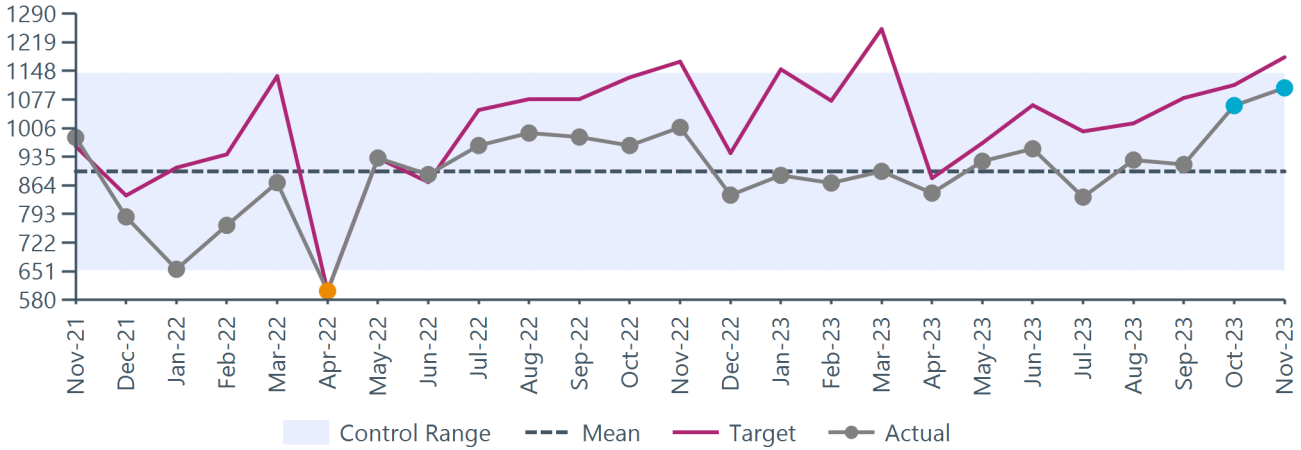
Elective Activity Against Plan (volumes)

Total elective activity rated against plan. 217796

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,182	1,106	H	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Total elective activity reported externally against 2023/24 plan of 1182 in November was 1106, shortfall of 76 (93.57%).
Elective spell activity is broken down as follows:
- Elective patients discharged in reporting month following operation - plan was 1021; 825 delivered (80.80%)
- Elective patients discharged in reporting month, no operation - plan was 161; 281 delivered (174.53%)
Non-theatre activity accounted for 25.41% of elective spells this month; plan was 13.62%.

Although below plan, it is worth noting that November saw the highest level of elective activity delivered in the last two years and is now reporting special cause variation of an improving nature.

Actions

* Greater focus on Theatre Improvement programme:
- commencement of early session starts by a number of consultants
- regular weekly use of Headley Court Day Case facility
- Sunday working
- 5 major joint lists
All initiatives are subject to staffing alignment; additional activity is being taken at the weekly 6-4-2 meeting and utilisation of our theatres is reviewed as part of this process.
* Clear, staggered workforce pipeline for new starters; delivery of personalised local training plans via simulation lab and an element of double scrubbing.
* Workforce Improvements completed to improve recruitment and retention opportunities, report in development.
- The aim to move to 12 theatres is proving challenging at present due to the Theatre workforce not reaching the assumed and forecasted levels to facilitate the increased usage. Where staffing allows 12 theatres are being run however the daily average is 11 in November.
- Focus on maximising capacity in theatres staffed and available, implemented through 6-4-2 and daily CommCel meeting.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
1008	840	889	870	899	845	924	955	835	927	916	1062	1106

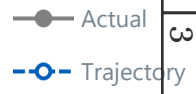
Overall BADS %

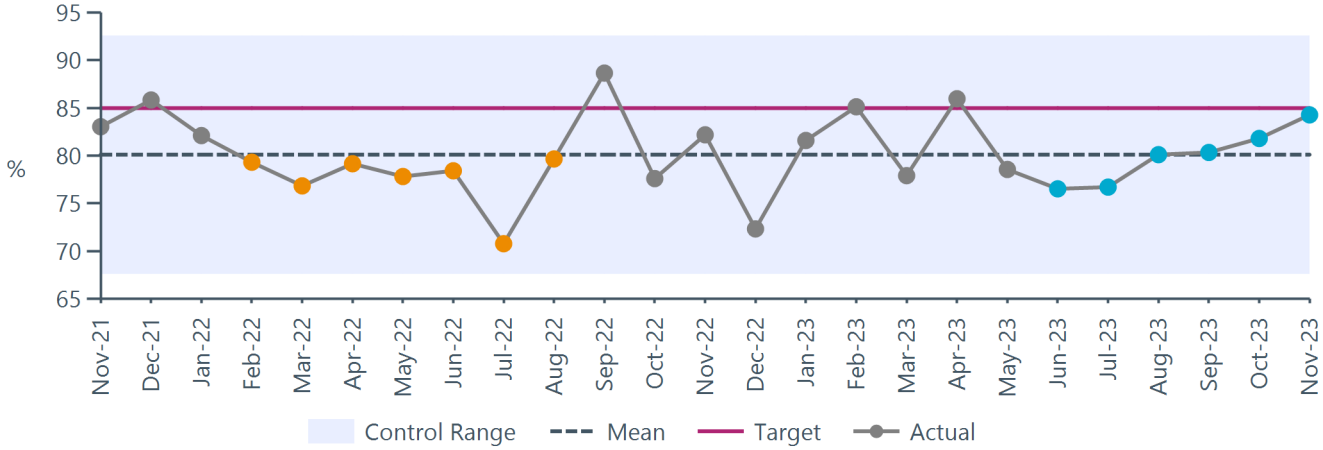
% of BADS procedures performed as a day case 217813

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	84.29%	H	?

Trajectory





What these graphs are telling us

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

Narrative

This measure reflects the overall % Trust performance of day cases against the latest online British Association Of Day Surgery directory of procedures; Orthopaedic and Urology pages.

In November the Trust is reporting 84.29% BADS day cases against a target of 85%. Although below target, this is the sixth consecutive month of improved performance and is above the mean in November.

Actions

Ongoing monitoring of performance via the Day Case Working Group; actions include:
* To improve day surgery success rates (against BADS).
* To extend range of procedures done as day cases.
* To meet process checklist set out in GIFRT day surgery delivery document.
- Theatres Manager to work with Day Case lead to support these ambitions.
* To improve the data quality of Day Case patients by:
- Working with Access Team to improve data quality of bookings and alignment between PAS and Bluespier.
- Working with nursing and admin staff to improve timeliness of patient discharge from PAS.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
82.20%	72.34%	81.61%	85.14%	77.92%	85.98%	78.57%	76.54%	76.72%	80.12%	80.35%	81.82%	84.29%

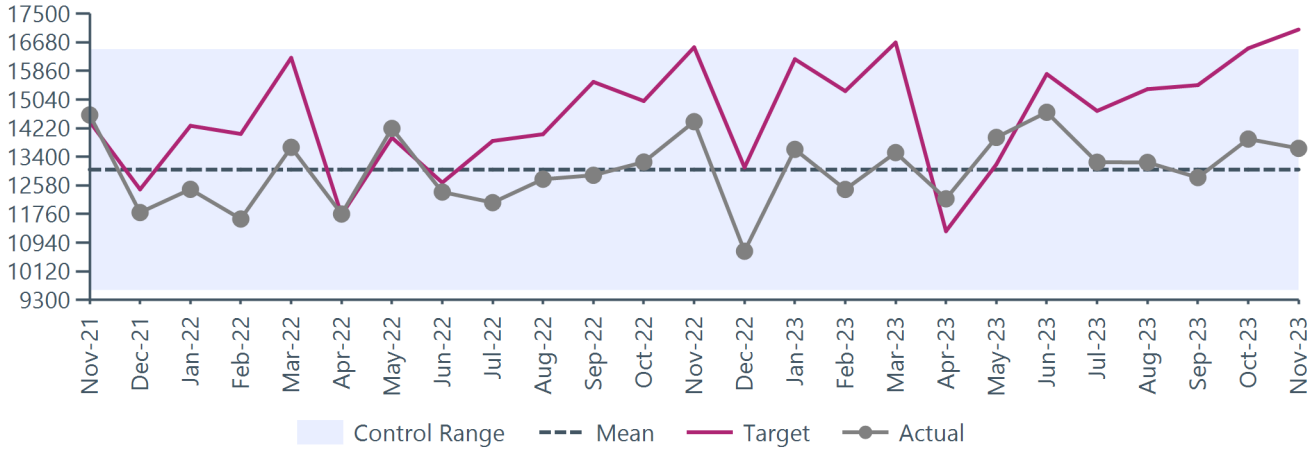
Total Outpatient Activity against Plan (volumes)

Total outpatient activity (consultant led and non-consultant led) against plan. 217795

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
17,045	13,642		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Total outpatient activity undertaken in November was 13642 against the 2023/24 plan of 17045; a shortfall of 3403 that equates to 80.04% of plan. This is broken down as; New Appointments – 3851 against 5123 - equating to 75.17% and Follow Up Appointments - 9791 against 11922 - equating to 82.13%
Factors affecting delivery:
- Reduction in SOOS activity on our PAS system as a result of the growth of the MUSST service (SOOS was 1503 behind plan). This has also impacted the level of Therapies activity with 851 behind in November.
- In 2023/24, a step change can be seen in the OJP plan as the plan significantly increased. Our OJP actual activity is within normal variation and not meeting this step change.
The following sub-specialities then reported the highest variance to plan:
* Arthroplasty – 1482 against 2095 - 613 behind plan; 90.79% of IJP plan met, 41.20% of OJP plan met
* Upper Limb – 916 against 1457 - 541 behind plan; 83.55% of IJP plan met, 32.83% of OJP plan met
Year to date performance is under plan by 11610 cases (90.27% of plan). The activity numbers are always taken on 5th working day to allow 4 working days for administrative transactions.

Actions

Outpatient Improvement Group meets fortnightly to discuss performance and actions in relation to Overdue Follow Ups, DNAs, PIFU & Virtual KPI's.
* Three other groups are in their infancy but will support with key areas of improvement, which are: Therapies Improvement Group, Radiology Improvement Group and Rheumatology Improvement Group
* All four of the above groups then feed into an Oversight group that meets monthly.
* Requirement to revisit plans at sub-speciality level.
* Plans being reviewed for 23/24 and 24/25.
* The impact of MUSST service is under assessment with areas identified that impact plan. A separate presentation has detailed this for F&P Committee.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
14407	10696	13613	12466	13521	12197	13956	14676	13244	13240	12805	13909	13642

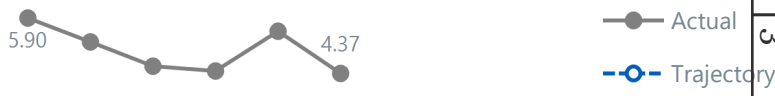
Total Outpatient Activity - % Moved to PIFU Pathway

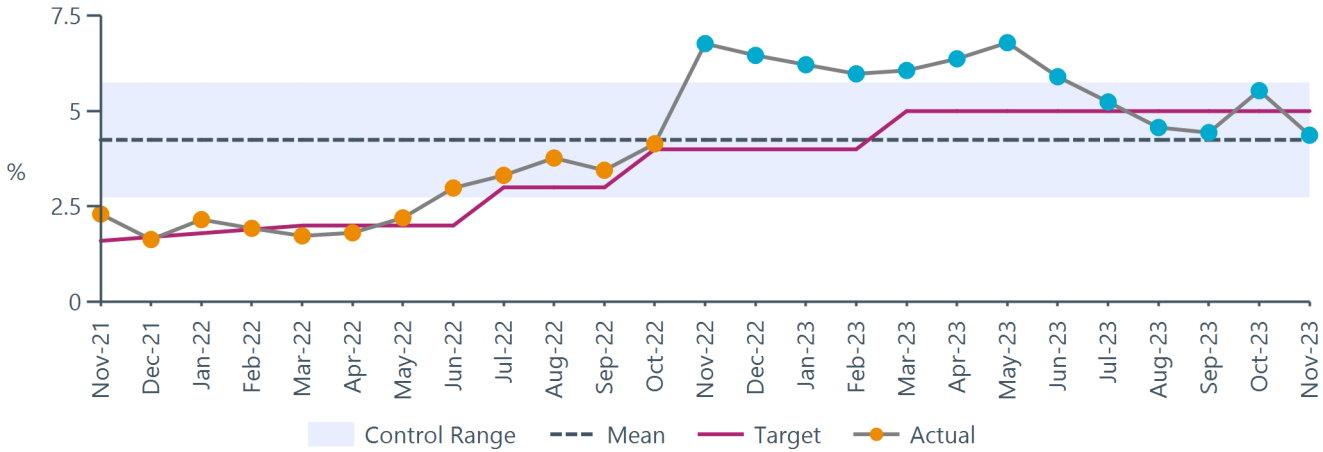
Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan 217715

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5.00%	4.37%	H	Moving Target

Trajectory





What these graphs are telling us

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

Narrative

The target for the number of episodes moved to a PIFU Pathway is 5% of all outpatients attendances. In November the target was not met with 4.37% of total outpatient activity moved to a PIFU pathway. This is primarily due to the reduction of SOOS activity being recorded on our PAS system due to the growth of the MSST service. If we exclude SOOS from the numerator and denominator then in November our performance stands at 4.35%.

The following Sub - Specialties achieved the highest % moved to PIFU rates in November:
* Upper Limb (15.14%)
* Spinal Disorders (9.13%)
* Knee & Sports Injuries (9.01%)

Actions

* System action - working with STW MSK with the transition of the MSST service from SOOS
* Review of PIFU utilisation by sub-specialties to be undertaken with focus on different working practices within firms
* Exploring new variation of PIFU called 'Continuous PIFU' which will apply to our lifelong patients. This has the potential to boost numbers in certain sub-specialties.
* Focus on working practices and process being reviewed within Rheumatology by Operational Manager and Access

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
6.77%	6.46%	6.21%	5.98%	6.06%	6.37%	6.79%	5.90%	5.24%	4.57%	4.44%	5.54%	4.37%

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

RJAH Long Waiters - 2023/24

Trust Board

10th January 2024

Aspiring to deliver world class patient care

2023/24 November and December** Performance

		Plan	Actual	Difference
November	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	66	
	English 78+ Weeks	0	10	10
	Welsh 78+ Weeks	-	253	
	English 65+ Weeks	365	318	-47
	Welsh 65+ Weeks	-	493	

		Plan*	Forecast	Difference
December**	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	71	
	English 78+ Weeks	0	10	10
	Welsh 78+ Weeks	-	242	
	English 65+ Weeks	378	356	-22
	Welsh 65+ Weeks	-	516	

** Revised H2 Plan*

*** Unvalidated Snapshot*.

NHS England Updates:

Patient choice: - NHSE Interim guidance - NHSE Active Monitoring RTT rule changes being made to patients declining mutual aid and 2 x TCI dates. Impacts English ONLY

System mutual aid: - Patients transferred from SaTH to RJAH during 2022/23. Ongoing assessments during 2023/24. Support for 72 x Shropshire Community pathways being transferred to RJAH during December 2023.

2023/24 – FOCUS TO MOVE TO 0 X 65+ WEEKS BY MARCH 2024

NHS Wales Updates:

Mutual aid being progressed following recent agreements

2023/24: - NHSE 65+ weeks Submitted Plans: - These are currently being further revised.

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Original Trajectory	365	321	303	196	0
Revised Trajectory	379	378	518	503	457

Trust Board - Finance
November 2023 – Month 8

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

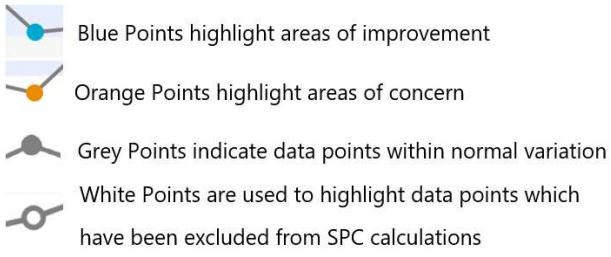
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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



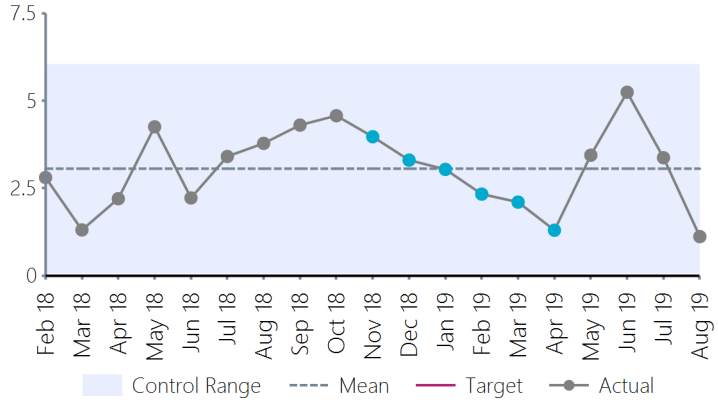
Some examples of these are shown in the images to the right:

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

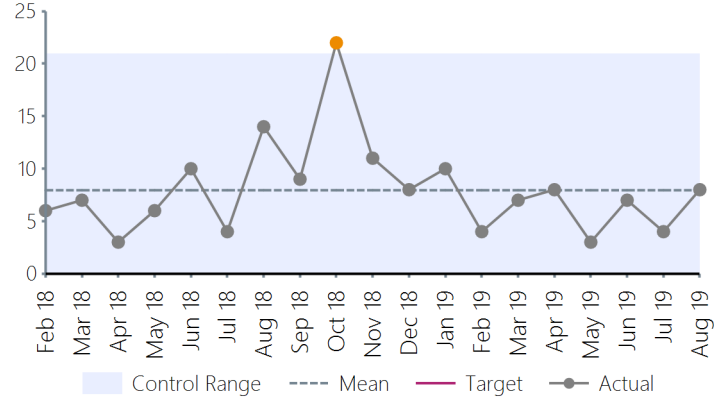
b) shows a point of concern sitting above the control range.

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

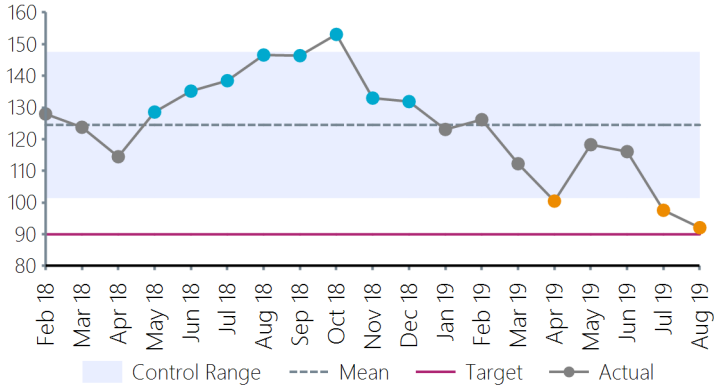
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

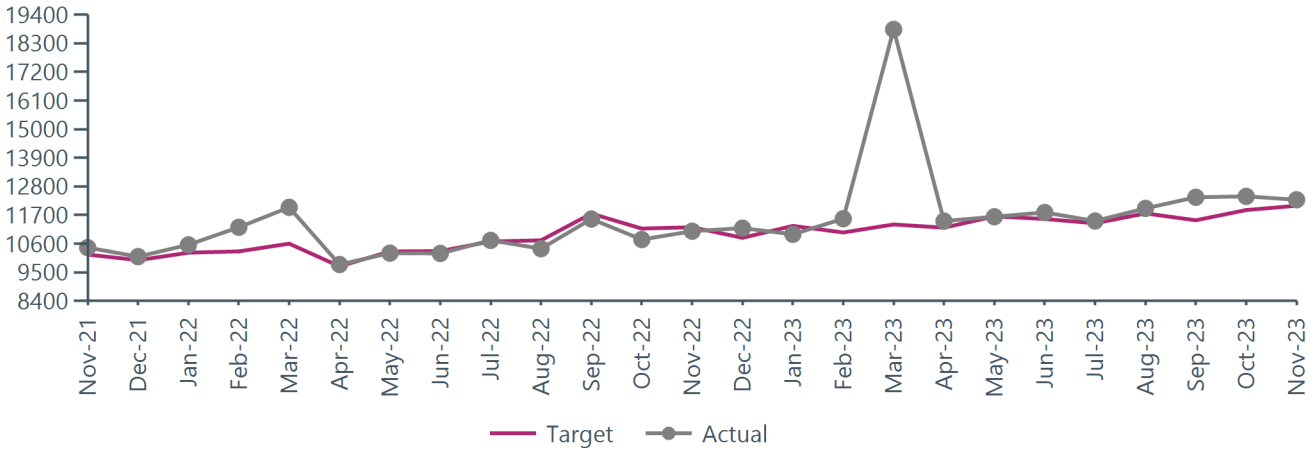
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	795	1,033	459	N/A to SPC	Moving Target		
Income	12,851.80	12,767	12,427	N/A to SPC	Moving Target		
Expenditure	12,056.56	12,289	12,037	N/A to SPC	Moving Target	+	
Efficiency Delivered	456	403	456	N/A to SPC	Moving Target	+	
Cash Balance	21,714	23,915			Moving Target		
Capital Expenditure	977	2,908		N/A to SPC	Moving Target		
Value Weighted Assessment	108.39%	100.76%		N/A to SPC	Moving Target	+	

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
12,056.56	12,289.00	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Expenditure favourable to plan £35k excluding pass through.

Material pressures in month:
- MCSI wards £140k adverse (agency & super numerary staffing)
- Theatres underlying casemix pressure on consumables and implants £76k adverse
- MSK wards £63k adverse (bank & agency)
- Theatres staffing £57k (agency driven and 10 wte supernumerary staff £32k)
- Sheldon ward £35k adverse (bank & agency)

Partially offset by vacancies and non recurrent balance sheet support (including annual leave accrual).

Finance costs £89k favourable (interest receivable)

Actions

Oversight of cost pressures, drivers and actions to mitigate by Financial Recovery Group .

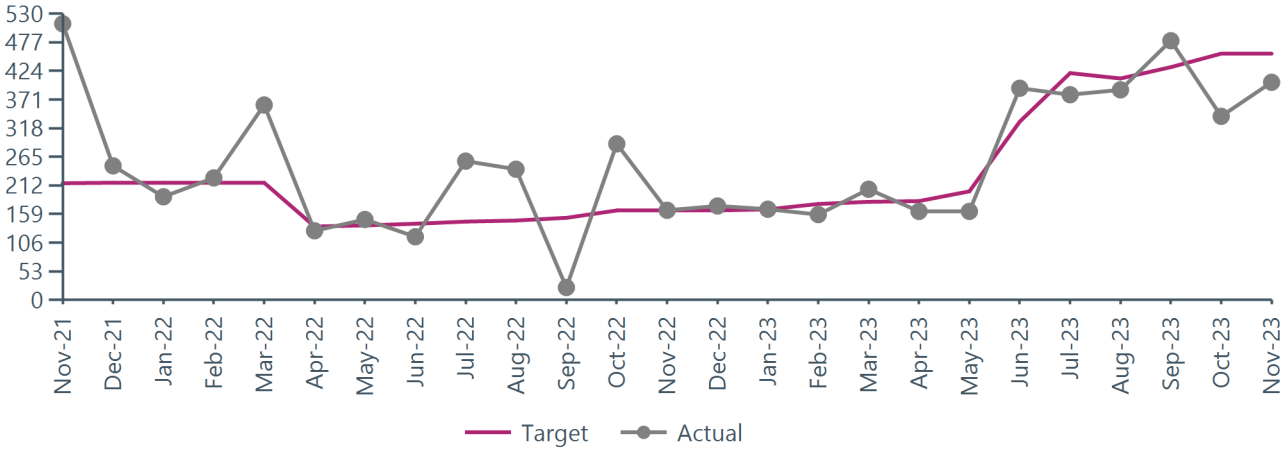
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
11080	11197	10960	11558	18833	11469	11635	11800	11472	11957	12384	12418	12289

Efficiency Delivered

Efficiency requirements 215298

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
456	403	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

£2,712k efficiency savings delivered against plan of £2,887k - 57% of annual plan delivered YTD.

Actions

- Units reviewing mitigating efficiency schemes
- Trust wide overview and opportunities through TPOIB
- Deep dive of Efficiency schemes undertaken by Finance & Performance Committee.

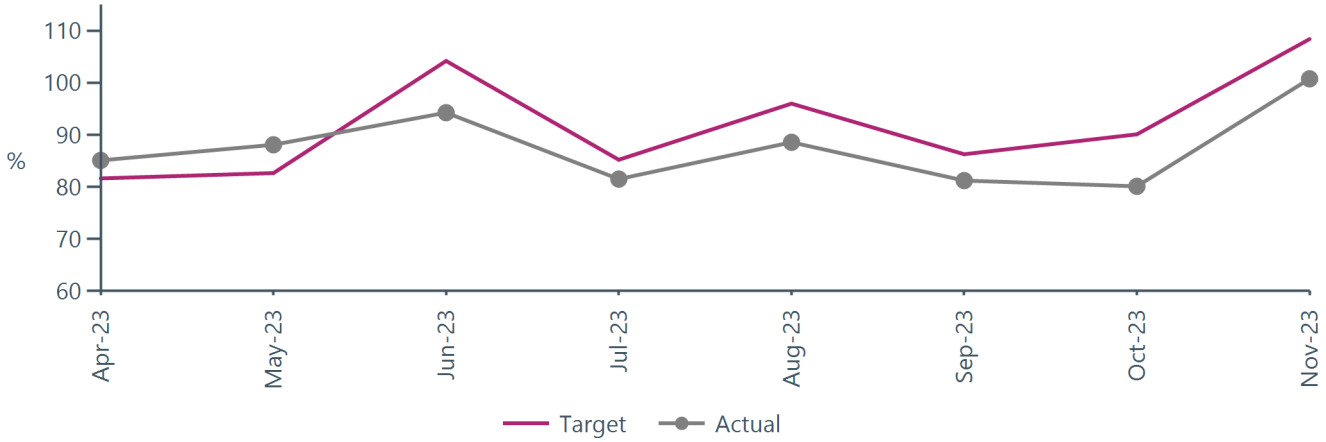
Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
166	174	168	158	205	164	164	392	380	389	480	340	403

Value Weighted Assessment

Relative value in pounds (£) of patient activity from the 2019/20 baseline to the 2023/24 actual delivery (English only) 217818

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
108.39%	100.76%	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Adverse to plan ytd driven by industrial action activity losses and underlying shortfalls in activity for theatres and outpatients due to workforce constraints.

Actions

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
					85.08%	88.08%	94.25%	81.49%	88.56%	81.20%	80.10%	100.76%

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

M8 Financial Position Update

Aspiring to deliver world class patient care

I&E Position

Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			23/24 YTD Position		
		Plan	Pass through Adj Actual	Variance	Plan	Pass through Adj Actual	Variance
Clinical Income	128,966	11,623	10,692	(33)	83,649	80,112	(3,537)
Private Patient income	6,354	620	694	74	4,282	4,740	458
Other income	7,302	609	683	74	4,865	4,965	100
Pay	(87,125)	(7,301)	(7,203)	98	(57,590)	(57,855)	(265)
Non-pay	(48,801)	(4,213)	(4,276)	(63)	(31,122)	(31,586)	(464)
EBITDA	6,696	1,338	1,488	150	4,084	376	(3,708)
Finance Costs	(7,341)	(612)	(523)	89	(4,851)	(4,226)	625
Capital Donations	150	0	0	0	100	73	(27)
Operational Surplus	(495)	726	965	239	(667)	(3,777)	(3,110)
Remove Capital Donations	(150)	0	0	0	(100)	(73)	27
Add Back Donated Dep'n	836	69	66	(3)	556	528	(28)
Control Total	191	795	1,033	238	(212)	(3,322)	(3,110)

Overall £1,033k surplus in month, £238k favourable to plan.

Position supported by directly allocated Industrial Action support of £524k and reversal of STW high cost drugs risk share £285k. **Underlying position therefore £600k adrift of plan**

YTD £3,322k deficit, £3,110k adverse to plan

Clinical Income £791k adverse:
- £899k adverse theatre activity shortfall 143 cases
- £94k adverse outpatient – volume driven
- £42k LVA income block overperformance

Partially offset by:
- £98k favourable non theatre activity (ORLAU/Rheumatology/Metabolic & Paeds)
- £66k favourable MCSI overperformance (subject to NHSE ERF pricing risk)
- £47k Spinal Injuries Mum & baby 1-2-1 funding (offset in costs)

- Non NHS Income £74k favourable:
  - £74k favourable private patients - driven by volumes
  - £44k Research income (strong trial performance)
- Pay £74k adverse:
  - MCSI £142k adverse – largely driven by agency
  - MSK Wards £63k adverse (bank & agency)
  - Theatres £57k adverse (agency driven and 10 wte supernumerary staff)
  - Sheldon ward £35k (bank & agency)

  Partially offset by vacancies
- Non Pay £86k adverse
  - Theatres Implants/consumables £76k adverse
- Finance costs £89k favourable driven by interest receivable

Aspiring to deliver world class patient care

I&E YTD Drivers

Control	Financial Position Drivers	YTD				Month 8			
		Activity	Income £'000	Cost £'000	Net £'000	Activity	Income £'000	Cost £'000	Net £'000
External	Industrial action theatres	-557	-3,008	451	-2,557				
	Industrial action new outpatients	-1,162	-232	0	-232				
	Industrial action Diagnostics	-446	-156	0	-156				
	Elective baseline adjustment mitigation	0	1,378	0	1,378	0	524	0	524
	Sub Total Industrial Action Impact	**-2,165**	**-2,018**	**451**	**-1,567**	**0**	**524**	**0**	**524**
Internal	Theatre Capacity	-408	-2,040	408	-1,632	-143	-772	154	-618
	Outpatients Capacity	-1,456	-249	0	-249	-498	-138	0	-138
	Private patient mitigation	65	459	-76	383	14	74	13	87
	Theatre Recovery (Additional Sessions)	0	0	0	0	0	0	0	0
	Sub Total Capacity Impact	**-1,799**	**-1,830**	**332**	**-1,498**	**-627**	**-836**	**167**	**-669**
Internal	Out of job plan (net of vacancies)		0	-337	-337		0	-8	-8
	Casemix (implants & consumables) complexity		343	-1,289	-946		98	-180	-82
	Supernumary staffing		0	-347	-347		0	-34	-34
	MCSI premium staffing		617	-1,090	-473		66	-143	-77
	Estates & facilities (energy, materials, maintenance)		0	-480	-480		0	-28	-28
	Efficiency programme slippage		0	-174	-174		0	-53	-53
	TIF2 Theatres Delay		0	0	0		0	0	0
	Sub Total Internal Pressures	**0**	**960**	**-3,717**	**-2,757**	**0**	**164**	**-446**	**-282**
External	Low Value Agreement (LVA) block impact		-298	0	-298		-46	0	-46
	Injury Cost Recovery (ICR/RTA) Income Shortfalls		-210	0	-210		-70	0	-70
	Rheumatolgy and High Cost Drugs Growth		0	0	0		283	0	283
	Excess inflationary impact		0	-324	-324		-41	0	-41
	Sub Total External Pressures	**0**	**-508**	**-324**	**-832**	**0**	**127**	**0**	**127**
Internal	Finance costs mitigation (interest recievable)		0	625	625		0	89	89
	Vacancies / Non recurrent		0	1,434	1,434		0	210	210
	Balance sheet mitigation		0	1,403	1,403		0	197	197
	Enhanced financial controls		0	52	52		0	12	12
	Sub Total Mitigations	**0**	**0**	**3,514**	**3,514**	**0**	**0**	**508**	**508**
Interventions	OJP Follow Up Clinics Reduction		0	0	0		0	0	0
	TIF2 Development		0	0	0		0	0	0
	18 Weeks Insourcing Pre-op		0	0	0		0	0	0
	AHP Agency		0	0	0		0	0	0
	8 Beds Enhanced Recovery		0	0	0		0	0	0
	Restore Costs		0	0	0		0	0	0
	Private Patient - Extra weekend lists		0	0	0		0	0	0
	MCSI Temp Staffing Improvement		0	23	23		0	23	23
	MSST Physio Recharge		7	0	7		7	0	7
	Sub Total Mitigations	**0**	**7**	**23**	**30**	**0**	**7**	**23**	**30**
External Support			**0**	**0**	**0**		**0**	**0**	**0**
	Grand Total Variance to Plan	**-3,964**	**-3,389**	**279**	**-3,110**	**-627**	**-15**	**252**	**238**

External pressures outside of the Trusts control total £2.4m YTD :

- £1.6m unmitigated industrial action (of which £0.8m is Wales)
- £0.5m technical income (ICR/RTA and LVA)
- £0.3m inflation above funded levels
- Note: this includes £0.5m NHSE support for industrial action in M8 bringing YTD support to £1.4m

Internal pressures total £4.3 YTD offset by £3.5m mitigations leaving a net impact of £0.8m :

- Cost pressures total £2.8m but are offset by mitigations largely in the form of vacancies, interest receivable and balance sheet support.
- Capacity challenges total £1.5m and are partially mitigated by private patient income and remaining mitigations.
- Operational interventions are largely phased in from Q4 with some minor improvements in month 8.

Forecast Out-turn

Most Likely Scenario		Income £m	Cost £m	Total £m
	Planned I&E Surplus			0.2
External Drivers	Unmitigated industrial action - England	-2.3	0.3	-2.0
	Unmitigated industrial action - Wales	-1.1	0.1	-1.0
	NHSE Industrial Action Support	1.4	0.0	1.4
	Low Value Agreement block overperformance	-0.5	0.0	-0.5
	RTA/ICR income shortfalls	-0.5	0.0	-0.5
	Excess inflation	0.0	-0.5	-0.5
	Support to systems	0.0	0.0	0.0
	External Sub Total	-3.0	-0.1	-3.1
Internal Drivers	Workforce capacity shortages (impact on activity/income)	-2.2	0.3	-1.9
	Cost pressures (agency, supernumary, energy)	0.9	-2.3	-1.4
	Casemix pressures	0.4	-1.8	-1.4
	Efficiency slippage (stretch target)	0.0	-0.2	-0.2
Mitigations	Non recurrent savings & balance sheet support	0.0	2.0	2.0
	Interest recievable	0.0	0.8	0.8
	Private patient income	0.7	-0.2	0.5
	Theatre activity recovery	0.4	-0.3	0.1
	Enhanced financial controls	0.0	0.1	0.1
	Further operational interventions Nov reforecast	0.4	1.0	1.4
	Mitigated sub total	0.6	-0.6	0.0
	Forecast Deficit	-2.4	-0.7	-2.9
	Variance to plan			-3.1

- Forecast post IA support is £4.3m deficit, £4.5m adverse to plan with drivers as follows:
- Unmitigated Industrial Action income loss £1.6m
- Externally driven pressures £1.5m
  - Low value activity block overperformance £0.5m
  - RTA income shortfalls £0.5m
  - Excess inflation £0.5m
- Internally driven (net of mitigations) £1.4m .
  - Activity (income shortfall) and casemix (higher cost complexity) driven
  - Forecast assumes activity delivers to plan from December (risk of £2m based on current run rate)
- Further operational interventions for Q4 identified totalling £1.4m opportunity (subject to QIA)
- Support requested from the ICS discretionary national funding has been requested at £3.1m

Capital

Position as at	2324-08		Capital Programme 2023-24						
Project	Submitted Annual Plan £000s	Revised Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
Backlog maintenance	430	430	30	56	-26	295	412	-117	430
I/T investment & replacement	600	600	150	24	126	200	80	120	600
Capital project management	130	130	11	12	-1	86	92	-6	130
Equipment replacement	750	750	100	76	24	500	504	-4	750
Diagnostic equipment replacement	500	300	0	0	0	50	13	37	300
IPC & safety compliance	170	170	10	0	10	110	109	1	170
Estate reconfiguration	100	100	8	0	8	66	16	50	100
EPR planning & implementation	4,600	4,600	114	1,568	-1,454	2,284	2,066	218	4,600
Invest to save	300	300	100	0	100	200	37	163	300
Theatre replacement strategy	4,380	4,380	454	1,171	-717	3,695	1,338	2,357	4,380
Donated medical equipment	150	150	0	0	0	100	73	27	150
Leases (IFRS16)	120	120	0	0	0	120	66	54	120
Contingency	0	200	0	1	-1	100	23	77	200
Total Capital Funding	12,230	12,230	977	2,908	-1,931	7,806	4,829	2,977	12,230
Donated medical equipment	-150	-150	0	0	0	-100	-73	-27	-150
NHS Capital Funding - Charge to CDEL	12,080	12,080	977	2,908	-1,931	7,706	4,756	2,950	12,080
Less leases (IFRS16)	-120	-120	0	0	0	-120	-66	-54	-120
Charge to CDEL excluding IFRS16	11,960	11,960	977	2,908	-1,931	7,586	4,690	2,896	11,960

The capital programme for the year is £12.2m with the Theatre replacement and Apollo EPR implementation being the most significant schemes.

The YTD underspend, which is due to the profiling of these 2 schemes, has reduced to £3m in November, as expenditure has been accrued to recognise milestones achieved to date on the Apollo EPR and Theatre development.

The Trust submitted a plan which is 105% of the allowable CDEL budget so is required to reduce spend by 5% in year (equivalent to £350k). To support this a contingency is formed where possible through scheme review managed by the CMG (currently £200k).

Risks to the revenue

Risk Type	Risk name	Risk Description	Estimated Value	Risk ID	FURTHER POTENTIAL RISK NOT IN FORECAST £'000	Likelihood	Consequence	Risk Rating	Mitigations / actions
Internal	Variable income performance - Restoration Inpatients	Planned activity requires an increase of c10% on previous year average for inpatients.. As the Trust now operates under PbR, failure to deliver carries an income risk.	Risk based on continuation of activity shortfalls for Dec to March not factored into forecast.	3027	£ 2,000	5	4	20	Financial recovery group oversight of performance with weekly meetings to oversee actions. Theatre improvement group to oversee service change and productivity gains.
External	Industrial Action (Strikes) Impact on Income	Further strike action potential for doctors and nurses impacts on ability to delivery planned activity levels with a resulting impact on pbr income.	Strike action averaging at £100k impact per day. 9 working days declared in Dec / Jan not included in forecast.	3054	£ 900	4	4	16	Mitigating actions to ensure maximum levels of activity are protected during the strike action.
Internal	Variable income performance - Restoration Outpatients	Planned activity requires an increase of c15% on previous year average. As the Trust now operates under PbR, failure to deliver carries an income risk.	Risk based on continuation of activity shortfalls for Dec to March not factored into forecast.	3142	£ 400	5	3	15	Financial recovery group oversight of performance with weekly meetings to oversee actions. Outpatient improvement group to oversee service change and productivity gains.
External	Insourcing Arrangements Regulatory Intervention	Insourcing arrangements must be reported as agency expenditure from April 2023 complying with rules for hourly rates and on framework procurement. The majority of RJAH insourcing is undertaken by OO LLP which currently breaches hourly rates (but delivers value for money) and is not on a procurement framework. This is flagged as non compliant by the regulator.	No value assumed in this financial year.	3097	£ -	3	5	15	Regular dialogue with regulator and ICS to explain the model delivered by insourcing at RJAH and the positive impact on activity, quality and finances. Board led approach to future strategy following contract expiry in June 2024. Considered pausing activity and shared impact with NHSE, this would cause a £1.4m deterioration in financial position in Q4.
Internal	Low Value Activity Block Overperformance	Low Value Activity (non contract) is funded as a block but valued at historical levels (3 year average), this doesn't adequately reflect growth in tertiary referrals for specialist work aligned to national and local strategy.	Impact factored into forecast.	3052	£ -	4	3	12	Look to identify offsetting non recurrent contract gains to offset potential risk. Ensure clear communication with regulator on impact.
External	NHSE ERF Baseline and Performance Calculation Errors	The national calculation of ERF performance does not take into account local pricing, this is significant for MCSI in particular where the trust is paid on a bed day rate and the national calculation only recognises this as an inpatient stay regardless of duration. The baseline activity target for specialised commissioning is also overstated by £800k, while this is assumed to not impact on actual performance it deteriorates the Trusts WVA score and potentially puts risk on any overperformance being recognised.	Value is based on forecast impact of national ERF calculations vs internal monitoring. Includes £100k risk for NHSE baseline adjustment potentially not recognised in full.	3143	£ 900	3	4	12	Discussions with NHSE to understand the impact with a view to agreeing a position with no impact on RJAH. Escalation to national team for advice and resolution. Escalation within NHSE for advice and agreement.
Internal	Efficiency Programme Slippage	Challenges within STW system have led to organisations setting very ambitious efficiency plans of 3.7%, this improvement is built into the delivery of the financial plan.	Further risk based on red rates schemes not factored into forecast.	2858	£ 200	3	4	12	Executive review of efficiency plans at outset, where plans fall short continued escalation until 20% contingency identified. Monthly review of performance through TPOIB. Monthly assurance through F&P.

Risks to the revenue

Risk Type	Risk name	Risk Description	Estimated Value	Risk ID	FURTHER POTENTIAL RISK NOT IN FORECAST £'000	Likelihood	Consequence	Risk Rating	Mitigations / actions
External	Inflationary Environment	UK RPI is still running high, tariff funding has been devolved for 5.5% so potential for further pressures to arise in year if current inflationary environment continues.	Risk based on further extrapolation of YTD inflationary pressures on non pay above level factored into forecast.	2886	£ 400	3	3	9	Procurement steering group monthly review of inflation pressures. Robust management of inflation proposals from supplies and strategic use of inflation reserve. Robust negotiation of controllable costs under contracts and pricing challenges.
Internal	Agency Pressures leading to breach of cap	If workforce recruitment trajectories slip there will be continued overreliance on agency to fill gaps to deliver planned activity levels.	Agency forecast to deliver within cap factored into forecast.	3050	£ -	3	3	9	Recruitment plans linked to operational plan delivery assurance focused on RN, HCSW and consultants overseen by People Committee. Oversight through internal and external agency reduction groups led by CNO. Actions in units to target off framework agency reductions, review of processes and sign off arrangements.
External	Urgent Care / System Pressures	System escalation pressures requiring Sheldon ward beds to be used for rehabilitation - this would impact on agency costs and additional income from extension of spinal injuries bed base.	No impact assumed on forecast.	3053	£ -	3	3	9	System process for RJAH involvement in escalation. System winter funding allocations.
Internal	Injury Cost Recovery (ICR) / Road Traffic Accident Income (RTA) income notification reductions	Injury Cost Recovery (ICR) previously known as Road Traffic Accident (RTA) is a passive income source to the Trust linked to the treatment of patients who have been involved in a road accident. This income is unpredictable and reductions in notifications impact the bottom line.	Value is based on H1 income notifications and withdrawals continuing in 23/24 which RJAH has no control of.	3084	£ 400	2	4	8	Closely monitor income notifications and withdrawals through the ICR system ensuring prompt recognition and avoid duplications. Where possible identify non recurrent income sources to mitigate in year impact.
Internal	Variable income performance - Theatre Development	Delays to the new theatre development planned to go live in January 2024 will have adverse impact on elective inpatient activity which will in turn impact on clinical income.	Impact factored into forecast.	3083	£ -	2	4	8	All options being explored to bring forward the Go Live date. Further sessional/productivity mitigations in development to recover net activity shortfalls against plan.
				Total	£ 5,200				

- The remaining risk not included in the forecast is c£5.2m – the largest component of which is theatre plan delivery at £2m
- A new risk 3054 has been added to separate out the outpatient performance from inpatient performance
- The industrial action risk has been increased to 16 from 8 in recognition of additional action taking place in Dec & Jan by junior doctors
- Some of the lower scoring risks have been reviewed and reduced as factored into the forecast (2886, 3050, 3084)

Risks to capital

Risk Type	Risk name	Risk Description	Estimated Value	Risk ID	FURTHER POTENTIAL RISK NOT IN FORECAST £'000	Likelihood	Consequence	Risk Rating	Mitigations / actions
Internal	Apollo EPR financial risk	Risk that the Apollo EPR costs exceed the budgeted envelope. The Trust has received external Frontline Digitisation to fund the implementation so any costs above this level would present financial risk to the organisations capital programme. The project is currently delayed by 3 months with a revised Go Live date, this has utilised all available contingency. Further delays to the implementation date, alteration of scope or additional works, increased contractor costs and deviation from business case assumptions would all result in cost overruns.	Value based on 5% of project value as contingency has now been fully utilised.		£ 500	3	4	12	Project overseen by EPR Programme Board with escalation through Digital Committee. Financial forecast regularly updated with latest project milestones and workforce, risk register is maintained for project. Review of project costs to ensure as efficient as possible.
Internal / External	Future capital programme affordability	The Trust requires significant investment in capital over the next few years to replace key assets and develop its strategy. Insufficient cash balances due to below plan financial performance and insufficient CDEL budgets allocated through the ICS will compromise investment levels.	Value based on investment requirement above notional CDEL allocation over the next two years (assumes cash balances are sufficient).		£ 10,000	4	4	16	Close discussion with ICS capital prioritisation to ensure RJAH issues and ambition are fully understood. Financial recovery group and plan oversight to ensure delivery of financial objectives to meet required cash levels.

- Risks have been split between capital and revenue impacts with two new risks added for capital

Chair's Assurance Report
Finance and Performance Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	10 January 2024
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	04 January 2024
Paper Reviewed by:	Sarfraz Nawaz, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors – Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the Finance and Performance Committee. The Board is asked to consider the recommendations of the Finance and Performance Committee.

2. Context

2.1 Context

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

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Finance and Performance Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from Finance and Performance Committee

This report provides a summary of the items considered at the Finance and Performance Committee on 18 December 2023. It highlights the key areas the Finance and Performance Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The Finance and Performance Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

Performance Report

The Committee raised concerns with the current performance as follows:

- Overall activity levels continue to fall short of agreed plan particularly in Theatres but Outpatients also becoming an increasing concern.
- In job plan activity continues to be the main driver of the shortfall and more work required to understand the drivers
- Theatre workforce continues to be a constraint and the WTE forecasts previously assumed are falling short and pose a significant risk for the go forward plan unless mitigations identified.

- The Trust reported the anticipated plateau of English patients waiting list has commenced, although waiting lists remain a concern.

Financial Performance Report

- The Committee noted that the financial challenges continued in month with an underlying shortfall against plan of £0.6m before adjustments were applied for the Industrial action elective baseline reduction and high-cost drugs risk share agreement with the ICB. As per previous months income shortfalls continues to be the biggest driver of the variance with a £0.8m shortfall overall.
- The Trust is still forecasting a £3.1m adverse to plan for year end and the month 8 performance was consistent with previous assumptions.
- Clarity over the allocation of the System support funding which was received by the ICB (total of £4.7m) is outstanding. The Trust have submitted a bid for a proportion of the funding. It was noted this is separate from the Industrial Action funding received.
- The Committee acknowledged the continued risk to the financial performance as further industrial action is scheduled for December and January and the outlook for December theatre activity was concerning.
- The Finance Recovery Group continue to review options to stabilise and improve the financial performance.

Recurrent Plan Scenarios

Three scenarios were presented to the Committee pending confirmation of assumptions to be applied from national planning guidance still to be released.

- The base case highlighted a £2m recurrent deficit reflecting known recurrent pressures with case mix being the largest shift. Additionally, non-recurrent efficiencies and shortfalls of income from LVA and ICR had been included.
- Scenario 1 showed a deficit of £6m illustrating the impact of the current activity shortfalls should they persist.
- Scenario 2 showed a deficit of £6.8m and reflected the impact of the LLP work ceasing in its entirety.

It was noted for all options the Intelligent Fixed Payment income adjustment had been reversed in full which re-instated the final £2m of income deducted by the ICB to the Trust. It was noted that as part of this agreement that any Trust planning a surplus would be subject to the same financial controls as a Trust in deficit whilst the system remained in material deficit.

Theatre Development Delivery Update

The Committee received an update report on the delivery of the new TIF2 Theatre and noted the following:

- A further delay to the construction timeline of 6 weeks taking the hand over to mid-May 2024
- A projected cost overspends of £1.3m with additional risks of £1.9m still under discussion with the contractor.

Concerns were raised that the Trust did not have external evidence to support the build being completed by the renewed timescale.

Agreement was given to report this updated position externally and that the remaining risks to delivery be more closely scrutinised by the Theatre Project Board with a regular Chairs's report back to Committee.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Finance and Performance Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

There were no items to advise.

3.3 Areas of assurance

ASSURE - The Finance and Performance Committee considered the following items and did not identify any issues that required escalation to the Board.

Performance Report

The Committee gained assurance on the following areas:

- Workforce metrics continue to be favourable overall
- Noted a decreased in OJP utilisation since the summer
- Significant improvements have been noted for the average length of stay
- Trajectory for weekend working was reported as positive
- Reduction in month relating to overdue follow ups report
- DNA rates continue to be below the national target of 5%

Long Waiters Presentation
The Committee were assured with the ongoing work with relation to waiting lists and commended the comprehensive presentation which gave assurance that the Trust is on track for 65-week waiters. It was noted that there are ongoing discussions with external organisations to support with mutual aid for Welsh patients.

The following papers were circulated to the Committee for information only:

- Model Health System – theatre utilisation
- STW Opportunities to improve productivity.
- Protecting and expanding elective capacity NHS England assurance

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps.
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.

Chair's Assurance Report
Extra-Ordinary Digital, Education, Research and Innovation Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	10 January 2024
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	**Paper written on:**	02 January 2024
Paper Reviewed by:	Penny Venables, Committee Chair	**Paper Category:**	Governance
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1. Purpose of Paper

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

This is an assurance report from the Digital, Education, Research and Innovation Committee. The Board is asked to consider the recommendations of the Digital, Education, Research and Innovation Committee.

2. Context

2.1 Context

The Trust Board has established a Digital, Education, Research, and Innovation Committee. According to its terms of reference: *"The Board of Directors has delegated responsibility for the oversight of the Trust's Digital, Education, Research performance to the Digital, Education, Research, and Innovation Committee. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."*

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Digital, Education, Research and Innovation Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from Finance and Performance Committee

This report provides a summary of the items considered at the Extraordinary Digital, Education, Research and Innovation Committee on 19 December 2023. It highlights the key areas the Extra-Ordinary Digital, Education, Research and Innovation Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The Digital, Education, Research and Innovation Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

Quality Oversight and Assurance Committee

Due to the focus required on the digital agenda, it was discussed that the Trust may benefit from a focused Quality Oversight and Assurance process. Consideration is to be given as to:

- whether this is to be aligned to the Board of Directors Meeting
- how to link the Programme Board into the work to ensure work is not duplicated as a number of the Executive Team are members of the Programme Board.
- whether a Non-Executive Director would be added to the Programme Board membership.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Digital, Education, Research and Innovation Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

EPR Key Deliverables and Current Status

The Trust reported that following a recent meeting the providers an improved position has been noted. Daily project team calls have been scheduled which has supported in the gaining assurance on outstanding actions which have reduced. The Committee were informed that a realistic milestone for reaching assurance on the achievability of the deliverables was noted as February.

The Committee were assured a review on the roll out of the system has been scheduled for February and will be completed by NHS England.

Risks and Mitigations

A total of 4 risks were shared with the Committee – 2 high risks scored at 16 and 2 medium risks scored at 12. The risks are reviewed as part of the risk management process within the Trust.

- R82 | (12) There is a risk that if the lack of clear direction from System C on the Patient Portal solution and provider continues then the Programme Team will be unable to determine the timescales, tasks and resource required to deliver the patient portal and its associated benefits and there will be insufficient time to complete the required work. The Programme Team need to have early visibility of the tasks and dependencies to help plan and align work across workstreams.
- R95 | (16) There is a risk to go live readiness of the electronic Prescribing and Medicine Administration (ePMA) solution due to a lack of dedicated time from the pharmacy team will impact go live.
- R106 | (16) Delays to System C functionality and integration delivery.
- R24 | (12) Lack of Contingency may impact on delivery of EPR system.

Further assurance was requested on other risks which are noted on the register however not shared at Committee level. The Committee were reassured that the risks are discussed at the EPR programme meeting and suggested a chair report is presented to DERIC in the future.

Chairs Assurance Report – Digital Transformation Group

Assurance was noted on the increase communication and dialogue between the organisation and system provider. However, further assurance was sought on the following:

- Forms library as system C have requested the forms from Apollo team.
- The modules and whether they will be fit for purpose. Is there evidence that the electronic prescribing module is working well in other organisations? The Trust confirmed ePMA module (an established system within the NHS) has been selected by the Trust as this best aligns the existing stock control system.

Feedback from System C/CCN

The Contract Change Notice (CCN) is due to be finalised with System C at a meeting planned for 20/12/23. Final review has been completed in conjunction with NHSE and System C. The revised go live date of 28th June 2024.

Apollo Implementation Plan

This summary plan included the most recent adjustments. Further detail on individual modules could be produced for a Task and Finish group if deemed necessary.

3.3 Areas of assurance

ASSURE - The Digital, Education, Research and Innovation Committee considered the following items and did not identify any issues that required escalation to the Board.

NHS England Review

The Committee were assured with the documentation.

RJAH EPR Full Business Case

The business case was shared for information only.

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps.
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.