The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 08.11.2023

MEETING

8 November 2023 09:30 GMT

PUBLISHED

7 November 2023

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	Vice-Chair /Acting 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	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	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
06 SEPTEMBER 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	*x*
Martin Newsholme	Non-Executive Director	*x*
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	*x*
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 Kingston	Associate Non-Executive Director	*x*
Paul Maubach	Associate Non-Executive Director	*x*
John Pepper	Associate Non-Executive Director	✓
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Mark Salisbury	Operational Director of Finance	✓
Jo Banks	Managing Director of MSK Unit	✓
Kirsty Foskett	Head of Governance and Quality (part)	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minutes)	✓
Chris Hudson	Head of Communications	✓
Colin Chapman	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 Andrea Hughes, who joined the meeting to present her staff story. HT also welcomed Mark Salisbury, Operational Director of Finance who attended the meeting to represent Craig Macbeth and Jo Banks, Managing Director of MSK Unit who joined the meeting to represent Mike Carr.
1.1	**Apologies**
	Apologies were received from Sarfraz Nawaz, Martin Newsholme, Paul Maubach, Paul Kingston, Craig Macbeth 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.

Ref.	Discussion and Action Points
	Following an action from the previous meeting, the declaration of interest's register was incorporated into the Board papers to enhance oversight. The Board reviewed the register and requested the following amendments were completed: • PV – has stood down as Vice Chair for Birmingham Ethnic Education Advisory Service. • LW – update to 'Non-Executive Director'. • ME – update to 'Non-Executive Director'. • PK – update to 'Associate Non-Executive Director'. • AI – amend to includes AI interests. ACTION: update the declaration of interest register accordingly.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 05 July 2023 were approved as an accurate record on the meeting. It was noted that there were some typing and grammatical errors which would be reviewed outside of the meeting – these did not affect the content. ACTION: minutes of the meeting to be reviewed to amend all typing/grammar errors.
1.4	**Matters Arising and Action Log**
1.4.1	There were no further matters to raise.
1.4.2	The following actions updates were noted: • Action number 3: Agency to be an exceptional item on the agenda going forwards. The Board agreed to close the action. • Action number 4: Q1 review of the operational and financial plan to be completed in August. The Board agreed to close the action. • Action number 5: Presentation of the Theatre Build to be delivered to the Council of Governors. The Board agreed to close the action. • Action number 6: A report to be presented following the recommendation/suggestion received following the Chair/Board appraisal. The Board agreed for the action to remain open and the report to be tabled for discussion at a future meeting.
2.0	**Patient Story**
	PKF welcomed Andrea Hughes to the meeting who joined to share a verbal update on her patient journey at the Trust. Andrea described the following: • Grateful to the Trust who has provided 23 years of superb care. • Currently being treated on Sheldon Ward. • Surgeons treat you as a person and not a number. • Described the organisation as a 'exemplar hospital'. • Andrea has been able to walk again thanks to the Trust and its encouraging staff. • Treatment and support which she has received has allowed her and her children to have a good quality of life. • Praised Dr Askari and Mr. Munigangaiah. • Staff are happy and friendly. • Cleaning is of a high standard. Andrea explained that she wished to share some improvement suggestions outside of the meeting. PKF agreed to visit Andrea on Sheldon Ward to gain feedback and have a discussion regarding constructive criticism. LW asked for Andrea to feedback any suggestions on improving how the Trust can improve of listening to patients and how we can encourage others to share their journey. ACTION: PKF to visit Andrea Hughes on Sheldon Ward to gain feedback and improvement opportunities following the delivery of her patient story. On behalf of the Trust, HT thanked Andrea for sharing her story highlighting the importance of learning from patients and being an open organisation, which listens to their patients and staff. HT praised Andrea for her mental positivity which was inspiring. ME explained that it was a pleasure listening to Andrea and it appears that she is a pleasure to have within the Trust. The Board thanked Andrea and wished her all the best for her continued recovery.
3.0	**Chair and Chief Executive Officer (CEO) Update**
	HT provided a verbal update – sharing the following key points with the Board: • Conversations are continuing with other providers within the System in relation to improving collaboration. This will be discussed in detail in the private meeting this afternoon.

Ref.	Discussion and Action Points
	• The Trusts thoughts are will all the patients and staff effected with the Lucy Letby trail at the Countess of Chester Hospital. The Trust will be completing some reflection work to ensure recommendations from the review are embedded following the receipt of the letter from NHS England. • Highlighted the importance of the Board listening to staff and acting on concerns raised. • The Trust celebrates that there are 6 Board members that are clinician. • There are more steps to take following the trial, including the review of the Fit and Proper Persons Test process. SK provider an update on the CEO Report. The update covered the following areas: • Industrial Action – the effects of the impact will be discussed within the agenda, however, SK expressed thanks to all staff who have supporting the action. A lot of effort has been taken to ensure robust planning and mitigations that staff complete to ensure the site remain safe is inspiring. Industrial action is expected to continue for another 6 months with Junior Doctors and Consultant strikes scheduled for October along with the RCN going back to ballot. • Togetherness Week – listening to feedback from previous year, the Trust has reviewed the events and have a lot of activities planned throughout the whole week. It is a great opportunity for teams to come together and celebrate. • Nursing and AHP Celebration – the event took place in July. Staff members joined the session to showcasing work which has been completed. Congratulations to the Nurse, AHP and Support Worker who all received the Dame Agenus Hunt Award – Ambily Sunil, Nurse / Geraint Davies, AHP / William Walter, Support Worker. Dame Ruth May, Chief Nursing Officer for England joined the meeting as a welcome and introduction. • The Trust has been awarded the NJR Quality Data Provider for the 5th year running. • Recognition for 2 NOA excellence of orthopaedics awards. The Trust has been shortlisted for the recruitment campaign and cost of living support. The celebration evening is scheduled for October. • The Headley Court Veterans Centre have been shortlisted for Social Infrastructure Project of the Year at the national British Construction industry Awards. The celebration event is scheduled for later this month. The Trust continuously receive positive feedback regarding the centre. • Thank you to the 21 marathon runners who supported the Trust this year – an event was been held celebrate the £43k+ funds raised. • Congratulations to Jeanette Jones! Jeanette has worked on the MSCI ward for 40 years and for the past 20 years has been working with the Great Britain rugby team within the Paralympics. Jeanette received an award for her Outstanding Service to Sport Award. • Star Awards – congratulations to Jenny and Rebecca, Practice Development Nurses within Theatres who have been nominated for their continued support to new starters. The effort they put into staff retention, induction, education and training is valued. Well done Jenny and Rebecca!
3.1	**Lucy Letby Letter and Freedom to Speak Up Briefing** The Board considered the submitted paper and members noted the following points in particular: • The Trust received a letter regarding the Lucy Letby Trial which highlighted keys areas for the Trust review. • The Trust has reflected on the content of the letter and noted the key areas to review in to order to ensure staff are support and confident in raising concerns. • The Executive Team have spent some time discussing process and have discussed the letter openly in different forums across the organisation. • Staff are encouraged to share ideas on how current communication and escalation process can be improved. • The Freedom to Speak Up (FTSU) Briefing provides assurance to the Board on the elements of the letter relating to the FTSU process. • The paper outlines some next steps which includes a review of the Fit and Proper Persons Tests. Following consideration of the report and subsequent discussion, the Board discussed: • It was positive to note that within Q1, there were 0 anonymous FTSU concerns raises. • The culture of raising concerns need to be supported. • Highlighted the importance of listening to staff and following through with actions.

Ref.	Discussion and Action Points
	• Through discussions with staff, reassurance has been received on staff understanding the process of raising concerns if they are not content with support from Senior Managers, Board members including the executive team. • Noted that the Board Walkabouts can be used as an opportunity to share idea, discussion and answer questions which the staff may have. • Suggested that similar conversation is held at a future Board Meeting or informal catch-up meeting. • Consideration to be given as to, whether further support can be offered by the Board. • Highlighted discussions should also take place with members of staff who work in less visible roles for example, back offices, night workers, and theatres.
3.2	**Corporate Objectives** The Board considered the submitted paper and members noted the following points in particular: • The draft version was shared at the last Board meeting for consideration and suggestions. • The Executive Team have since reviewed following the comments from the Board meeting - workforce and productivity have both been reflected in the final version. • The team have reviewed the objectives to ensure they are relatable and meaningful to all. • The Board is asked to consider and approve the corporate objectives and consider and approve the suggested timeframe of the next review. Following consideration of the report and subsequent discussion, the Board: • Approved the Corporate Objectives • Agreed the objectives would be a period of 2-years due to the timing of the final document and the work the Trust is completing to review the Strategy. • The corporate objectives will be revised in 2025. • SK confirmed the Medical Illustration and Communications teams are supporting with visuals and engagements on the document. The Board approved the corporate objectives for 2023/24 and 2024/25.
3.3	**Royal Orthopaedic Hospital (ROH) Collaboration** The Board considered the submitted paper and members noted the following points in particular: • ROH is presenting the same document at their Trust Board meeting this morning. • All Orthopaedic Hospital share a framework for collaboration through the National Orthopaedic Alliance (NOA) however additional conversations have taken place between the specialist Trust ROH to enhance collaboration. • A counterpart meeting between CEO and Chair took place earlier in the year. • A joint Executive Team Meeting was held in the summer. • A shared priority list was agreed and compiled between the ROH and RJAH – addressing key areas which the trusts wish to commence collaborating in. • The next steps included formalise the governance arrangements. • A shared learning day has been scheduled for October with the organisation's clinicians. • The Board is asked to note and support the collaboration between ROH and RJAH. Following consideration of the report and subsequent discussion, the Board commented: • This is a tremendous opportunity for the Trust and a unique collaborations. • Encouraged for the collaboration to be extend to Stanmore Hospital which would further enhance, support, engagement, and learning. • Welcomed the peer reviews – noted this to be a powerful and positive opportunity for the organisation. The Board supported the ROH Collaboration.
4.0	**Quality and Safety**
4.1	**Chief Nurse and Patient Safety Officer Update (verbal)**
	PKF provided a verbal update – sharing the following key points with the Board: • The Trust is collaborating with ROH to facilitate a nurse session at the National Orthopaedic Alliance (NOA) conference which is scheduled for October. The session will include a presentation on transition services. • Working alongside the NOA to implement the pathways to excellence which is a new accreditation.

Ref.	Discussion and Action Points
	• Invited to participate in the workforce professional standards team as the Trust have been shortlisted for the staff retention award. • In relation to the Lucy Letby issues shared, PKF confirmed visits have been taken place to ensure staff are feeling supported and reassurance was received by the Board. • A new discreet and designated space has been created for the Freedom to Speak Up Guardian. • A restructure of the safeguarding is being completed to ensure robust staffing is in place. • Supported in togetherness week by delivering pizza to night staff. The Board thanked PKF for the update.
4.1.1	**IPC Feedback Letter**
	The Board considered the submitted letter and PKF highlighted the following points in particular: • The letter outlines the outcome following the last visit in March 2023. • Within the letter, there is a recommendation that the findings are shared with the Board of Directors for information. • All recommendations noted within the letter have been incorporated into the IPC improvement plan and assurance reports will be presented to the Quality and Safety Committee. • The Quality and Safety Committee agreed for the IPC reporting to revert to business as usual. • The team is currently writing a paper regarding the Trusts' IPC journey for publication. PV assured the Committee that some points which are outlined within the letter have already been considered and discussed as part of the Quality and Safety assurance Committee. ACTION: PFK to confirm with NHSE that the letter has been presented and discussed the Board meeting.
4.2	**Chief Medical Officer Update (verbal)**
	RL provided a verbal update – sharing the following key points with the Board: • Industrial Action – there has been no patient safety incidents recorded following the recent action which included junior doctors and consultants. It was noted that further action is scheduled for October where junior doctors and consultants' strikes will be aligned. • GMC have updated the good medical practice which includes a further 8 guidelines in addition to the usual. RL confirmed this included conflict of interest. RL has invited all clinical leads to join the GMC webinar in order to understand the changes which will be embedded from January 2024.
4.3	**IPR Exception Report**
	The Board considered the submitted paper and members noted the following points in particular: • 1 Serious Incident – internal investigations taking place which is being led by a Consultant Anaesthetist. The learning from the incident will be shared via the Quality and Safety Committee. • 2 ecoli infections – this was a result of the post infection review processes. LW added there is on review which is due to be completed imminently. • 1 expected death. The Board noted the steady performance update.
4.4	**PSIRF Implementation and Policy**
	The Board welcomed KF to the meeting who presented the PSIRF implementation plan and policy for approval. KF highlighted the following key points: • The framework and policy plan are presented at the meeting for consideration and approval from the Board members. • The implementation of the framework has been implemented following a national change which formed part of the NHSE strategy. • The Trust have been transitional from the Serious Incident framework to the PSIRF documentation in line with the October launch date. • The Trust implemented a formal project group in January 2023 which supported the roll out of the framework. • PSIRF will continue to be a standard agenda item on the Quality and Safety Committee agenda and have been assured with processes in place to implement the framework. • LW assured the Board that the policy has been considered by the Committee and recommends the documents are approved by the Board.

Ref.	Discussion and Action Points
	The Board discussed the following: • PV commended the Trust on the great work and following a query, KF confirmed this isn't linked to safety legislation. It is a statutory requirement for the Trust in ensure NHS best practice and national guidelines are embedded and adhered too. • KF explained the roles of the PSIRF are embedded into current roles – mainly resulted to processes changes for the patient safety specialist. • PKF highlighted that KF has completed a masters degree in human factors and has been a key factor in implementing and rolling out the framework – well done Kirsty! • Training for patient safety specialist has been offered from NHSE. It was a 2-day training course completed for PSIRF and was aligned to the patient safety specialist remit including roles, responsibilities and prioritising. The patient safety specialist will be an advisor to members of staff and support with action alerts. • The Trust explained there are patient safety partners which are the organisations patients – those individuals have joined the patient safety meeting and patient experience working group. • Following a query, KF explained there is no training for patients at present but noted this is something the Trust can complete as part of the next steps. The Board agreed on the importance of ensuring patients are empowered within the role and can effectively speak up and challenge appropriately. • The Board welcomed the informative discussion and highlighted the areas of this this will support to address in health inequalities. The Trust is completing an assessment and will receive a breakdown of the data in due course. • It was noted that the EDS2 self-assessment highlighted accessible standards. The Trust is gaining information and support from George Lee from ICB on how to improve. • Patient safety walkabouts are to continue, and the Trust are to consider how the information can be aligned to the process. Following discussion and consideration of the documentation, the Board approved the PSIRF policy. On behalf of the Board, HT thanked KF and the team for their hard work – congratulations!
4.5	**Duty of Candour Annual Report**
	The Board received the submitted paper and members noted that assurance was received at the Quality and Safety Committee in August 2023 – there were no issues to raise. The Board noted the Duty of Candour Annual Report.
4.6	**Safeguarding Annual Report**
	The Board received the submitted paper and members noted that assurance was received at the Quality and Safety Committee in August 2023 – there were no issues to raise. It was noted that the report will be presented to the Committee within the first quarter of the new year going forwards. The Board noted the challenges faced with geography of the Trust being on the England/Wales boarder. The English safeguarding structure was highlighted within the report and assurance was sought on how the Trusts link into other safeguarding boards. The Trust attends the relevant meetings within the ICS system and work with the relevant local authority eternal to the Trust. The Board noted the Safeguarding Annual Report.
4.7	**Learning From Deaths Q1 Report**
	The Board received the submitted paper and members noted that assurance was received at the Quality and Safety Committee in August 2023 – there were no issues to raise. RL highlighted the following key points: • Thanked James Neil, Consultant Anaesthetist who is the Trusts lead for Mortality. • Learning from deaths is discussed in an open forum for clinical staff at the multi-disciplinary clinical audit meeting. • Mortality report is presented to the Patient Safety Meeting. • There were 2 sudden death in April – noting there were no concerns to raise regarding the patients care. • There was 1 death in June – noting the Trust received positive feedback from the family. • This Trusts process reflects that of the NHS England process. The Board noted the Learning from Deaths Q1 Report.
4.8	**Chair Report | Quality and Safety Committee**
	The Board considered the submitted paper and members noted the following points in particular:

Ref.	Discussion and Action Points
	• The Committee welcomed the briefing paper relating to the Lucy Letby. It was noted that the Committee spent time at the recent meeting discussing the issues highlighted with the outcome report and were assured to note the Trust have commenced reviewing processes. • The Committee asked for a review of deaths which have happened over the past 12months. • The Trust reported one never event at the beginning of August and the Committee will be expected a further report at the meeting in October. • Safe staffing annual review is to be completed. • The Committee received the QIA CIP which was noted to be helpful however, requested further information on budget setting to ensure the QIA is completed ahead of the assessment being completed. • The Committee agreed business as usual reporting was to resume related to the IPC reporting following the arrival of IPC letter from NHS England. The Committee confirmed the IPC expectation report will continue to be received on a monthly basis. • A review of the clinical effectiveness meeting is underway to enhance the scrutiny and gain assurance on clinical audit. The Board were assured following the presentation of the chairs report and thanked the Trust and the Committee for their continued hard work.
4.8.1	**Quality and Safety Committee Terms of Reference** Following a discussion, it was noted that the Quality and Safety Committee asked for further information relating to the CQC to be incorporated in to the document – this has not been reflected within the document presented for approve. Therefore, the Board asked for the approval of the terms of reference to be deferred to the next meeting. ACTION: amend the terms of reference for the Quality and Safety Committee to the next meeting.
5.0	**People and Workforce**
5.1	**IPR Exception Report**
	The Board considered the submitted paper and members noted the following points in particular: • The Trust continues to report successful performance against the KPIs - sickness, turnover and vancacy rates. The Board commended the work being undertaken to sustain the improvement. • The areas will continue to be a focus on for the Committee and ensuring the improvements are embedded and sustained. • The next recruitment day has been scheduled for the 08 October. • Agency framework continues to be a focus for the Committee – the Trust are expecting improvements to be reported. • It was noted that overall off framework agency has reduced and is only being utilised for 1:1 care which is required for complex patient to ensure patient safety. The Board noted the performance report.
5.2	**Freedom to Speak Up Q1 Report**
	The Board considered the submitted paper and members noted the following points in particular: • The paper is presented to the Board for information and is asked to note the content of the report. • It was noted that the report has aligned to previous years quarter report. • The Trust have increased the working hours of the freedom to speak up guardian and reminded the Board a discreet designated space is now available for staff members to visit the guardian. • There have been 6 concerns reported within the quarter. 5 were resolved following gaining advice and direction however, 1 concern reported was relating to bully and harassment (HR processes are being followed) • The Committee noted that assurance was received on the Trusts approach to freedom to speak up process. • PKF added there are regular catch up between the guardian and the Executive Lead to ensure support is in place. Following the discussion, the Board noted the Freedom to Speak Up report.
5.3	**Guardian of Safe Working Hours Q1 Report**
	The Board received the submitted paper and members noted that assurance was received at the People and Culture Committee in August 2023 – there were no issues to raise. RL highlighted the following key points: • Thanked Mr Chris Marquis who is the lead for the Trust.

Ref.	Discussion and Action Points
	• Confirmed there are approximately 20 junior doctors at the Trust. • There continues to be no exception report and therefore no fines for the organisation. • Acknowledged the hard work completing in order to fulfil the requirements in light of the current challenges. The Board commented the great work completed by Chris and the team. The Trust should be proud of its accomplishment and the report continues to offer assurance to our staff and patients that our workforce are supported and cared for. The Board noted the Guardian of Safe Working Hours Q1 Report.
5.4	**EDI Strategy**
	The Board considered the submitted paper and members noted the following points in particular: • It is presented at the Board meeting for consideration and approval. • The documents have been compiled following feedback from the Trusts recent listening events which were noted to be insightful and informative. • Encouraging for the organisation to have a plan and strategy in place to drive forward change and improvements. • Noted that Caroline Noakes-Lawrenson has been appointment the Associate Chief People Officer on a 12month secondment. It was confirmed that organisational development and EDI will be aligned to Caroline's portfolio. Following consideration of the report and subsequent discussion, the Board noted the following: • Expressed thanks to the Medical Illustration team who have supported with the visual presentation of the strategy. • Noted that the strategy was considered at the People and Culture Committee in August 2023. The Committee endorsed the strategy and recommended the Board approves. • The strategy will remain a live document under review as actions have been aligned. • The EDI actions will be presented to the EDI meeting and assurance will be presented to the People and Culture Committee via the monthly Chairs assurance report. The Board approved the EDI Strategy.
5.5	**Openness Policy**
	The Board received the submitted policy and members noted that following consideration at the People and Culture Committee in August, the members of the meeting endorsed the policy. The Board noted the importance of the policy in light to the earlier Lucy Letby discussion. The Board approved the Openness Policy.
5.6	**Chair Report | People and Culture Committee**
	The Board considered the submitted paper and members noted the following points in particular: • Positive results are being reported through the KPI and the recruitment agenda – discussions were held relating to the theatre recruitment. The Committee acknowledged that there is further work to be completed but noted the good work is underway. • In relation to sickness, the Committee asked for a breakdown of the data against the department as some areas are higher than others. This is to be shared at the next meeting. • There was a positive reduction in last months agency spend. • The Committee welcomed a story from the Trusts international nurses. It was noted to be an impactful session, positive points were raised in relation to the recruitment process, overall welcome and staff being friendly/supportive. Noted areas of improvement included induction training on the wards and challenges with accommodation. The Trust is investigating options on how to support staff further in this area. It was agreed that all international nurses are to be spoken to in order to gain feedback on their experience. The information will be provided with the People and Culture Committee in due course. The Trust reassured the Board that discussion have already commenced, and the leads continue to the explore other options available. This includes, liaising with Shropshire council, housing association and supporting individuals with tenancy applications. • The Trust were pleased to remind the Board that the pastoral care nurse role has been embedded. • AI suggested a simple digital tool is supplied to the staff to support in budgeting.

Ref.	Discussion and Action Points
	• Further assurance is required regarding the achievement of the E-rostering compliance. A deep dive is to be completed to understand what further work is required. A detailed action plan will be presented at the next meeting. • Assurance was obtained on the compliance audit on recruitment on employment documents. • The Committee welcomed a staff story from a member of the organisation who had completed the leadership programme and shared examples of learning which she had implemented into her work. • The Committee considered and reviewed the revised terms of reference and recommended the document is approved by the Board. The Board discussed the in-month leavers performance indicator, and it was highlighted that the registrar rotation data is to be removed. The Board also requested the development of the OPOD – asking for a further forecast (up to 12 month) to be included in the dashboard. The Board were assured from the chairs report from the People and Culture Committee.
5.6.1	**People and Culture Committee Terms of Reference**
	The Board approved the revised terms of reference for the People and Culture Committee.
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: • MSK services went live recently, the service will enhance the support offered to patients. The Trust will continue to work towards the implementation of the next phrase. • The Trust have submitted an expression of interest to be a GIRFT accreditation organisation – more information will follow in due course. • Local authority discussion on how to improve health inequalities has commenced.
6.1.1	**Industrial Action (verbal)**
	JB highlighted the points which had been made throughout the meeting in relation to the ongoing industrial action and thanked the operational team for their continued hard work, support and determination to ensure the site it safe and patients are cared for.
6.2	**IPR Exception Report**
	The Board considered the submitted paper and members noted the following points in particular: • The Trust performance was below plan in July, the key drivers for this include industrial action, workforce and annual leave utilisation. • The Trust continues to highlight the challenges faced with industrial action and noted the impact is expected to continue through September and October 2023. 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: • HSE have submitted interim guidance for patients that are declining mutual aid offers. • It was explained that if a patient has declined the offer for mutual aid, they will be removed from the long waiter list. • The Trust are still awaiting confirmation from Welsh commissioners on how the Trust can support those patients further. 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**
	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, Performance and Digital Committee • The presentation included the plans which the Trust have implements and noted in order to support the recovery. • The Trust continue to work hard to ensure the 11 theatres are up and running – this is a key driver to ensure the backlog of patients.

Ref.	Discussion and Action Points
	• Focus area which has been highlighted included – extended days, increase joint lists, triangulating the workforce and consideration the capacity to open to 12 in the new year. The Board thanked JB for the update and acknowledged that due to the apologies received at the Board meeting today, representation from the Committee was lacking to provide assurance. It was therefore agreed that the presentation will be discussed in detail at the next meeting. 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: • Levels remains similar to July's performance. • Off framework has reduced. This has been a credit to the nursing team who continue to flexible to meet the needs of the service. • There has been a noted increase in the use within the AHP roles. This is the next focus area for the Trust and usage has been due to vacancies. The Board verbal update and asked for a report to be produced for the next meeting.
6.6	**Finance Performance Report**
	The Board considered the submitted paper and members noted the following points in particular: • It was noted to be another challenging month for the Trust – reporting £200k within month which is £0.5m cumulative off plan this year. • The main drivers being theatre activity due to the industrial action and annual leave. • The Trust confirmed that the overall income is adverse to plan. • Costs pressures have improved from last month, these are relating to OJP and agency usage. • Mitigations include private patients, interest receivables and releasing some balance sheet. • It was noted there is a 266-case shortfall which required further mitigation. • The Trust is expecting the industrial action to be mitigated however, this is to be confirmed and the Trust is still awaiting further information (this total approximately £3m) • A £2.1m residual risk related to the theatre development. • The Trust reported the organisation was under the agency cap in July and it is forecasting to be the same until the end of the financial year. The Board thanked MS for providing the update and commended the organisation for reducing the reliance upon the agency usage. It was noted that agency off framework is used when specialist care is required due to the nature and demand on the role. The Board welcomed a further update at the next meeting to include other mitigations identified to support the achievement of the plan.
6.7	**Finance Performance Report**
	Chair Report | Finance, Performance and Digital Committee The Board considered the submitted paper and members noted the following points in particular: • Mitigations have been identified for half of the productivity challenge which the Trust face – there is approximately a further 266 cases to mitigate. • The impact of the industrial action aligns to £1.7m adverse to plan. • There is a further financial risk that funding will not be received to support the shortfall. The Trust is awaiting the guidance. • The Committee confirmed the digital element on agenda has been realigned to the Digital, Research, Education and Innovation Committee. The Board approved the reviewed terms of reference. Following a discussion, the Board suggested the Trust revisits the policy relating to annual leave in order to demonstrate that we are reviewing all avenues. The Board discussed ensuring annual leave and school holidays are considered when planning the activity for the next year. The Board thanked MS and JB for their contribution to the meeting however asked for an in-depth discussion to be held at the next meeting relating to activity, long waiters, finances and assurance report.

Ref.	Discussion and Action Points
6.7.1	**Finance, Performance and Digital Committee Terms of Reference**
	The Board approved the revised terms of reference for the Finance and Performance Committee.
7.0	**Questions from the Public and the Governors**
	The governors raised the following comments: • Welcomed the Chief Nurse, Paul completing a walkabout on the MSCI wards yesterday afternoon – it was noted as encouraging and supportive. • Suggested an assurance report on a building within the Trust following the incidents with air rated concrete. The Trust welcomed the suggestion and noted the estates and facilities team are currently reviewing. 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 | 08 November 2023 | RJAH Conference Suite, Main Entrance

Board of Directors

Updated: 06 November 2023

Action Log No.	Original Meeting Date	Public or. Private	Minute reference	Action	By Whom	By When	Comments/Updates Outside of the Meetings	Status
6	05-Jul-2023	Public	Any Other Business	Board appraisal has been completed and there have been some recommendation suggested. A report to be shared with the Board at the next meeting (August)	Harry Turner	06-Sep-2023	On going	ONGOING
10	06-Sep-2023	Public	Patient Story	Visit Andrea Hughes on Sheldon Ward to gain feedback and improvement opportunities following the delivery of her patient story.	Paul Kavanagh Fields	04-Oct-2023	Complete	COMPLETED
11	06-Sep-2023	Public	IPC Feedback Letter	PFK to confirm with NHSE that the letter has been presented and discussed the Board meeting.	Paul Kavanagh Fields	04-Oct-2023	Complete	COMPLETED

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director – Public Meeting, 08 November 2023

Author:		**Contributors:**
Name:	Stacey Keegan	Chris Hudson,
Role/Title:	Chief Executive Officer	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	
NHS	National Health Service
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
AHP	Allied Health Professional
NJR	National Joint Registry
NOA	National Orthopaedic Alliance
GB	Great Britain

Chief Executive Officer Update

1. Adult Inpatient Survey

A definite highlight since our last public Board meeting was the publication of the Adult Inpatient Survey results for 2022. This came out in the middle of September and showed us to be delivering the best overall patient experience in the NHS in England for the fourth year in a row. The Adult Inpatient Survey is produced annually by the Care Quality Commission (CQC) and is based on feedback from more than 63,000 people who had a spell as a hospital inpatient during November 2022. RJAH has been named as one of just eight organisations placed in the top band of Trusts delivering results that are considered “much better than expected”, with patient experience that is substantially better than elsewhere. It is also classed as “much better” for the quality of its doctors, nurses, care and treatment, and operations and procedures. You will hear more about this later in today’s meeting.

2. Mike Carr appointed as Deputy CEO

I was delighted to announce last month that Mike Carr has been appointed to the post of Deputy Chief Executive, a role he is fulfilling alongside his substantive duties as Chief Operating Officer. Mike was appointed following a thorough interview which took place as part of a formal recruitment process, and I am pleased that he has accepted the position. He has made a significant contribution since taking up the post of Chief Operations Officer, and I know he will continue to do that – be that in tackling our challenges around waiting times, driving transformation in MSK care across Shropshire, Telford and Wrekin, or providing executive leadership to our Apollo Electronic Patient Record project. Now I look forward to his further leadership support in his expanded role as Deputy Chief Executive.

3. Simon Whitehouse appointed as substantive CEO for STW ICB

Last month Simon Whitehouse was appointed as the substantive Chief Executive of NHS Shropshire, Telford and Wrekin. Simon has over 30 years of extensive experience in the NHS and joined the system on 1 January 2022 as the interim Chief Executive Designate for the Integrated Care Board (ICB) to lead the organisation as it transitioned to a new statutory body.
The appointment follows a comprehensive recruitment process and was subject to sign-off by Amanda Pritchard, Chief Executive Officer of NHS England.

4. Trust Corporate Objectives 2023-2025

Following Board approval of the Trusts Corporate Objectives for 2023-2025, we have been undertaking engagement across the organisation with easy read infographics and visuals, designed by our Medical Illustration team. Feedback has been positive and it has been great to hear from staff how the objectives have been cascaded and have relevance and understanding for all staff groups and departments.

5. RJAH aiming to become accredited Elective Surgical Hub

RJAH has been selected to be part of the third cohort of organisations taking part in the Elective Surgical Hub accreditation scheme run by GIRFT (Getting It Right First Time). There are more than 90 Elective Surgical Hubs operating across the NHS in England, of which we are one. So far, only a handful have been successful in gaining this accreditation, which has been introduced to help patients get quicker access to common procedures. 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. We know we already deliver outstanding care – gaining this accreditation would be another positive confirmation of that. It is endorsed by the Royal College of Surgeons, which is another marker of its value and importance.

6. Patient Choice - PIDMAS

On Tuesday last week, a new national initiative was launched, aimed at offering patients a potential alternative choice of where to have their treatment. The Patient Initiated Digital Mutual Aid System (PIDMAS) has been created to help manage the process. Under this scheme, patients who have been waiting over 40 weeks for treatment and do not have an appointment date within the next eight weeks, could be eligible to request to move to a different hospital to be treated sooner. Those eligible are being contacted by the hospital and given a weblink and telephone number to submit a request to explore their options.

7. Launching the new Patient Safety Incident Response Framework (PSIRF)

October saw the launch of the new Patient Safety Incident Response Framework across the Trust. PSIRF replaces the Serious Incident Framework, which was first introduced by NHS England back in 2015. It sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF isn't just a framework, but a change in culture across the organisation around patient safety – it's all about how we can compassionately engage with staff and patients, as well as their families and carers, to understand what we can do better when something goes wrong and how we can make improvements.

8. National Orthopaedic Alliance Conference and Awards

Last month, I attended and presented at the National Orthopaedic Alliance's annual conference and its Excellence in Orthopaedics Awards event. It was great to see a large RJAH presence at the Conference – and especially to see RJAH staff presenting at the event. Highlights included Lisa Newton, one of our Assistant Chief Nurses, joining colleagues from ROH and RNOH to present an insight into orthopaedic and MSK nursing and Sarah Ford, Clinical Nurse Specialist, Transitional Care presenting the Transitional care work here at RJAH. We also had two finalists at the awards evening – for our Time To Care recruitment campaign, and for our cost of living work. Neither picked up the prize on the night, though I would say they are already winners for the impact they have had on the organisation with their work.

9. Employers Working in Partnership Award

We were delighted to receive the prestigious 'Employers Working in Partnership – Helping to Make our Community Safer' plaque from Shropshire Fire and Rescue Service (SFRS) recently. The award was presented to representatives who attended a glittering awards ceremony on behalf of the Trust. It was in recognition of the support given to Chloe Upton, a Project Support Officer here at RJAH, who also works as a retained firefighter with SFRS. Chloe was also presented with two awards at the SFRS Celebration of Success 2023, held at Theatre Severn in Shrewsbury. We will always strive to support our staff, and Chloe is a fine example of how to go above and beyond to support the local community.

10. Recruitment work

Last month saw our fourth and final recruitment day of the year as part of our Time To Care campaign that has run throughout 2023. It was another highly successful event, and I have been very pleased to see the enthusiastic buy-in we have had for these events from teams across the Trust. Our staffing numbers are up across pretty much every staff group, and you can feel that on the ground now when you are out and about talking to teams. Time To Care will carry on into 2024, and I look forward to seeing further progress.

11. League of Friends donations

We're always grateful for the support we get from our incredible League of Friends, and their latest donation has funded a state-of-the-art Anetic Aid Beach Chair Operating Table – equipped with a headrest and storage trolley – will be used by our Upper Limb Surgeons. This shoulder table helps the surgeons position the patient safely and securely, whilst allowing good access for keyhole or open shoulder surgery. The addition of this table takes our total up to two and will effectively double our capacity, meaning we can treat more patients in a day, reducing wait times and ensuring timely, high-quality care.

12. RJAH hailed as an exemplar for Catering standards

I was delighted last week to see the Trust formally accepted onto the NHS Exemplar Trusts Programme for Catering for their innovation, high food standards and consistent service in providing food for staff, patients and visitors. We are one of 21 Trusts nationally selected as exemplars, and will serve as a pilot site for national initiatives and feedback to the wider group to raise standards. We are involved with topics such as menu choices, staff training, food safety management, food waste and much more. "It's a real collaborative approach in a bid to share ideas and improve standards for the NHS nationwide.

13. NHS Chef of the Year

Linked to the exemplar catering programme, it has been fantastic to see Gill Owen and Dan Roberts, two of our chefs, competing in the national finals of the NHS Chef of the Year competition over the last couple of weeks. NHS Chef of the Year was launched in 2021 following recommendations in the Independent Review of NHS Hospital Food to support and develop hospital chefs and aims to raise their profile by giving them a platform to showcase their talent, skills and creativity. We are well known as a hospital for the quality of our food, so it was fantastic to see Gill and Dan flying the flag for the team. We couldn't be prouder of their achievements having got to the final rounds and down to the last five teams.

14. 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 September winner was Chloe Ellis, who is the Communications Manager within our Communications Team. She was nominated by Lake Beckley for her drive and determination to make a success of launching our LGBTQIA+ Training as part of our commitment under the Safe Ageing No Discrimination (SAND) Covenant. Chloe was described as a superstar for her hard work in making this happen.

- The October winner was Yasmin Heath, who works as a Charity Administrator in our League of Friends team and was nominated for her work in facilitating several initiatives – and especially our recent Togetherness Week. Her work to make this a success was done over and beyond her day job, and the way she managed the whole project was really quite outstanding.

Congratulations to both of our latest winners!

Board Assurance Framework Update

Committee / Group / Meeting, Date

Board of Directors, 8 November 2023

Author:

Name: Dylan Murphy
Role/Title: Trust Secretary

Contributors:

Mary Bardsley
Assistant Trust Secretary

Report sign-off:

N/A.

Is the report suitable for publication?:

YES, subject to removal of the detail of BAF 7 which contains "Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime".

Key issues and considerations:

1. The Board Assurance Framework (BAF) captures the risks to delivery of the Trust's strategic objectives. The current BAF was developed to reflect the 2022/23 objectives, as outlined in **Table 1**. The risks to delivery of those objectives – the BAF risks - are outlined at **Table 2.** These risks are each aligned to a committee of the Board.

2. The detail of the risks and associated mitigating actions etc. overseen by this committee is outlined at **Appendix 1**. Revisions since the last time they were presented to the Board are identified by tracked changes – new content in blue text; removed content in ~~struck-through, red text~~.

3. Though it is not captured as a risk in its own right, the industrial action undertaken in recent months has had a significant impact on the Trust's ability to deliver its plans. Actions have been undertaken to mitigate the impact of the unavailability of staff but there has been a significant impact on activity and associated income. In addition, ongoing industrial action poses a risk to overall staff wellbeing and satisfaction.

4. A revised set of corporate objectives covering the period to April 2025 has recently been agreed by the Board. These revised objectives are about to be launched. The Board has also recently held a workshop on its risk appetite. This will be developed further before approval and adoption by the Board. Once this risk appetite is agreed, a revised BAF will need to be developed to reflect that appetite and the updated corporate objectives.

5. Committees of the Board considered the elements of the BAF they oversee during the October round of meetings. Comments made during the discussion will inform the next iteration of the BAF. Points raised, which will be taken into account in developing a revised BAF, included:
   - It may now be possible to remove BAF 2, *The workforce does not have the required capacity and capability,* due to the good progress made in recruitment. That could now be considered business as usual but there would need to be a continued focus on retention.
   - Consideration could be given to amalgamating elements of BAF 1, *Lack of effective engagement with the workforce*, and BAF 3, *Failure to effectively promote equality, diversity and inclusion*, to reflect a focus on productivity and innovation within the workforce.
   - There were increasing pressures on activity and the financial position and thought should be given to how those should best be reflected in the BAF (as there were both immediate and long-term pressures to consider).
   - Thought could be given to reducing the score for BAF risk 4, *High levels of community infection,* due to the mitigations now in place.

Strategic objectives and associated risks:

This work has supported all of the Trust's objectives.

Table 1 – The Trust's strategic objectives (as reflected in the existing BAF)

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

Table 2 – The Trust's updated objectives (to April 2025)

1. Deliver high quality clinical services	
Ensure the highest standards of care for our patients.	• Delivery of Trust's Quality Improvement Priorities for 2023/24. • Implementation of Quality accreditation programme. • Roll-out of PSIRF. • Nursing & AHP Strategy and Quality strategy signed-off.
Empower departments to develop services	• Departmental-led implementation of clinical strategies. • Annual Departmental Business Plan in place for each Clinical service.
Optimise productivity and efficiency within our services	• Delivery of the performance, workforce, productivity and transformation schemes set out as part of the Trust's Operational plan. • Deliver Elective Hub efficiency standards.
Ensure a fair, equal and inclusive culture across the Trust	• Delivery of the Trust's Inclusion priorities for 2023/24.

2. Develop our Armed Forces and Veterans service as a nationally recognised centre	
Increase or workforce capacity to reflect service demand.	• Delivery of Consultant recruitment plan • with targeted consultant recruitment to reduce waiting times.
Develop our rehabilitation facilities	• Develop Business case for Veterans Rehabilitation service.
Maintain Veterans Accreditation standards	• Veterans accreditation training for new starters.
Strengthen partnerships with armed forces and veteran friendly organisations.	• Consider opportunities for future working with Headley Court charity and Ministry of Defence. • Develop links with GIRFT in line with the Improving Veterans MSK Rehabilitation Report.
3. Integrate MSK pathways across STW	
Lead the MSK Transformation Board and contributing to the delivery of the transformation programme.	• Establishing RJAH as the lead provider for MSK services through the development of a provider collaborative agreements. • Governance structure in place for the MSK transformation programme. • Work collaboratively to standardise pathways and equity of access for STW patients.
Work towards Elective Hub Accreditation.	• Self-assessment completed against the Elective Hub accreditation criteria.
4. Grow our services and workforce sustainably	
Recruit, support, retain and provide an exemplar experience for our staff	• Delivery of year 1 objectives contained within the RJAH People Strategy.
Optimise use of estate through capital investment & partnership working.	• Review opportunities to utilise estates and facilities within our geographical catchment to deliver services locally and in line with our Green Plan.
Expanding our reach and specialist expertise to other providers and sectors.	• Scope the appropriate resources and skills required to strengthen commercial and business expertise within the organisation.
5. Innovation & research at the heart of what we do	
Create the cultural environment to promote continuous Improvement.	• NHS Improvement Impact self-assessment to be completed. • Roll out continuous improvement training across all staff groups. • Establish Digital Education, Research and Innovation Committee.
Enhance capability and opportunities for research across all professions	• Increase Nurse and AHP led research. • Delivery of in-year objectives contained within the RJAH Research Strategy.
Optimise the potential of digital technologies to transform care	• Implementation of the EPR programme. • Appropriate digital training & awareness programme in place

Table 3 – BAF risks overseen by the Committees

The BAF risk scores are summarised in the table below which present the risk score, which is calculated by multiplying the consequence "C", by the likelihood "L":

Risk ref.	Title (Linked objectives)	Oversight Ctte	Inherent Risk (C X L)	Current Risk (C X L)	Target Risk (C X L)
BAF 1	Lack of effective engagement with the workforce (1,2,3,4,5)	P&C	(4 X 4) 16	(4 x 3) 12	(4 x 1) 4
BAF 2	The workforce does not have the required capacity and capability (1,2,3,4,5)	P&C	(4 X 4) 16	(4 X 4) 16	(2 X 2) 4
BAF 3	Failure to effectively promote equality, diversity and inclusion (1,2,3,4,5)	P&C / Q&S	(4 X 4) 16	(4 X 3) 12	(3 X 1) 3
BAF 4	High levels of community infection (1,5)	Q&S	(5 X 5) 20	(5 X 2) 10	(5 X 1) 5
BAF 5	Insufficient capacity to meet demand (1,3,5)	F&P	(4 X 4) 16	(4 X 4) 16	(4 X 1) 4
BAF 6	IT unable to support new ways of working (1,2,3,4,5)	DERIC / Q&S	(5 X 4) 20	(5 X 3) 15	(5 X 1) 5
BAF 7	Loss of data / inability to restore services following a cyber attack (1,3,5)	DERIC	(4 X 4) 16	(4 X 4) 16	(4 X 3) 12
BAF 8	Adverse impact of system financial deficit (1,2,3,4,5)	F&P	(5 X 4) 20	(4 X 4) 16	(3 X 2) 6
BAF 9	Inability to deliver year on year efficiencies and productivity gains (1,2,3,4,5)	F&P	(5 X 4) 20	(4 X 4) 16	(3 X 2) 6
BAF 10	Failure to comply with the NHSE regulatory requirements (1,4,5)	F&P	(5 X 4) 20	(5 X 2) 10	(5 X 1) 5

Table 4 – "Heat map" of current BAF risk scores

Likelihood	Consequence: (1) Insignificant	(2) Minor	(3) Moderate	(4) Major	(5) Catastrophic
(5) Almost certain					
(4) Likely				BAF 2 BAF 5 BAF 7 BAF 8 BAF 9	
(3) Occasionally / Possible				BAF 1 BAF 3	BAF 6
(2) Unlikely					BAF 4 BAF 10
(1) Rare					

Recommendations:

That the Board:

1) Consider the BAF risks, as presented at Appendix A, and:
   - REVIEW the risk scores, existing and planned control measures, and assurances;
   - CONSIDER any required revisions to the risk scores.
2) Consider the key risks that should be taken into account when developing the BAF for 2023-25

Report development and engagement history:

The BAF has been reviewed and updated by the relevant lead executive and extracts were reviewed by the Quality & Safety Committee; People & Culture Committee; Finance & Performance Committee; and Digital, Education, Research and Innovation Committee during their October meetings.

Next steps:

The BAF will be reviewed and updated to reflect the Trust's objectives for 2023-25 and the Trust's updated risk appetite statement. The updated BAF will be presented to the Board for consideration and adoption.

Work will continue to develop the presentation of the BAF in 2023-25.

Acronyms

BAF	Board Assurance Framework

Appendices

Appendix A	Board Assurance Framework (BAF)

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED - Lack of effective engagement with the workforce				BAF 1
IF	*Managers and clinical staff are unable to give sufficient time to engage with one another due to the pressure of operational and clinical duties…*			
THEN	*Opportunities for innovation / improvement will be missed and staff morale will deteriorate…*			
LEADING TO	*The loss of staff, which will exacerbate the pressures on existing staff and adversely affect the Trust's ability to deliver its objectives.*			
Linked Strategic Objectives:	1,2,3,4,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score *People (Workforce)*:	Appetite: Cautious Tolerance: Risk Score of 6 Rationale: We are prepared to take limited risks with regard to our workforce. If attempting to innovate, we would seek to understand where similar solutions had been successful elsewhere before taking any decision.			
Assurance Committee:	People and Culture Committee			
Executive Owner (strategic lead):	Chief People Officer			
Risk Owner (overall managerial lead):				
Date Opened:	August 2022	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	4			4
Likelihood	4	3	**< >**	3			1
Total	**16**	**12**	**< >**	**12**			**4**

< > = no change v = a positive downward change ^ = a negative upward change

Rationale for the current score, including an explanation of any movement:
Plans are in place and good progress has been made. A revised score is not suggested at this point but it should be possible to reduce the risk score at a future review date, when sustained improvements in retention can be evidenced.

REVISED - Lack of effective engagement with the workforce | BAF 1

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	Rolling half days		
C 2	Monthly Trust Management Group meeting to include Clinical Leads		
C 3	Staff briefing open to all staff		
C 4	Appointment of COO and strengthened operational team		
C 5	Ward / department buddying by Executive Team		
C 6	Communications and engagement strategy		
C 7	Performance framework in place		
C 8	Weekly update from CEO		
C 9	Comms bulletin		
C10	Q&A sessions with members of the Executive Team		
C11	Awards/Health Heroes		
C12	Freedom to Speak up initiative		
C13	'Chats with Harry'		
C14	Exec and NED board day walkabouts		

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
P 1	Listening in action framework to be established The Trust is developing its Engagement Strategy/ plan for staff derived from staff feedback both direct and via implementation of App approach - LivingWell	Chief People and Culture Officer	~~Mar 23~~ May 23 July 23	Staff listening session to be developed as part of the wider people engagement support. Listening events will support shape what staff need and steer the overall people agenda for the Trust. Feedback extended beyond and EDI agenda and will feed into wider engagement plan. Implementation Group and rollout programme being developed with provider.
P 2	Leadership Training	Chief People and Culture Officer	May 23 July 23	Leadership course has been advertised across the organisation. Cohort 1 is to be the pilot for the training. Dates have been secured in the diary. Confirmation of delegates to be confirmed and invited. We are currently on cohort 5, with cohort 6 due to start in September, 55 will have then completed all three sessions.

BAF Risks, controls and assurances – OCT/NOV 2023

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
				We are planning to start cohort 7 in September with a target of 15 per cohort. It was originally estimated that we would need 237 to complete which leaves 182 so we will need an additional 12 cohorts.
P 3	Staff wellbeing work / cost of living support / staff career cafes … etc.		January 23 July 23 Sept 23	Cost of Living Programme includes; Free Breakfast, Subsidised meals, Finance advice. Career Cafes commenced for registered nursing/ Therapy colleagues to provide safe space to discuss career change or development opportunities for staff. To be extended to other staff groups

Sources of assurance	
Ref:	**Description**
A1	Medical Advisory Committee overseeing engagement with management
A2	Regular updates to People and Culture Committee and the Board
A3	NHSE Quarterly System Review Meetings
A4	Staff Survey
A5	NHS Oversight Framework
A6	Oversight from People and Culture Committee
A7	Health and Safety Committee oversight of staff health
A8	JCGroup partnership working

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls / assurances		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
~~**G 1**~~	~~Control: Staff experience group not established – consider shared governance model~~	
G 2	Control: Leadership training and bite-sized modules for wider organisation	
G 3	Assurance: Lack of real-time measure of workforce engagement levels (all staff)	
G 3	Assurance: Responding to staff concerns in a timely manner	

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED – The workforce does not have the required capacity and capability				BAF 2
IF	*The Trust does not have an adequate workforce strategy, including recruitment, succession and talent management plans in place…*			
THEN	*Its workforce will not have the required skill mix, leading to deterioration in staff morale, resulting in increased turnover and a lack of innovative roles to attract staff to the organisation (or retain existing staff) ...*			
LEADING TO	*An inability to maintain services / increase activity to meet national targets, resulting in further regulatory scrutiny; poor patient experience; and potential patient safety risks.*			
Linked Strategic Objectives:		1,2,3,4,5		
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score People (Workforce):		Appetite: Cautious Tolerance: Risk Score of 6 Rationale: We are prepared to take limited risks with regard to our workforce. If attempting to innovate, we would seek to understand where similar solutions had been successful elsewhere before taking any decision.		
Assurance Committee:		People and Culture Committee		
Executive Owner (strategic lead):		Chief People Officer		
Risk Owner (overall managerial lead):				
Date Opened:	April 2021	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	4			2
Likelihood	4	4	**< >**	4			2
Total	**16**	**16**	**< >**	**16**			**4**

< > = no change **v** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
Workforce plans are in place and good progress has been made with the recruitment pipeline. A revised score is not suggested at this point but it should be possible to reduce the risk score at a future review date, when sustained improvements can be evidenced.

REVISED – The workforce does not have the required capacity and capability | BAF 2

Pre-existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C1	Recruitment plans to target vacancy hotspots		
C2	Sickness absence management relaunch		
C3	Staff turnover monitoring including exit interviews and 'itchy feet' conversations		
C4	Leadership training to support effective management and engagement of staff – compulsory for all managers		
C5	Business Continuity Plans		
C6	KPI in place for overtime hours by unit, sickness absence (including reasons)		
C7	IPR includes breakdown of activity for IJP & OJP at point of delivery		
C8	Recruitment timeline KPIs		
C9	Vacancy rates by professional staff group		
C10	Nursing associate roles now in training		
C11	Nursing strategy on a page		
C12	Nominated EPRR Lead appointed		
C13	Professional Development Review Compliance		

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
P 1	Ward and Theatre establishment review to be complete	Chief Nurse and Patient Safety Officer	~~Jan 2023~~ ~~Mar 2023~~ ~~Apr 2023~~ Jun 2023	Theatre establishment review to be confirmed. Theatre recruitment and theatre workforce model paper to be presented to the QS Committee ~~in April~~ before onward reporting to Board. Ward establishment review has been completed - actions are underway.
P 2	Review of workforce assurance	Chief People and Culture Officer	~~Feb 2023~~ Jun 2023	Additional resource to support the review of people services including people service policies. Review of people services has been completed with additional support gained externally. Key posts being recruited to. Benchmarking resources and gaps are being mitigated
P 3	Review of application of the flexible working policy	Chief People and Culture Officer	~~Feb 2023~~ ~~Apr 2023~~ ~~Jun 2023~~	A review is due to be undertaken in June.

BAF Risks, controls and assurances – OCT/NOV 2023

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
			August 2023	
P 4	People Services capacity to be reviewed	Chief People and Culture Officer	Jun 2023	Funding has been secured to support the recruitment within the people services department. A verbal update to be provided to the People and Culture Committee for oversight. Gaps are being mitigated until recruitment is complete.
P 5	Workforce improvement plan – to be considered by the Committee	Chief Nurse and Patient Safety Officer	~~Jan 2023~~ ~~Mar 2023~~ ~~Apr 2023~~ Jun 2023	Theatre establishment review to be confirmed. Theatre recruitment and theatre workforce model paper to be presented to the QS Committee before onward reporting to Board. Ward establishment review has been completed - actions are underway.
P 6	Development of new/supporting roles and apprenticeships would be appropriate	Chief People and Culture Officer	July 2023	

Sources of assurance	
Ref:	**Description**
A1	Performance report
A2	Safe staffing audits
A3	People and Culture Committee oversight
A4	Agency usage monitoring
A5	Independent review of e-rostering
A6	Turnover and sickness absence rates
A7	Recruitment working group
A8	Quarterly review of Nursing and Midwifery retention tool

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 1	Control: Unit level workforce plans aligned to operational activity	
G 2	Control: Exit interview completion and themes	
G 3	Control: People Services team resource and capacity	
G 5	Control: Unit level workforce plans aligned to operational activity	
G 6	Assurance: Alignment of workforce to optimise capacity	
G 7	Assurance: Workforce plan monitoring triangulated with activity and quality	
G 8	Assurance: Succession plan	

BAF Risks, controls and assurances – OCT/NOV 2023

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 9	Assurance: Talent management strategy	
G10	Assurance: CPD gaps and allowance of time	
G11	Assurance: Recruitment process assurance -line of sight on milestones	
G12	Assurance: Escalation process for staffing rota concerns	

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED - Failure to effectively promote equality, diversity and inclusion				BAF 3
IF	*The Trust does not have effective strategies / plans in place to promote equality, diversity and inclusion…*			
THEN	*Staff will not feel valued and will have a poor experience at work, adversely affecting morale, increasing sickness absence and turnover and resulting in poor staff survey results; It will not be an attractive employer for potential staff;* *It will not be able to identify and address inequalities in the provision and outcome of services…*			
LEADING TO	*Reputational damage, affecting the Trust's ability to retain / recruit staff (and therefore its ability to deliver its objectives); variable experiences / outcomes for patients; potential non-compliance with statutory and regulatory requirements.*			
Linked Strategic Objectives:	1,2,3,4,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score People (Workforce):	Appetite: Cautious Tolerance: Risk Score of 6 Rationale: We are prepared to take limited risks with regard to our workforce. If attempting to innovate, we would seek to understand where similar solutions had been successful elsewhere before taking any decision.			
Assurance Committee:	People and Culture / Quality and Safety			
Executive Owner (strategic lead):	Chief People Officer			
Risk Owner (overall managerial lead):				
Date Opened:	April 2021	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	4			3
Likelihood	4	3	**< >**	3			1
Total	**16**	**12**	**< >**	**12**			**3**

< > = no change **v** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
Plans are in place and good progress has been made. A revised score is not suggested at this point but if planned work delivers the expected results, it should be possible to reduce the risk score at a future review date.

REVISED - Failure to effectively promote equality, diversity and inclusion | BAF 3

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	ED&I Committee members taking ownership to drive the agenda forward		
C 2	NHS Standard Contract requirements		
C 3	System transformation work (includes consideration of health inequalities)		
C 4	Accessible Information Standards - regular reviews		
C 5	PLACE assessments		
C 6	ED&I training (ICS) and Veteran Awareness training		
C 7	Data quality improvement plan including ethnicity and deprivation index		
C 8	Menopause awareness		

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target Date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
P 1	ED&I resource to be secured	Chief People and Culture Officer	~~Jan 2023~~ Jun 2023	The Trust are reviewing other options regarding EDI leads. Chief People and Culture Office recruitment re-started in February 2023 External EDI project lead in Trust in April to take forward EDI strategy and engagement Senior EDI Lead post secondment starts Sept 2023 for 12 months to lead this agenda
P 2	Health inequalities working group to be established	Chief Nurse and Patient Safety Officer	~~Jan 2023~~ Mar 2023	Request for RJAH to join Healthy Lives Steering Group (ICS). Nominated staff to join the meeting and terms of reference have been drafted
P 3	EDS 2022 self-assessment and action plan – Complete an assessment against the EDI framework	Chief Nurse and Patient Safety Officer	May 2023	Healthwatch are facilitated patient led workshops in March 2023 as part of the assessment. Aiming to present to the Patient Experience Committee in May
P 4	Review of all staff networks	Chief People and Culture Officer	~~Feb 2023~~ May 2023	Discussed at December EDI Committee – proposal to have one inclusion network which will be a topic at the listening events to gain a view from staff New format EDI Meeting scheduled 17 Aug.

BAF Risks, controls and assurances – OCT/NOV 2023

Sources of assurance	
Ref:	**Description**
A1	Staff surveys/pulse surveys
A2	NHSE oversight/ NHS Oversight Framework
A3	People and Culture Committee
A4	System People Board and establishment of a System People Committee
A5	Executive lead in place both for patients and staff
A6	ED&I Committee oversight
A7	WRES, WDES and EDS 2022 returns
A8	Bi-annual report on health inequalities (includes digital exclusion)
A9	Monthly EDI reports to People and Culture Committee

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 3	Control: Talent Management	
G 5	Assurance: Effectiveness of ED&I Committee	

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED - High levels of community infection				BAF 4
IF	*There is high prevalence of respiratory infection in the community…*			
THEN	*There may be an in increase in staff absence, an increased potential for respiratory outbreaks and reduced capacity in the Infection Prevention and Control team to deliver routine IPC services…*			
LEADING TO	*An adverse impact on service delivery, patient safety and experience with increased scrutiny from regulators to ensure the Trust is managing the outbreak effectively*			
Linked Strategic Objectives:	1,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score Quality (Outcomes):	Appetite: Cautious Tolerance: Risk Score of 6 Rationale: 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.			
Assurance Committee:	Quality and Safety			
Executive Owner (strategic lead):	Chief Nurse and Patient Safety Officer			
Risk Owner (overall managerial lead):				
Date Opened:	April 2021	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5	**< >**	5	< >	5	5
Likelihood	4	3	**V**	2	< >	2	1
Total	**20**	**15**	**V**	**10**	< >	**10**	**5**

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
The national and local position is less severe than it was. The Trust has made significant progress in terms of IPC. Consideration could be given to further reducing the score if/when the national situation changes.

REVISED - High levels of community infection — BAF 4

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	External support from NHSE/I	Regulators	Meeting minutes
C 2	Alignment to Clinical Governance from 1 April 2022		
~~**C 3**~~	~~Investment in the IPC team~~		
C 4	IPC Governance role established		
C 5	Quality Management System		IPC Board Assurance Framework reporting
C 6	IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review	DDIPC	IPCWG, IPC Meeting and Q&S Committee minutes
C 7	Deputy DIPC recruited in partnership with Shropshire Community Trust	DIPC	IPCWG, IPC Meeting and Q&S Committee minutes 1:1
C 8	~~Increased~~ IPC staff training programme	IPC Team People Team	Training compliance reported through IPCM and Q&S Committee minutes
C 9	~~Learning from previous SI's – actions completed~~ Shared learning from previous outbreaks	IPC Team	Outbreak Minutes
C10	Compliance with ~~Covid guidance~~ National guidance and National IPC Manual	IPC Team	Health and Social Care Act and IPC BAF compliance report through Q&S Committee
C11	Sickness policy and communication in place to advise and guide staff	People Team	
C12	~~Risk assessments~~ Respiratory illness risk assessment and recommendations in line with Hierarchy of Controls to minimise spread of respiratory viruses	IPC Team	Respiratory Policy and Outbreak Meeting Minutes
C13	~~Flu campaign~~ Staff Flu vaccination campaign	People Team	
C14	~~Covid booster~~ Staff Covid vaccination programme	People Team	
C15	IPC ICS Meeting to share information and guidance	DDIPC and IPC Team	IPC ICS Meeting minutes
C16	NHSE monitoring and reporting of respiratory viruses (nationally and internationally) on emerging threats, risk and mitigations	DDIPC and IPC Team	Updates through SNAHP and IPCWG
C17	Updates through SNAHP and IPCWG	IPC Team	Policy available online

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / impact –** *when will the measure be in place / what impact will it have?*
P 1	Progress with improvement action plan	Chief Nurse and Patient Safety Officer	Complete	Reported through IPC Quality Assurance Committee. ~~The reporting continues, IPC Quality Assurance Committee has been extended to March 2023. To be aligned to the IPC Quality Assurance Committee~~

				Undertaking letter received from NHSE. Review of the IPC QA Committee presented at the Feb meeting. Confirmation received from NHSE that undertakings achieved. Dedicated Board committee to oversee IPC Quality Assurance stood down. IPC Quality assurance is ongoing but now reporting via the Quality and Safety Committee.

Sources of assurance	
Ref:	**Description**
A1	IPC Quality Assurance Committee
A2	Increased committee reporting
A3	External clinical governance review with focus on IPC commissioned
A4	People and Culture Committee oversight
A5	IPC Board Assurance Framework
A6	Flu and Covid Vaccination update report
A7	Gap analysis against the hygiene code

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 1		
G 2		
G 3		
G 3		

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED - Insufficient capacity to meet demand				BAF 5
IF	*The Trust does not have sufficient capacity….*			
THEN	*It will be unable to restore activity levels to the levels outlined in the activity plan…*			
LEADING TO	*Increased waiting times; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from system partners / regulators resulting in reputational damage (affecting the Trust's ability to retain and recruit staff and deliver its objectives).*			
Linked Strategic Objectives:	1,3,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score Quality (Outcomes):	Appetite: Cautious Tolerance: Risk Score of 6 Rationale: 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.			
Assurance Committee:	Finance and~~,~~ ~~Planning~~ Performance ~~and Digital~~			
Executive Owner (strategic lead):	Chief Operating Officer			
Risk Owner (overall managerial lead):				
Date Opened:	November 2020	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	4	< >	4	5
Likelihood	4	4	**< >**	4	< >	4	1
Total	**16**	**16**	**< >**	**16**	< >	16	**5**

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
The current score remains at the previous level while the workforce recruitment work progresses. It is anticipated that, given the workforce recruitment pipeline, it may be possible to reduce this score during the next quarterly review. Good progress has been made in retaining and recruiting staff but slippage in activity has resulted in a shortfall and there will be insufficient capacity to recover the position.

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED - Insufficient capacity to meet demand			BAF 5
Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	Demand and capacity modelling at local level		
C 2	Monitoring of efficiency KPIs		
C 3	6-4-2 implemented		
C 4	Recovery programmes in place for Outpatients, Theatres and Diagnostics		
C 5	Weekly tactical restart activity meeting		
C 6	Key restoration of capacity KPIs		
C 7	Weekly meetings for management of delayed discharges		
C 8	Daily dashboards		
C 9	Outpatient room usage report in place		

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target Date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
P 1	Establish reporting on impact of complexity and consider mitigating actions	Chief Medical Officer	~~Jan 22~~ ~~Apr 2023~~ Complete	~~A verbal updated was presented to the QS committee previously. Paper to be presented in April 2023 which outlines no difference has been noted.~~ A verbal update was presented to the Q&S Committee in February, followed by a paper at Q&S in April 2023. The paper showed the amount of complex surgery undertaken has risen steadily since 2004/05 but has remained relativity stable over the last 6 years. The Committee has request 6 monthly updates, plus further exploration of the impact of complexity, such as LOS at time in theatre and social demographic that may contribute to increased complexity.
P 2	All job plans to be signed off by e-job planning	Chief Medical Officer	~~Ongoing~~ July 2023	Tracking of this to be looked at so that there is line of sight. Allocate is being used to support. Job plans signed off total 26. 1 waiting 3rd sign off. 25 waiting 2nd sign off (MJPCC). 17 awaiting 1st sign off (clinical). 2 waiting 1st sign off by manager. 25 in discussion and 12 expire – need to be renewed.
P 3	Revising STW MSK model	Chief Operating Officer	~~Feb 2023~~ Jun 2023	~~Actions related to phase one due to be launched on 01/02 – future phases are to be confirmed~~ RJAH confirmed as strategic lead for MSK services across STW, delivery timetable in place across 2023/24.
P 4	Optimising internal capacity (theatre)	Chief Operating Officer	~~Dec 2022~~ Aug 2023	~~Theatre workforce review has been completed. Action plan in place. – **ongoing process.**~~ Ongoing theatre productivity plan in place to increase throughput, RJAH performing favourable against GIRFT theatre utilisation metrics.

BAF Risks, controls and assurances – OCT/NOV 2023

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target Date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
			Jan 2024	Recruitment focus in 2023/24 weighted towards theatre and reopening 12th theatre and staffing the additional 13th theatre from January. There is now an executive-led theatre user group focused on addressing a range of operational issues within theatres.
P 5	Optimising internal capacity (inpatient beds)	Chief Operating Officer	~~Jan 2023~~ Apr 2023 Jul 2023	~~Review opportunities to increase day case activity and reduce length of stay.~~ Enhanced recovery programme commenced April 2023. Ongoing work to increase day case rates.

Sources of assurance	
Ref:	**Description**
A1	Monthly Performance Improvement Board oversight
A2	Inpatient Survey Performance
A3	System and regulatory oversight
A4	Internal audit regarding job planning
A5	Patient Experience Committee oversight
A6	Finance, Planning & Digital Committee oversight
A7	Outpatient Transformation Board restored
A8	STW Planned Care Delivery Board Oversight
A9	System Governance Framework
A10	Integrated Performance Reporting
A11	Consultant annual leave reporting through People Committee
Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 1	Control: Impact on capacity of increasing complexity of cases due to increased waiting times	
G 2	Control: Implementation of current job planning policy	
G 3	Control: Inability to meet target for reducing number of patients who no longer meet 'criteria to reside'	
G 4	Control: Revising STW orthopaedic model	

REVISED – IT unable to support new ways of working				BAF 6
IF	*The development of IT is hampered by financial constraints, inability to recruit staff with the required skills, or ineffective working with partners across the system…*			
THEN	*IT capacity and functionality will be limited; the roll-out of the Electronic Patient Record will be compromised; and digital innovation will be limited…*			
LEADING TO	*A failure to deliver more efficient practices; inability to improve the patient experience; failure to meet the accessible information standards.*			
Linked Strategic Objectives:	1,2,3,4,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score Financial Risk / Value for Money:	Appetite: Open Tolerance: Risk Score of 9 Rationale: 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.			
Assurance Committee:	Finance, Planning and Digital / Quality and Safety			
Executive Owner (strategic lead):	Chief Medical Officer			
Risk Owner (overall managerial lead):	Digital Director			
Date Opened:	August 2022	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5	**< >**	5			5
Likelihood	4	3	**< >**	3			1
Total	**20**	**15**	**< >**	**15**			**5**

< > = no change **v** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
The original business case for EPR included a provision for staff and that project is progressing (including staff training). For new projects, due to a competitive labour market, it is difficult to recruit to IT roles as they can attract a significant premium.

REVISED – IT unable to support new ways of working | BAF 6

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	Digital Transformation Programme Board in place to review Digital plans, risks and progress including prioritisation.		
C 2	Workforce plan agreed for life of programme		
C 3	Digital Steering Group in place for operational delivery		
C 4	Sub groups as created by Digital Transformation Programme Board to oversee delivery of EPR implementation		
C 5	Digital Strategy and Roadmap in place 2018 – 2023		
C 6	Programme plan in place		
C 7	Outpatient processes to identify and flag patient needs before admission		
C 8	Accessible Information Working Group established		
C 9	Translation and interpretation services available		
C 10	EPR Training and awareness sessions to be scheduled prior to go live		
C 11	Functional design groups running to look at current and future state of EPR		
C 12	Recruited an EPR Trainers / Training Lead		

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
P 1	EDS 2022 self-assessment and action plan – Complete an assessment against the EDI framework	Chief Nurse and Patient Safety Officer	~~March 2023~~ May 2023	Healthwatch are facilitated patient led workshops in ~~March~~ May 2023 as part of the assessment. (date was postponed due to adverse weather)
P 2	Progress with EPR Solution - Functional design groups and training to ensure staff are enabled to use digital platforms. The EPR programme was resourced to deliver the agreed programme.	Director of Digital	~~Ongoing~~ Apr 2024	Programme in place with monitoring via Digital Group and FPD. Started in December 2023 with an expected completion date prior to go live
P 3	Contacts are being made with students / Digital, Data and Technology (DDAT) graduates through NHSE.	Director of Digital	Complete	

BAF Risks, controls and assurances – OCT/NOV 2023

Sources of assurance	
Ref:	**Description**
A1	ICS Digital Strategy Board
A2	Digital Transformation Board oversight reporting to FPD Committee
A3	New EPR contract includes ability to meet Data Standard Notices
A4	Oversight of Accessible Information Group and Patient Panel
A5	Regular reporting on progress of EPR (provided monthly) to the FPD Committee
A6	Digital Transformation Board meets monthly and has a sub group to review risks, including staffing

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 2	Assurance: Monitoring of additional patient needs to ensure services and facilities are suitable to meet the needs of patients	

REVISED - Adverse impact of system financial deficit				BAF 8
IF	*The triple lock process implemented to tackle the system financial deficit requiring three tiers of authorisation (Organisation, System and Regulator), results in approved investments being paused, pending identification of system funding…*			
THEN	*Essential investment may be delayed or rejected …*			
LEADING TO	*Inability to deliver the Trust's objectives, resulting in adverse impact on patient care / patient experience etc.*			
Linked Strategic Objectives:	1,2,3,4,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score Financial Risk / Value for Money:	Appetite: Open Tolerance: Risk Score of 9 Rationale: 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.			
Assurance Committee:	Finance and ~~, Planning~~Performance ~~and Digital~~			
Executive Owner (strategic lead):	Chief Finance and Planning Officer			
Risk Owner (overall managerial lead):	Operational Director of Finance			
Date Opened:	August 2022	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	4	**< >**	4	< >	4	3
Likelihood	4	4	**< >**	4	< >	4	2
Total	**20**	**16**	**< >**	**16**	< >	**16**	**6**

< > = no change **V** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
The consequence is severe as it could lead us being in breach of our statutory requirements. The likelihood is lower as we have set precedent with the housekeeping investment which was eventually approved on the back of compliance although it should be noted there were still significant delays.

REVISED - Adverse impact of system financial deficit | BAF 8

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	Investment Decision making policy	RJAH CFO	Policy in date and amended to reflect triple lock requirements
C 2	Triple lock process for new investments	ICB CFO	Policy in place and precedent set on compliance issues
C 3	System financial improvement plan	ICB CFO/ Provider CFO's	Ongoing discussion across ICB/Escalation meets with NHSE to track progress.

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / impact –** *when will the measure be in place / what impact will it have?*
P 1	Ongoing discussions/engagement with NHSE regarding financial performance of ICS – now escalated to the national team	Chief Finance and Planning Officer	ongoing	~~RJAH improved on plan by £1.1m with a further £0.6m proposed non recurrently relating to Annual Leave accrual release for non clinical roles. Regular check in's on progress with NHSE and updates provided to RJAH FPD Committee ICS expecting to out-turn at £65.5m deficit for 2022/23 (RJAH component a surplus of £2.4m). Attention has switched to 2023/24 with a submitted plan of £76.9m deficit for the ICS (RJAH component £0.4m deficit) System remains in escalation and regular meets with NHSE Regional and National Team~~. System Plan agreed for £60m deficit for 23/24 subject to conditions regarding enhanced controls. Medium Term financial plan under development with a requirement to return to a sustainable break even position. Forecast outturn scenarios under discussion for 23/24, likely to exceed planned deficit by material amount, will further effect investment prioritisation and autonomy for ICS and partner organisations.
P 2	~~Recurrent rollover financial plan to be agreed for all ICB partners as part of 23/24 planning process~~ Delivery of RJAH 2023/24 Financial Plan	Chief Finance and Planning Officer	~~March 2023 Complete~~ March 2024	~~Complete as part of Operational Plan submission – Cost pressures of £1.5m recognised offset by an efficiency programme of 3% £0.3m off plan at month 2 linked to Industrial Action impact on activity/income. Risks to delivery (unmitigated) identified as £2.4m with continued internal review for opportunities to mitigate~~. £2.1m adverse to plan at month 6. Forecast outturn scenario's modelled with challenges expected to continue into H2 with continued industrial action, inflation and casemix pressures. All scenarios make investment and management of financial risk extremely challenging.

BAF Risks, controls and assurances – OCT/NOV 2023

P 3	~~Re-assessment of financial gap for 23/24 based on confirmed system allocation and agreement of organisational share of expected shortfall between ICB partners under Intelligent Fixed Payment System~~ Full implementation and embedding of enhanced financial controls as per planning conditions letter	Chief Finance and Planning Officer	~~March 2023~~ ~~Complete~~ August 2023 December 2023	~~Complete as part of Operational Plan submission. IFP methodology amended so that income earned under PbR excluded from baseline. RJAH taking a £2m hit from the system deficit within the 23/24 plan~~ Self assessment undertaken against planning conditions and additional controls to be introduced regarding agency sign off, establishment and non pay. Controls implemented August 2023. Further 48 financial controls issued by NHSE, self assessment undertaken to assess compliance. Further actions required to address requirements with leads and due dates agreed.

Sources of assurance	
Ref:	**Description**
A1	Executive Team scrutiny and approval process for all investment cases proposed
A2	Finance Planning and Digital Committee scrutiny and approval for cases over £250k
A3	Investment Panel within ICS comprises multi-disciplinary roles from each partner with agreed prioritisation protocol
A4	QEIA process in place
A5	IPC investment approved following amendments to triple lock process based on regulatory/safety concerns

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 1	Control: Unmitigated financial risks within RJAH stands at £2.4m ~~the ICS currently stand at £59m which is preventing routine investments from occurring~~	Full implementation of enhanced financial controls as required by NHSE planning conditions. Escalation of the impact of issues outside RJAH control to ICB/NHSE. Guidance on treatment of industrial action impact from a financial perspective remains outstanding.
G 2	Assurance: Fully mitigated ~~ICS~~ financial plan ~~– ongoing discussions with NHSE~~	Transparent reporting of issues/risks/opportunities through FPD/NHSE monthly reports.

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED - Inability to deliver year-on-year efficiencies and productivity gains				BAF 9
IF	*We do not achieve our efficiency targets included in the financial plan…*			
THEN	*We will not achieve our plan and face a legacy impact into next year as well as failing our statutory requirement to deliver a balanced financial position…*			
LEADING TO	*NHSE breach of statutory duties/increased intervention*			
Linked Strategic Objectives:	1,2,3,4,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score Financial Risk / Value for Money:	Appetite: Open Tolerance: Risk Score of 9 Rationale: 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.			
Assurance Committee:	Finance and ~~, Planning~~Performance ~~and Digital~~			
Executive Owner (strategic lead):	Chief Finance and Planning Officer			
Risk Owner (overall managerial lead):	Operational Director of Finance			
Date Opened:	August 2022	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	4	**< >**	4	< >	4	3
Likelihood	4	4	**< >**	4	< >	4	2
Total	**20**	**16**	**< >**	**16**	< >	16	**6**

< > = no change **v** = a positive downward change **^** = a negative upward change

Rationale for the current score, including an explanation of any movement:
The 2023/24 efficiency plan requires an additional stretch target to be achieved in excess of national requirements. ~~Around £0.5m is currently unidentified and will likely need non recurrent schemes to address~~. Around £0.4m is red rated half way through the year and £0.4m is non recurrent. Productivity improvements built into inpatient and outpatient planning assumptions are not delivering to date.

REVISED - Inability to deliver year-on-year efficiencies and productivity gains | BAF 9

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	Cost improvement schemes identified	Chief Financial officer	Targets devolved to units and performance tracked/reported monthly with escalation to FPD when required
C 2	Access to good quality benchmark information as per model hospital	Chief Operating Officer	Regular reports to FPD
C 3	Tracking of theatre productivity	Chief Operating Officer	Regular reports to FPD
C 4	Risks reviewed on a monthly basis and addressed through performance reviews	Chief Financial officer	Regular reports to FPD
C 5	Agency controls in place	Chief Nurse	Temporary staffing policy updated and Regular reports to People Committee

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / Impact –** *when will the measure be in place / what impact will it have?*
P 1	Productivity improvements to be incorporated 23/24 Operational plan as part of overall delivery plan Monitoring of planning assumptions versus actual to ensure prompt intervention where required	Managing Director for Strategy and Planning	~~March 2023~~ ~~Complete~~ Ongoing	~~Completed with identified monitoring in place for 22/23 against the planned productivity benefits identified.~~ Regular reports are standing agenda items for Board and its sub committees
P 2	Efficiency target gaps to be identified ~~to be assessed and agreed for 2023/24 based on national planning guidance~~	Chief Finance and Planning Officer	~~March 2023~~ ~~Complete~~ Ongoing	~~Efficiency programme of 3% agreed for 2023/24 against a minimum national requirement of 2%. Schemes fully identified~~ Continued focus on identifying new efficiency opportunities to meet stretch target – regular updates provided to Trust Performance and Improvement Board and FPD.

Sources of assurance	
Ref:	**Description**
A1	~~SLG~~ Exec Team Oversight
A2	Finance Planning and Digital Committee oversight
A3	Scrutiny at organisation, system and regional level of delivery of the financial plan
A4	Monitoring of CIP delivery via performance meetings
A5	System wide transformation Boards including MSK

BAF Risks, controls and assurances – OCT/NOV 2023

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 1	Control: Agency spend running ahead of control limit driven by workforce pressures	Agency Improvement task and finish group established to oversee planned reductions/improvements
G 2	Control: Agency spend contains off framework agency which is no longer allowed by NHSE	Agree exit date for usage of off framework agency linked to recruitment pipeline

BAF Risks, controls and assurances – OCT/NOV 2023

REVISED – Failure to comply with NHSE regulatory requirements				BAF 10
IF	The Trust does not comply with the requirements of the NHSE System Oversight Framework.			
THEN	It will be subject to increased levels of support / oversight from NHSE and may breach its license.			
LEADING TO	Reduced autonomy to act and reputational damage, adversely affecting the Trust's ability to recruit and retain staff and deliver its objectives.			
Linked Strategic Objectives:	1,4,5			
Linked System Objectives / Risks:				
Risk Appetite / Target Risk Score Compliance Regulation:	Appetite: Cautious Tolerance: Risk Score of 6 Rationale: 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			
Assurance Committee:	~~Quality and Safety~~ Finance and~~,~~ Performance ~~and Digital~~			
Executive Owner (strategic lead):	~~Chief Nurse and Patient Safety Officer~~ Chief Operating Officer			
Risk Owner (overall managerial lead):				
Date Opened:	August 2022	**Date Last Reviewed by the Board:**	~~May~~ August 2023	
		Date Last Reviewed by the assurance Committee:	~~April~~ July 2023	

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	5	**< >**	5			5
Likelihood	4	3	**< >**	2			1
Total	**20**	**15**	**< >**	**10**			**5**

< > = no change **V** = a positive downward change **Λ** = a negative upward change

Rationale for the current score, including an explanation of any movement:
Reduced in April due to official step down following the completion of the IPC undertakings and the Trust providing evidence of sustained improvement. The other key focus area relates to failure to meet referral to treatment targets. The Trust has completed a significant amount of work in relation to this and there are only a small number of patients waiting for treatment (outside of the NHSE waiting targets for English patients). The Trust is on trajectory to meet the 65 week wait target by the end of 2023/24. This performance has been acknowledged as the Trust is no longer required to attend the regional elective care "Tier 2 support" meetings. The Trust has self-assessed that it should be moved from segment 3 to segment 2 of the Oversight Framework but awaits the outcome of the assessment.

REVISED - Failure to comply with NHSE regulatory requirements | BAF 10

Pre-Existing Controls			
Ref.	**Description –** *what measures are in place to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Assurances / impact –** *what evidence do we have that this is taking place / what impact it is having? Include source of assurance reference where appropriate.*
C 1	IPC Governance role established		
C 2	Quality Management System - IPC dashboard		
C 3	IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review		
C 4	Senior IPC/ Deputy DIPC recruited in partnership with Shropshire Community Trust		
C 5	Temperature checks using sustainability tool for IPC improvements		
C 6	Identification of gaps against NHS Oversight Framework		
C 7	CQC action plan and Niche well led review action plan		
C 8	CQC engagement meetings		

Planned Controls (since adding to BAF)				
Ref.	**Description –** *what further measures are planned to address the risk?*	**Owner –** *who is responsible for implementing / overseeing these measures?*	**Target date**	**Progress / impact –** *when will the measure be in place / what impact will it have?*
P 1	CQC stakeholder engagement plan	Chief Nurse and Patient Safety Officer	~~Feb 2023~~ ~~Apr 2023~~ Complete	Bi-monthly CQC engagement meetings ~~are~~ have been scheduled with the new relationship manager. ~~– due to commence on 29 March 2023~~ A positive engagement meeting was held on 29/03. Discussions were held relating to never events, IPC, staffing, training, and long waiters. The Trust is not currently a priority for the CQC.
P 2	Self-assessment to evidence against new CQC Quality statements	Chief Nurse and Patient Safety Officer	~~Feb 2023~~ Apr 2023	CQC relationship manager has changed – statements to launch in January. PMO has been established. - delayed due to implementation of the new CQC strategy.
P 3	Intensive waiting list management to eliminate 78 week waits for English patients.	Chief Operating Officer (Managing Director for Specialist Unit)	June 2023	Missed target by 5 patients. The reasons for this are well understood.
P 4	Further management of the English patients waiting list to meet targets for 65 weeks	Chief Operating Officer (Managing Director for Specialist Unit)	June 2024	On target to deliver.

Sources of assurance	
Ref:	**Description**
A1	IPC Quality Assurance Committee

BAF Risks, controls and assurances – OCT/NOV 2023

A2	NHSE oversight and support for delivery of IPC improvement plan
A3	Self-assessment against undertakings monthly
A4	Formal improvement review meeting with NHSE monthly
A5	Formal NHSE IPC reviews to assess compliance against IPC standards
A6	IPC standing agenda item at Trust Board
A7	Self-assessment against strategic oversight framework completed and submitted
A8	Regulatory Oversight Group (ROG)

Level of confidence that the control measures will deliver the target risk score:	**HIGH / MEDIUM / LOW** *(delete as appropriate…)*

Gaps in controls		
Ref:	**Description** - *If the level of confidence is "MEDIUM" or "LOW", what is preventing the Trust from achieving the target score?*	**Potential actions to resolve –** *what, if anything, can be done to address this?*
G 1		
G 2		
G 3		
G 3		

Corporate Risk Summary

Committee / Group / Meeting, Date

Board of Directors, 8 November 2023

Author:		Contributors:
Name:	Dylan Murphy	Risk Owners / Executive Leads.
Role/Title:	Trust Secretary	

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 September Risk Management Group was considered at the October 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.

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
2653	Insufficient theatre staff establishment to meet activity plan, exacerbated by increased vacancies and difficulties in recruitment	Mike Carr	P&C	**12**	**15**	Score reduced and removed from CRR.
2696	Registered Nurse Vacancies on MCSI	Paul Kavanagh-Fields	Q&S / P&C	**12**	**16**	Score reduced and removed from CRR.
2934	Patient waiting times outside of national targets	Mike Carr	F&P	**16**	**16**	
2992	Call bell system for tetraplegic patients unavailable	Paul Kavanagh-Fields	Q&S	**0**	**16**	Risk closed and removed from CRR.
2993	Registered Nurse unavailability impacting safe staffing levels	Paul Kavanagh-Fields	P&C	**16***	**16**	Subsequently confirmed that score reduced to 12
3007	Diabetic demand into the Orthotics service	Mike Carr	Q&S	**Tbc**	**16**	Risk currently under review, awaiting Exec approval.
3027	Variable Income Performance linked to Elective Activity Performance	Mike Carr	F&P / P&C	**16**	**16**	
3050	Financial Plan Delivery - Agency/Temporary Staffing Pressures	Paul Kavanagh-Fields	F&P	**12**	**15**	Score reduced and removed from CRR.
3052	Financial Plan Delivery - Non Contract Activity Overperformance	Craig Macbeth	F&P	**15**	**15**	
3054	Financial Plan Delivery - Industrial Action	Craig Macbeth	F&P	**16**	**16**	
3056	Non-compliance with Legislation/Guidance Relating to FFP3 Face Masks	Paul Kavanagh-Fields	Q&S	**15**	**n/a**	New addition to CRR.

** Ref 2993 - see risk score note in comment column. Was reported to committee as 16, subject to review by Exec owner*

Corporate Risk Update

Ref	Title	Exec Owner	Oversight Committee/s	Current Score	Previous reported score	Comment
3066	Consultant Anaesthetist vacancies and recruitment impacting on operational plan	Mike Carr	F&P / P&C	**16**	**16**	Recruitment is completed, staff due to commence posts at the end of October, at which time this can be reduced.
3078	There is a risk that the tumour service may not be able to maintain delivery	Ruth Longfellow	F&P	**16**	**16**	Risk has been reworded, locum due to start in November, risk likely to be closed prior to Christmas.
3083	Variable income performance – New Theatre Development	Craig Macbeth	F&P	**n/a**	**16**	Removed from CRR as now represents an issue rather than a risk.
3097	Insourcing Arrangements - Regulatory Intervention	Craig Macbeth	F&P	**15**	**n/a**	New addition to CRR.
3105	Insufficient clinical capacity to follow up patients with a Metal on Metal Implant in line with national guidance	Mike Carr	Q&S	**16**	**n/a**	New addition to CRR

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 October 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).

Fit and Proper Persons Test

Committee / Group / Meeting, Date

Board of Directors, 8 November 2023

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Is the report suitable for publication?:

YES.

Key issues and considerations:

1. Introduction and implication for the Board of Directors

NHSE wrote to ICB and NHS trust / FT Chief Executives in 2 August 2023 to alert them to publication of the Fit and Proper Person Test ("FPPT") Framework. This was developed in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. It also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. The Framework, which applies to both Executive and Non-Executive Directors of NHS Boards, came into effect on 30 September 2023. Key elements include:

- A revised FPPT self-attestation form, for use of appointment and annually thereafter;
- The requirement for a series of checks to be undertaken annually, as well as on initial appointment;
- Use of a standard reference for Board members; and
- Linkages with the forthcoming NHS Leadership Competency Framework and associated board appraisal framework (neither of which have yet been published).

Board members are now subject to the requirements of the Framework, including the annual checks and self-attestation process, as described in the sections below. These will be put into effect in quarter 4 of 2023/24 to inform the Board member annual appraisal process.

2. Requirements of the FPPT assessment

Extracts from section 3 of the Framework which cover the scope of the assessments are included below:

Full FPPT

"A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. *New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:*
   a. *new appointments that have been promoted within an NHS organisation*
   b. *temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis*
   c. *existing board members at one NHS organisation who move to another NHS organisation in the role of a board member*
   d. *individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.*
2. *When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, e.g. chief financial officer).*
3. *Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months"*

The requirement for in-depth annual tests is a new requirement. These will entail:

- Consideration of any disciplinary findings; grievance against the board member; whistleblowing claim(s) against the board member; evidence of behaviour not in accordance with organisational values and behaviours or related local policies;
- the conclusions of the annual appraisal;
- A series of searches / checks of publicly available sources, including: professional register check (e.g. membership of professional bodies); insolvency check; Disqualified Directors Register check; disqualification from being a charity trustee check; Employment Tribunal Judgement check; and
  social media check;
- Confirmation by the Chair (or the Senior Independent Director, when the test relates to the Chair) that the various checks have been completed satisfactorily.

Annual Self-attestation

As well as the assessment undertaken the employing / appointing body, the FPPT process requires that: *"Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment".*

3. References

The Framework (at section 3.9) includes a detailed section on the provision / request of references for Board members. Standard references templates are to be used and "*the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire."*

NHS organisations also need to obtain references before the start of a board member's appointment. The standard template should be used for intra intra-NHS appointments . If the appointee "*is entering the NHS for the first time or coming from a post which was not at board member level… The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements*.".

4. Accountability and regulation

The Chair - The Framework states that "*Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime".* Compliance with the FPPT framework will be monitored / assessed through various channels:

Care Quality Commission - *"The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:*

- *quality of processes and controls supporting the FPPT*
- *quality of individual FPPT assessments*
- *board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference*
- *collation and quality of data within the database and local FPPT records."*

NHS England - *"NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations."*

Internal audit/external review - *"Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.*

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews."

Internal Governance - *"For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:*

- *an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually*
- *consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme*
- *relevant information to the Council of Governors (CoG) in an NHS foundation trust"*

Corporate objectives and associated risks:

Implementation of the FPPT will be within scope of the CQC well-led assessment and is therefore a key measure of the Trust's governance arrangements affecting the Trust's rating within the Oversight Framework.

Recommendations:

That the Boad of Directors:

1) NOTE the update on the implementation of the revised Fit and Proper Persons Test Framework.

Report development and engagement history:

The report reflects the content of NHS England *Fit and Proper Person Test Framework (FPPT) for board members* published on 2 August 2023 and the NHSE webinar on *Fit and Proper Persons Test (FPPT) Framework Implementation* held on 30 August 2023.

The Board of Directors received a more detailed version of this paper at their meeting in private in September 2023. A briefing paper has also been shared with the Council of Governors for noting at their meeting on 8 November 2023.

Next steps:

Other national developments will inform and support implementation of the FPPT. These are also summarised in the NHSE letter of 2 August 2023:

*"Working with system colleagues and wider stakeholders, we are currently finalising a new **NHS Leadership Competency Framework (LCF)** for board level roles. We will share this with you by September, so that you can implement this alongside the FPPT Framework.*

The LCF will help inform the 'fitness' assessment in the FPPT in line with the recommendation in the Tom Kark KC Review on professional standards. It takes account of the NHS Long Term Workforce Plan, NHS People Promise and ICB formation, and will support you to develop a diverse range of skilled and proficient leaders to deliver the best outcomes for our patients, workforce and wider communities.

*A new **board appraisal framework** will also be published, incorporating the LCF, by March 2024. By the end of Q1 2024, we will ask you to use this for all annual appraisals of all board directors for 2023/24."*

Acronyms

CQC	Care Quality Commissioner
CoG	Council of Governors
FPPT	Fit and Proper Persons Test
LCF	NHS Leadership Competency Framework
NHS	National Health Service

Committee / Group / Meeting, Date

People and Culture Committee, 23rd November 2023

Author:

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

Contributors:

Report sign-off:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Paper has been presented and discussed at the Executive Team meeting on 7th November 2023.

Is the report suitable for publication?:

YES

Key issues and considerations:

On the 23rd June 2023, all NHS Trusts and ICBs received a letter from Steve Russell, Chief Delivery Officer about Sexual safety of NHS staff and patients (https://www.england.nhs.uk/long-read/sexual-safety-of-nhs-staff-and-patients/).

This letter referenced recent media reports about sexual violence to both patients and NHS colleagues. This involved a media report by the BBC, Guardian newspaper and the BMJ. Most incidents related to incidents were patients had assaulted staff (58%), it also highlighted more than 35,000 incidents of sexual misconduct or sexual violence - ranging from derogatory remarks to rape - were recorded on NHS premises in England between 2017 and 2022. These included reports of patient to patient, staff to patient and staff to staff incidents (https://www.bbc.co.uk/news/health-65671018).

The letter explained that the Domestic Abuse and Sexual Violence programme had been commenced in 2022 and had now extended its scope so to include NHS's response to domestic abuse and sexual violence associated with NHS services and/or premises, whether experienced by patients, staff or visitors. The letter identified 3 workstreams:

1. Supporting our staff.
2. National leadership.
3. Improving data collection.

All ICBs and Trusts were asked to confirm that they had an executive and operational lead for this work. In September all NHS Trusts and ICBs received an update from Steve Russell, Chief Delivery Officer (https://www.england.nhs.uk/long-read/domestic-abuse-and-sexual-violence-leadership-update-launch-of-the-first-nhs-sexual-safety-charter/#domestic-abuse-and-sexual-violence-leadership-update-launch-of-the-first-nhs-sexual-safety-charter)

This explained that NHS England has set up an expert advisory group who have been tasked with reviewing policies, training and support, and we will share model guidance, e-learning and other products, as they are developed. Additionally, this launched the Sexual Safety Charter (https://www.england.nhs.uk/publication/sexual-safety-in-healthcare-organisational-charter/).

Sexual Safety Charter

On 4th September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. 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 ten core principles and actions to help achieve this. Signatories to the charter commit to implementing the following ten commitments by July 2024:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

The Chief Nurse and Patient Safety Officer requested for the Trust to be added as a signatory to the Sexual Safety Charter, this was confirmed on 12th October 2023. The Chief Nurse and Patient Safety Officer attended the Domestic Abuse and Sexual Violence (DASV) leadership webinar on 17th October 2023. These webinars will run on a quarterly basis. The Chief Nurse and Patient Safety Officer will be the Executive Lead with the Named Nurse for Safeguarding acting as Operational Lead for DASV.

Reporting and Oversight
A DASV task and finish group has been established to monitor progress against the 10 commitments if the Sexual Safety Charter. This group will report in to the Adult and Childrens Safeguarding Meeting and onwards to the relevant committees and Trust Board.

Sexual safety covers a range of inappropriate sexual behaviour with different legal and operational definitions and processes. It includes language of a sexualised nature, sexual harassment, sexual assault, and rape. Some behaviour will be unlawful, some will not. Consequently, there are different, sometimes overlapping, legal and operational processes in play, including safeguarding, employment or police.

Every part of the NHS must take a systematic zero-tolerance approach to sexual misconduct and violence, keeping our patients and staff safe. It is crucial that when our staff come to work, they feel safe and supported. We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

Strategic objectives and associated risks:

1. Deliver high quality clinical services.
5. Grow our services and workforce sustainably.

Recommendations:

Colleagues are asked to review the content of this report and embedded hyperlinks and approve the Trusts approach to the delivery of the DASV programme of work.

Report development and engagement history:

To date there have been meetings with STW ICB safeguarding colleagues in relation to how the work of RJAH will feed into the ICS agenda. The Chief Nurse and Patient Safety Officer has also met with the Chief People Officer and Chief Executive Officer to agree how the Trust moves the DASV agenda forward.

Next steps:

1) Review Domestic Abuse policy and introduce Sexual Safety policy, support and training. 2) Share with Staff side and agree comms roll out	People services and Named Nurses to update current policies to share with staff, to meet new recommendations.
3) Trust to collect data on domestic abuse and sexual violence for reporting and analysis	Data is currently collected via Datix reporting.
4) Trust to review how effective current data arrangements are for domestic abuse and sexual violence	Safeguarding team to work with Governance to ensure Datix dashboards separate DASV

Acronyms

BBC	British Broadcasting Corporation
DASV	Domestic Abuse and Sexual Violence
ICB	Integrated Care Board
ICS	Integrated Care System
NHS	National Health Service

Appendices

Appendix A	Sexual safety in the workplace: resources and support.

Sexual safety in the workplace resources

Trust Board - Quality & Safety
September 2023 – Month 6

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.

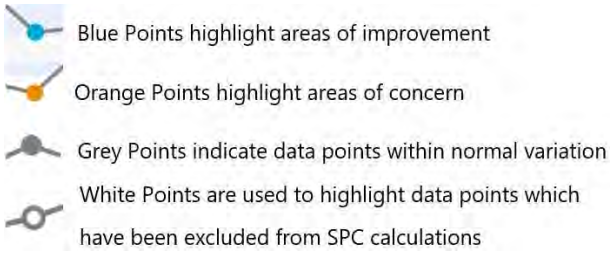
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

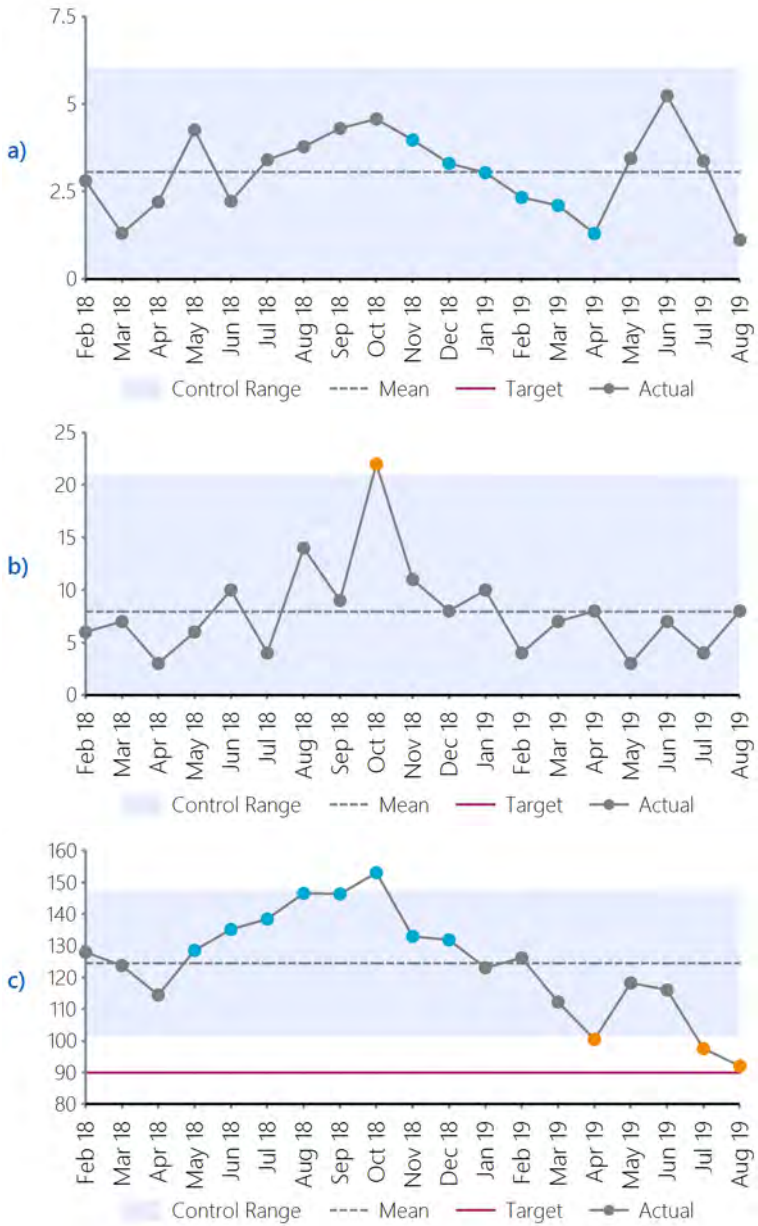


Some examples of these are shown in the images to the right:

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.



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
Serious Incidents	0	0		N/A to SPC	?		09/03/23
Never Events	0	0		N/A to SPC	?		09/03/23
Number of Complaints	8	10			?		11/05/18
RJAH Acquired C.Difficile	0	1		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	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?	+	

Summary - Caring for Patients

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

RJAH Acquired C.Difficile

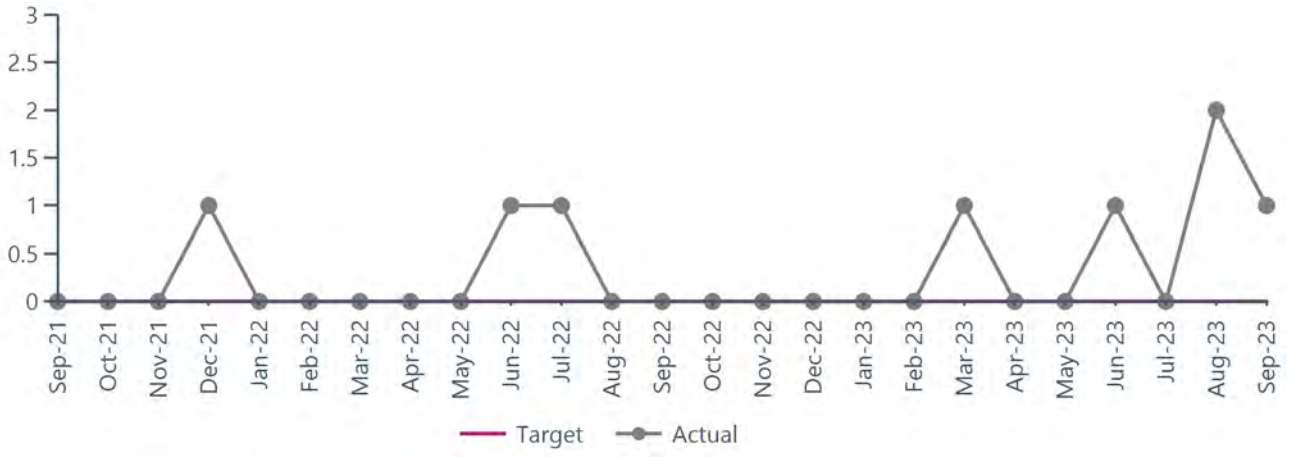
Number of cases of C.Difficile in Month 211149

Exec Lead
Chief Nurse and Patient Safety Officer

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

Trajectory

Actual
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 were was one case of RJAH Acquired C.Difficile reported in September. This is a patient previously reported who has relapsed. This patient has several risk factors that puts them at higher risk of developing a CDI.

Actions

There are no actions required as a result of the infection in September. The Senior Nursing and AHP Team continue to raise awareness regarding early identification of symptoms in relation to infection.

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

Surgical Site Infections

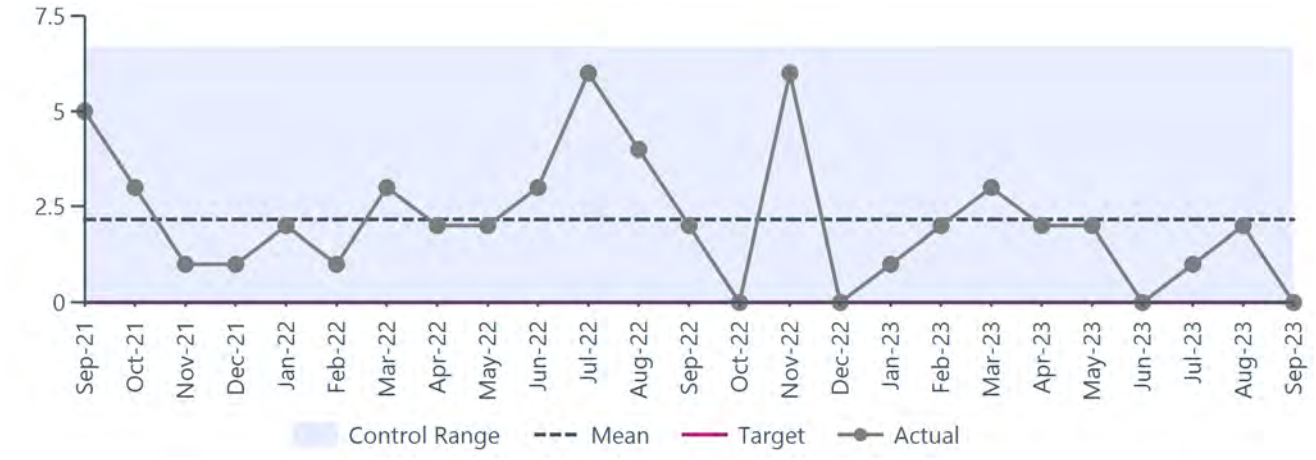
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	0		

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 two additional infections confirmed in September, both relating to procedures that took place in August-23.

Actions

The IPC Team have completed case reviews for all SSIs which shows compliance against the OneTogether assessment. Temperature monitoring has been identified as a common theme. This will be explored further during MDT review in line with PSIRF, and all actions will be added to the IPC Quality Improvement plan and actioned by the SSIPWG. Delays arranging of the MDT review due to a short term depletion in the IPC team. Plan for MDT review to be completed by the end of October.

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

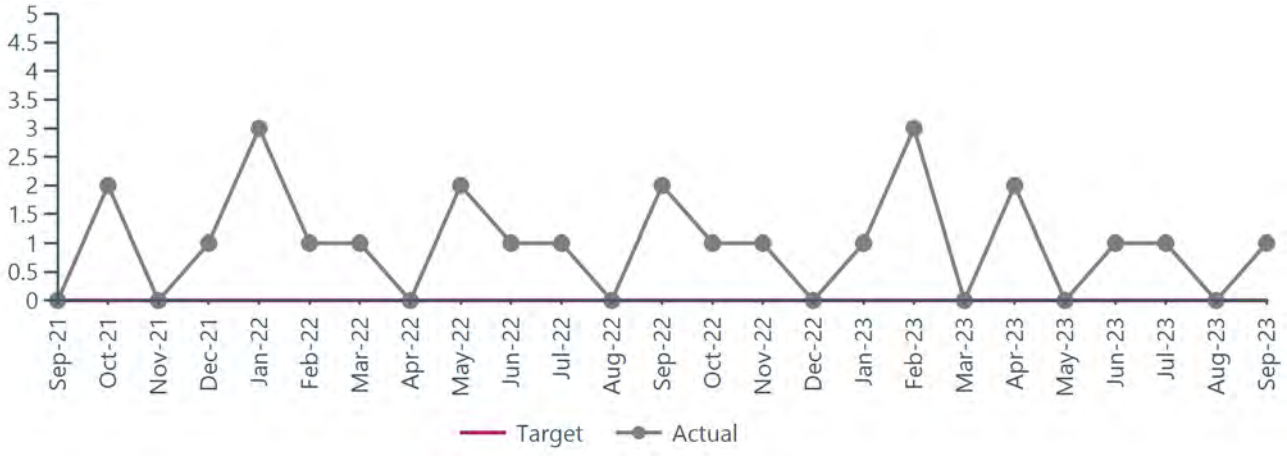
Total Deaths

Number of Deaths in Month 211172

Exec Lead
Chief Medical Officer

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

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 death reported in the Trust in September. This has been classified as an unexpected death. The patient experienced an acute MI in Recovery immediately post-surgery. The patient was referred and accepted for transfer to UHNM but rapidly deteriorated and suffered a cardiac arrest. The patient is known to have an extensive cardiac history.

Actions

Case referred to the coroner with no cause for concern. The patient's family requested that no post mortem was carried out. A Learning from Deaths Review will be completed.

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Inpatient Survey

Paul Kavanagh-Fields, Chief Nurse and Patient Safety Officer
Board of Directors, Public Meeting, 08 November 2023

Aspiring to deliver world class patient care

What is the Adult Inpatient Survey

This survey is a useful tool for all NHS organisations, as it gives us a strong measure of exactly what our patients think about us.

The Adult Inpatient Survey includes 133 NHS acute trusts in the country, and this year reveals what just over 63,000 adults who had stayed in hospital for at least one night during November last year said about the care they received.

A total of 1,250 RJAH patients were asked to complete the survey and 818 returned it. This equates to a response rate of 66% - well above the national average of 40%.

Positive

We have again been named by the CQC as one of just eight organisations placed in the top band of Trusts across England delivering results that are considered **“much better than expected”.**

We once again score **No 1 in the country for overall patient experience** – for the fourth year in a row.

Our **food has been rated No 1 in the country** for the 17th time in the last 18 years

We rated No 1, for the third year running, for patients reported that **their room or ward was clean**

A higher percentage of patients had **confidence and trust in both our doctors and our nurses** compared to any other hospital in England

Areas of Improvement

An action plan* has been developed to address the following areas:

- not prevented from sleeping at night
- able to get food outside of mealtimes
- asked to give views of quality of care during stay
- family or carers involvement in discussions about leaving the hospital (new question)

This action plan will be monitored through the Quarterly Patient Experience Group.

Key Indicators

Overall, how was your experience while you were in the hospital?		
1	RJAH	9.28
2	Liverpool Heart and Chest Hospital NHS Foundation Trust	9.22
3	Queen Victoria Hospital NHS Foundation Trust	9.14
Overall score for operations and procedures		
1	RJAH	9.47
2	Liverpool Women's NHS Foundation Trust	9.27
3	Queen Victoria Hospital NHS Foundation Trust	9.20
Overall score for care and treatment		
1	RJAH	9.15
2	Queen Victoria Hospital NHS Foundation Trust	9.09
3	Liverpool Heart and Chest Hospital NHS Foundation Trust=	9.05
Overall score for respect and dignity		
1	RJAH	9.81
2	Liverpool Heart and Chest Hospital NHS Foundation Trust	9.80
3	The Clatterbridge Cancer Centre NHS Foundation Trust	9.78

Key Indicators

Confidence and trust in the doctors treating you		
1	RJAH	9.80
2	Royal Papworth Hospital NHS Foundation Trust	9.74
3	Liverpool Heart and Chest Hospital NHS Foundation Trust	9.70
Confidence and trust in the nurses treating you		
1	RJAH	9.66
2	Liverpool Heart and Chest Hospital NHS Foundation Trust	9.55
3	The Walton Centre NHS Foundation Trust	9.47
How would you rate the hospital food?		
1	RJAH	8.97
2	The Royal Marsden NHS Foundation Trust	8.33
3	The Royal Orthopaedic Hospital NHS Foundation Trust	8.24
How clean was the hospital ward or room that you were in?		
1	RJAH	9.87
2	Royal Papworth Hospital NHS Foundation Trust	9.73
3	The Clatterbridge Cancer Centre NHS Foundation Trust	9.67

We may not have scored No 1 but are still amongst the very best in England:

Overall score for doctors	
Liverpool Women's NHS Foundation Trust	9.60
RJAH	9.53
The Clatterbridge Cancer Centre NHS Foundation Trust	9.45
Overall score for nurses	
Queen Victoria Hospital NHS Foundation Trust	9.32
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.23
RJAH	9.16
Hospital staff did everything they could to help you control your pain	
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.49
Queen Victoria Hospital NHS Foundation Trust	9.48
RJAH	9.47

The Full NHS Benchmarking Report can be found by clicking on the link:
[PowerPoint Presentation (nhssurveys.org)]

Committee / Group / Meeting, Date

Infection Prevention and Control & Cleanliness Meeting 25th July 2023

Author:	Contributors:
Name: Samantha Young Role/Title: Associate Director for IPC	Anna Morris – IPC Clinical Lead Hayley Gingell – IPC Assurance Lead Sian Langford – Estates and Facilities

Report sign-off:

Is the report suitable for publication?:

NO

Key issues and considerations:

The IPC Annual Report demonstrates the activities of RJAH relating to infection prevention and control from April 2022 to March 2023, including progress made against the work plan and targets identified in the Infection Prevention and Control Annual Programme. It also includes performance against key areas in Infection Prevention and Control. Ward specific audits are reported on a monthly basis through Trust wide Key Performance Indicators (KPIs).

Strategic objectives and associated risks:

The report fulfils its statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infection and related guidance, which sets out ten criteria of which a registered provider must be compliant. The prevention and management of infection is the responsibility of all staff working withing RJAH and is integral to patient safety. The Infection Prevention and Control Team maintains organisational focus and works collaboratively to deliver the IPC strategy to ensure continued compliance with IPC practices.

	What providers will need to show evidence of
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
Criterion 5	Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide or secure adequate isolation facilities.
Criterion 8	Secure adequate access to laboratory support as appropriate

Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Recommendations:

The IPCCM members are asked to review and approve the annual report as an accurate record of the implementation of IPC practices for 2022-2023.

Report development and engagement history:

This report is devised annually and offers an overview of quality specific to The Health and Social Care Act

Infection Prevention & Control and Cleanliness Report 2022/23

Forward

As the Director of Infection Prevention and Control (DIPC), I am proud to introduce the Trust's Infection Prevention and Control annual report for the year 2022/23. It describes the achievements of the Trust under the specialist advice, guidance and leadership of our Infection Prevention and Control (IPC) Team led by the Deputy DIPC.

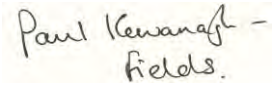
The report highlights the important changes we have made in managing IPC following the MRSA outbreak and the incredible achievements made by our clinical teams, estates and facilities in a short period of time to ensure our Trust met the required standard of IPC set by our Regulators and NHS England. This allowed increased oversight and leadership in managing IPC, which was strengthened by ensuring compliance with the new Health and Social Care Act update, as well as the new IPC Board Assurance Framework.

We have also enhanced our governance of infection prevention and control by stepping up an Infection Prevention and Control Quality Assurance Committee and I am delighted to say that the assurances provided to the Committee meant that this too could be stepped down to business as usual with the IPC Working Group operationally delivering and monitoring all IPC related activity through our IPC Quality Management System.

Following a series of away days, the IPC Team developed their IPC Strategy which was launched at the first ever IPC summit with our colleagues from Shropshire Community Health Trust. We also joined in a campaign entitled "gloves off" aligned with NHSE's campaign to reduce inappropriate PPE wearing and to do our bit in reducing unnecessary plastic waste and further campaigns are planned through next year to keep our staff and Teams motivated and educated on emerging evidence and guidance.

Infection Prevention & Control and Cleanliness Annual Report 2022/23

We can demonstrate that infection prevention and control is taken very seriously here at the Trust, and we are committed to providing the highest standard of care in a safe and clean environment.



Paul Kavanagh-Fields

Chief Nurse, Director of Infection Prevention & Control, and Patient Safety Officer

Glossary of terms

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
CDI	Clostridiodes difficile infection. It is a bacterium found in the intestines of around 1 in 30 adults, and usually causes no harm. It can produce toxins which cause infection and can be difficult to treat.
E coli	Escherichia Coli is a bacterium found in the intestines. It can cause infecitons and can prove difficult to treat.
HAI	Healthcare Associated Infection. An infection acquired after receiving treatment in a health care setting.
MRSA	Methicillin Resistant Stapholococcus Aureus, is a highly resistant strain of the common bacteria
MSSA	Methicillin Sensitive Stapholococcus Aureus, is the more common sensitive strain of Stapholococcus Aureus.

Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship Committee
ANTT	Aseptic Non Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
E.Coli	Escherichia coli
HAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
ICS	Integrated Care System

KPIs	Key Performance Indicators
MDT	Multi Disciplinary Team
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
SATH	Shrewsbury and Telford Hospitals
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
TSSU	Theatre Sterile Services Unit
UKHSA	UK Health Security Agency
WTE	Whole Time Equivalent

Introduction

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a specialist orthopaedic centre. We provide specialist and routine orthopaedic care to our local catchment area, as well as specialist services both regionally and nationally.

Our organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales. We serve the people of England and Wales, as well as acting as a national healthcare provider. We also host some local services which support the communities in and around Oswestry. The hospital is a specialist centre for the treatment of spinal injuries and disorders, and also provides specialist treatment for children with musculoskeletal disorders. Additionally, the Trust works with partner organisations to provide specialist treatment for bone tumours and community based rheumatology services.

The Trust is part of the National Orthopaedic Alliance (NOA), an acute care collaboration vanguard designed to improve orthopaedic care quality across England.

As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to deliver world class care by working in partnership to continuously improve and meet the needs of those we serve.

Health & Social Care Act

In December 2022 the Health & Social care Act 2008 was been revised. The code now reflects the changes required to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the role of infection prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance

	What providers will need to show evidence of
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Criterion 5	Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide or secure adequate isolation facilities.
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key Achievements 2022/23

- We have created a number of new roles in the IPC team this year. We recruited a 1.0 WTE B5 Surgical Site Surveillance Practitioner which has enabled us to expand the surgical site surveillance service and collaborate with the Multi-Disciplinary Team (MDT) to promote prevention of surgical site infection. We also secured a position for a B2 Support Secretary who was recruited in November 2022; this role has provided the IPC team with much needed administrative support. We recruited a 1.0 WTE B3 IPC Support Worker (IPCSW) who has worked hard to improve Trust compliance to hand hygiene practical competency assessments. The IPCSW role has developed throughout the year to include auditing and taking part in project work to promote IPC across the Trust. Hand hygiene competencies are now recorded on the Electronic Staff Record (ESR) which enables the Trust to monitor compliance to the Trust target.

- The Trust had a target of zero for MRSA bactereamia which we have successfully maintained for 2022-23.

- To strengthen our auditing process, we implemented a structured auditing programme with escalation process in place. Common themes for non-compliance are now easily identified using an internal software auditing system so that a targeted approach to improvement can be made.

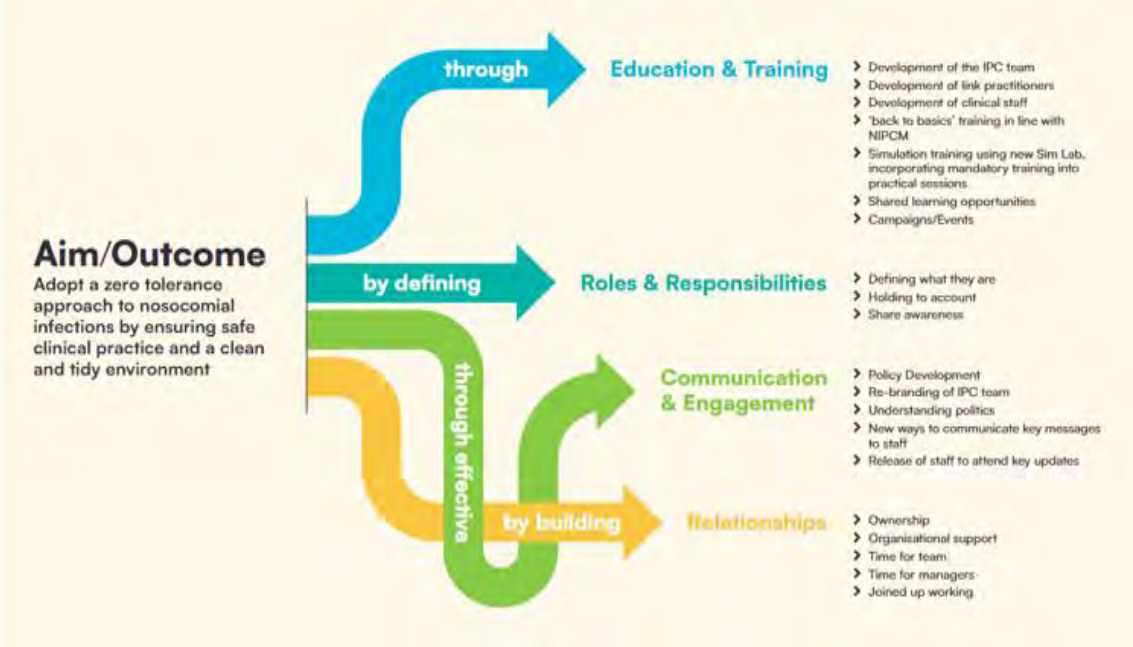
- The B6 IPC nurse completed a Master's course through Birmingham City University which has provided a foundation of theory to underpin practice.

- Following an outbreak of MRSA during summer 2021, which involved hospital acquired MRSA for eight patients, the Trust continued to work hard to implement changes outlined by NHS England. We acknowledge that the outbreak was caused by several failures in our processes and we have made the most of the opportunity to improve our estate, and practices; to ensure that IPC remains high a high profile across the Trust.

- The IPC team led an interactive IPC Fayre in collaboration with the Estate & Facilities team in June 2022 with a focus on standard infection control precautions. Over 200 staff attended the day and were provided with workshop style training around effective cleaning of the patient environment, including bed cleaning from the bed providers. As the day was such a success the IPC team plan to repeat the event at least once a year going forward.

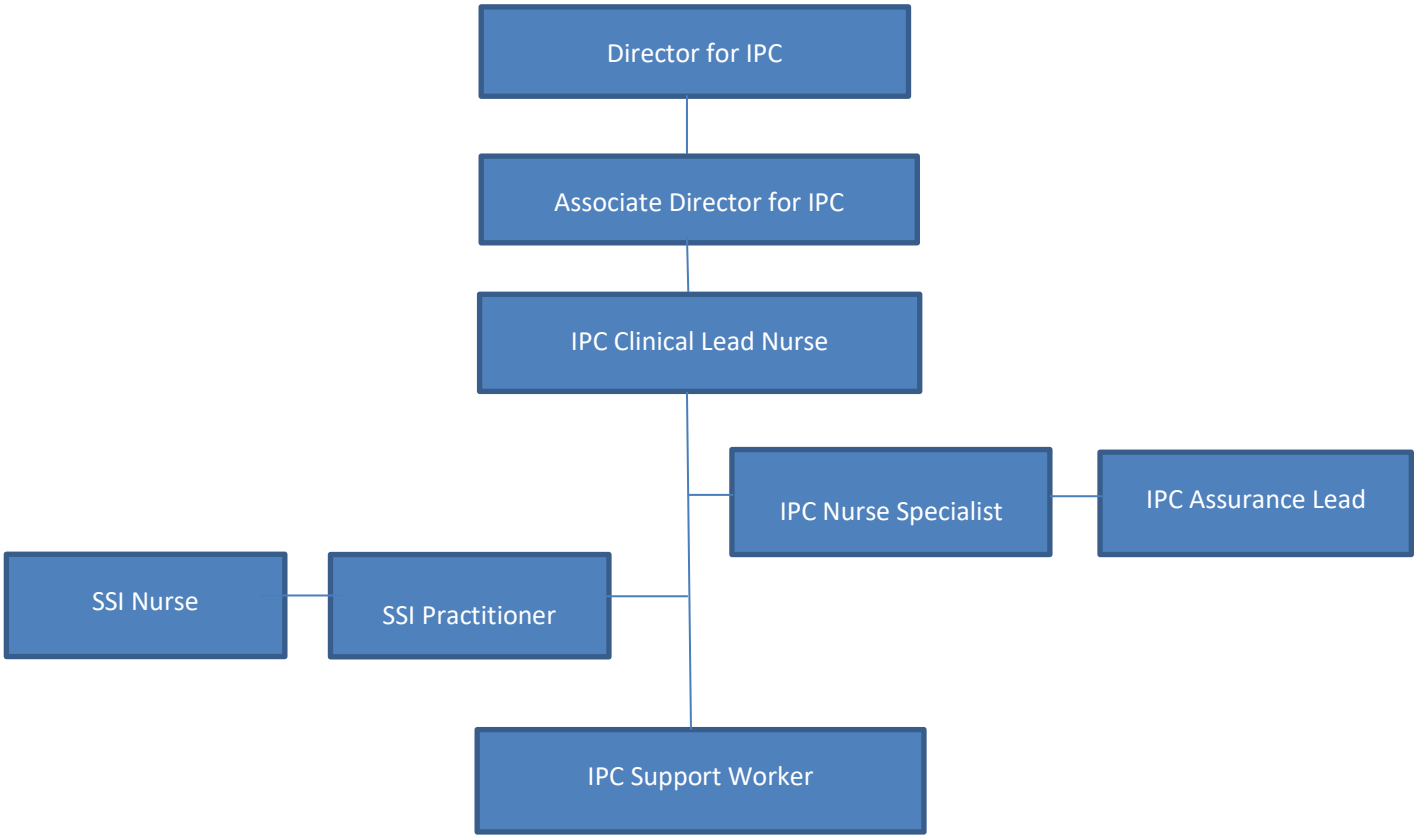
- After a series of IPC team away days, we developed our vision for the future of infection prevention and control within our Trust. We presented our journey of improvement and our vision to around 100 members of the ICS at an IPC Summit, which was supported by our

Associate Director for IPC for the Midlands Region. We worked jointly with SCHT IPC team to align our ambitions and have developed a collaborative approach to our aim to reduce healthcare associated infections. The below graphic shows our drivers which have lead to our ambitions:



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

IPC Structure



The **Chief Executive Officer** has overall responsibility to ensure that systems and resources are available to implement and monitor compliance with infection prevention and control at RJAH.

The **Director of Infection Prevention & Control (DIPC)** is the Executive Lead for IPC, and oversees the implementation of the IPC programme of work through their role as Chair of the Trust Infection Prevention and Control and Cleanliness Committee (IPC&CC). The DIPC delegates the responsibility and management of IPC for the Trust to the Deputy Director for Infection Prevention and Control (DDIPC). The DDIPC reports directly to the DIPC and on to the Chief Executive and the Board on all IPC matters.

The Trust employs an Infection Control Doctor who is employed by SaTH and has a contract to deliver services for RJAH in the in and out of hours period which includes clinical microbiology advice and reporting, microbiology ward rounds, antimicrobial stewardship and infection prevention and control advice. The ICD:

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

The Infection Prevention and Control Team (IPCT)

The Infection Prevention and Control Team (IPCT) are the medical and nursing infection prevention and control specialists responsible for providing a proactive IPC service to the Trust aligned to the National Infection Prevention and Control Manual, the IPC Strategy and their progamme of works.

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

- Deputy Director of IPC (0.5 WTE)
- Infection Prevention and Control Lead Nurse: Band 7 (1 WTE)
- Infection Prevention & Control Nurse Specialist: Band 6 (1 WTE)
- IPC Assurance Lead (1 WTE): Band 6
- Surgical Site Surveillance Nurse: Band 5 (0.4 WTE)
- Surgical Site Surveillance Practitioner Band 5 (1 WTE commenced in post May 23)
- IPC Support Worker Band 3 (1 WTE commenced in post May 23)
- IPC Administrator/Support Secretary Band 2 (1 WTE commenced in post Nov 22)
- The Infection Control Doctor (0.4 WTE)

In November 22 the IPC Data Analyst role was uplifted to a permanent IPC Assurance Lead. The IPC Assurance Lead will continue to manage the IPC Quality Management System (QMS) to refine and strengthen governance within the department.

In March 2022, we said goodbye to our B7 IPC Lead Nurse Sue Sayles who has taken retirement after a 13 year career in infection prevention and control. The Trust thank Sue for the hard work and dedication to the role at RJAH. We are delighted to announce that we are not losing her services as she continues to work in a role aligned to patient care.

The Antimicrobial Pharmacist

The Trust has a designated Antimicrobial Pharmacist role. They work with the ICD and other members of the IPC team. The role of the antimicrobial pharmacist includes:

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

Infection Prevention Control & Cleanliness Committee

The RJAH Infection Prevention & Control Committee (IPC&CC) is a multidisciplinary Trust Committee with stakeholder representation from UKHSA and the ICB. The IPC&CC oversees the activity of the IPCT and observes the implementation of the infection control programme of work. In February 2022 IPC&CC meetings were increased to monthly for additional assurance and increased oversite at Board level.

The IPC Programme of Work

The IPC Programme of Work 2022-23 was specifically designed to focus on achieving full compliance with the standards identified in the Health and Social Care Act, and to monitor compliance with national and local infection related thresholds. To ensure good momentum with improvements, the team opted to adopt an annual programme in order to meet deadlines assigned to works sited on the IPC Quality Improvement plan.

Quality Management System

We have designed a system to capture all data in relation to IPC. The system contains a data warehouse that consolidates all IPC related data and a central space for correlation of themes and trends. The system contains a dashboard providing a live position for IPC governance.

The system has been since evolved to include:

- Policy matrix and review tracker
- IPC unit reports linked to the system for auto-population of data. Reports are presented at Infection Control & Cleanliness Committee
- Reports to monitor and track actions relating to IPC generated from all sources.
- Rolling audit plan to include all IPC Assurance audits
- Live reporting to surgical site infections and statistical process charts.

Infection Prevention and Control Working Group

The Infection Prevention and Control, & Cleanliness Working Group (IPC&CWG) is group is to ensure that the Trust are fully engaged and proactive in delivering the IPC agenda aligned to the statutory requirements of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections (Revised December 2022) Care Quality Commission Standards and other national, regional or professional bodies. This involves robust oversight of leadership and ownership of IPC&C at a service and operational level.

The group provides a forum for discussion, review and approval of IPC&C and Estate related activity, policy, procedure and guidance, and monitors the progress of actions against the Infection Prevention and Control Quality Improvement Plan and IPC Quality Management System.

Infection Prevention and Control Working Group met on a weekly basis throughout 2022. The meetings were well attended with the IPC Quality Improvement plan as a standing item on the agenda to maintain traction

with actions. This group reports to the Infection Prevention & Control and Cleanliness Committee. In December 2022, the frequency of this meeting stepped back to bi-weekly following NHSEI visit and the positive feedback of sustained improvements. The meeting provides effective communication between the IPC team, operational areas and Estates & Facilities by identifying and resolving issues in line with Trust priorities.

The meeting now oversees and approves Estates and Facilities works required to meet IPC standards. Costings and plan is then completed by the E&F team for formal approval at Capital Management Group (CMG).

IPC Link Staff System

The IPC Link Staff system enables the IPC team to deliver key information, education, and advice that is shared to the wards and departments in a cascade system. IPC Link Staff form part of a group that meets bi-monthly. The IPC team and the link staff ward/department managers agree to roles and responsibilities which clearly define the expectations of the link staff role. Attendance at meetings has continued to improve following step down of COVID-19 social distancing precautions and reintroduction of face to face meetings in November 2022. Will Walter, our IPC Support Worker has increased the number of link practitioners by promoting responsibility for IPC, and provided 'train the trainer' style training so that they can become responsible for hand hygiene practical assessments in their respective areas; in order to promote ownership of IPC practices.

Board Assurance Framework

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

A further version of the BAF were released in 2021/22 with Version 1.11 released in September 22 with a renewed focus to 'business and usual' activities, alongside the ongoing management of COVID-19; supporting trusts to step down on IPC precautions to assist in the restoration of the services.

The Trust continue to demonstrate compliance to the Board Assurance Framework. Our compliance to the BAF is shown below:

Compliance to the BAF is monitored by the IPC team and reported through the IPC&CC for oversight.

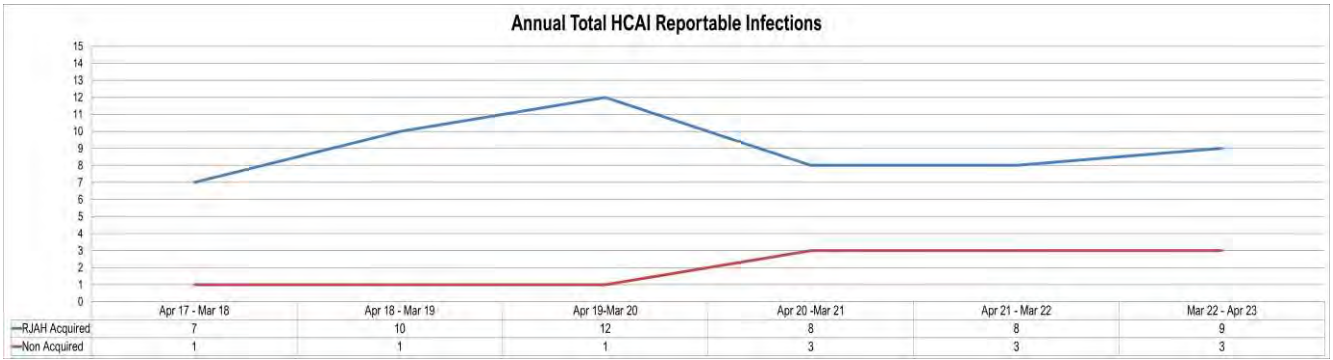
Mandatory Surveillance

All organisms of significance are monitored by the IPC team via a database supported by the SaTH laboratory so that timely action can be taken to support the clinical teams in the management of the patients, including safe patient placement and advise on isolation requirements.

Healthcare Associated Infections

Reducing health care-associated infections (HAIs) remains high priority, as we see the numbers rise nationally. The NHS Long-term plan supports a reduction in the number of Gram-negative bloodstream infections by 50% by 2024/25.

The graph below shows the total of Healthcare Associated Infections (HAI) blood stream infections reported from April 2017 to March 2023.



	Apr 17 - Mar 18	Apr 18 - Mar 19	Apr 19-Mar 20	Apr 20 -Mar 21	Apr 21 - Mar 22	Mar 22 - Apr 23
RJAH Acquired	7	10	12	8	8	9
Non Acquired	1	1	1	3	3	3

Methicillin Resistant Staphylococcus Aureus Bacteraemia (MRSA)

The Trust continues to report zero cases of MRSA bacteraemia for its 16th consecutive year.

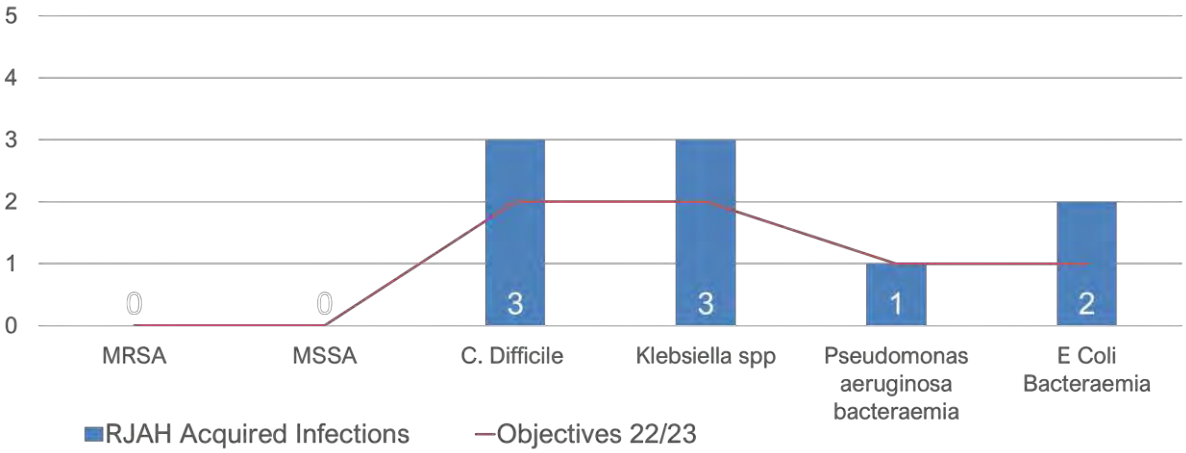
Methicillin Sensitive Staphylococcus Aureus (MSSA)

There were no Trust acquired MSSA bacteraemia reported in 2022-23.

RJAH Acquired Infections

The graph below shows that we exceeded our threshold for the following Alert organisms:

- E.***coli***
- Klebsiella ***spp***
- C.***difficile***



E.coli

There were 2 cases of E.coli bloodstream infections against an objective of 1, which is a reduction of 1 case from the previous year.

Post-infection review meetings were undertaken for both infections with no identified cause found. The post-infection review provided opportunity to celebrate good practice around the documentation of catheters, however acknowledge that as a Trust we could do more to monitor the ongoing care of invasive devices. The Trust is involved with a number of regional collaboratives for the prevention of infection and moving into next year will be working together with the Integrated Care System to work on quality improvements around catheter care.

Post-infection reviews are summarised into an After Action Review poster so that learning can be shared to the wider teams.

Klebsiella spp

There were 3 cases of Klebsiella bloodstream infections against an objective of 2, resulting ina breach of our nationally set objective by 1. This is an increase by 2 cases compared to last year, which reflects the national picture. Whilst these seem like small numbers, we have continued to work towards finding ways to improve the care of invasive devices, particularly around the documentation of the Visual Infusion Phlebitis (VIP) score, as this has been a common theme of non-compliance during the post-infection review process. The Trust is working towards including VIP scoring into the current system used to record patient observations (VitalPac), with a view to this being implemented in June 2023.

The IPC team have also re-launched the use of the High Impact Interventions toolkit which is a peer to peer observation tool used to promote best practice standards, and are working with the clinical teams to to provide a more proactive approach to infection prevention.

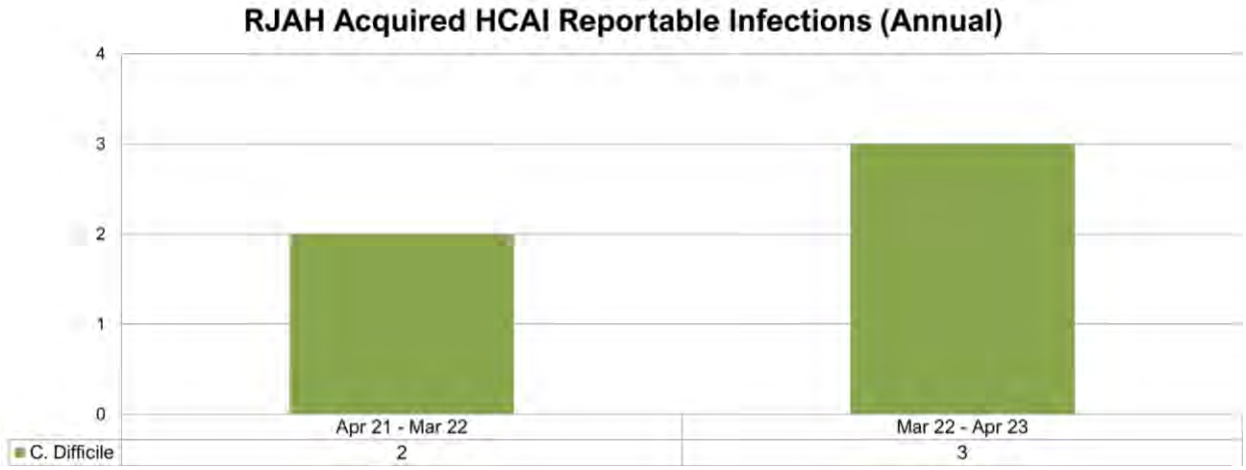
Pseudomonas aeruginosa

Psuedomanoas aeruginosa and Klebsiella species bloodstream infections have been reportable since April 2018. The Trust reported 1 case of pseudomonas bloodstream infection which through completion of a post infection review was deemed unavoidable.

Clostridiodies Difficile

Clostridiodies difficile (C.***difficile***) is a bacterium found in the gut which can cause diarrhoea afer antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut call pseudomembranous colitis. It forms resistant spores which require very effective cleaning and disinfection to remove them from the environment.

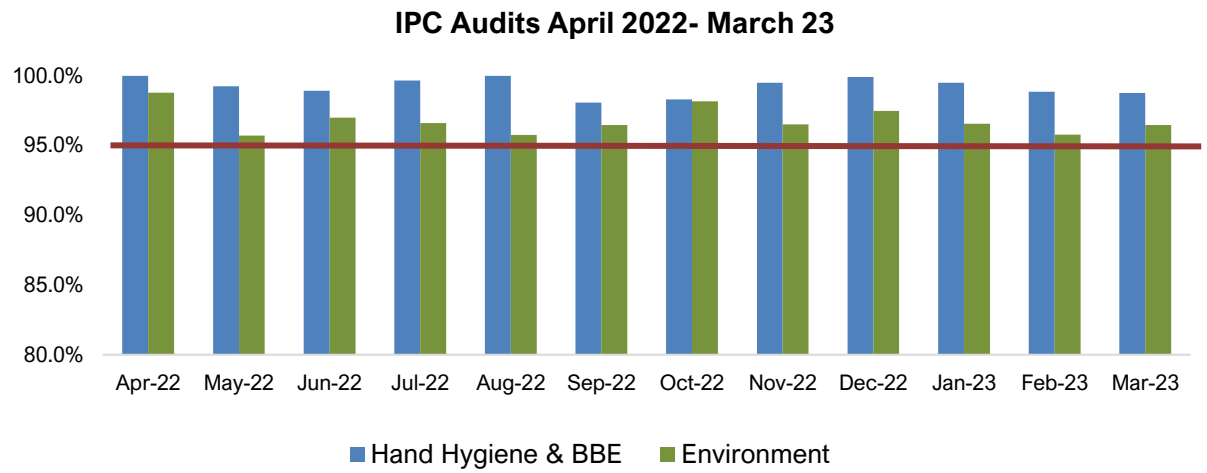
This year we reported 3 RJAH acquired cases of C.***difficile*** infection against an objective of 2. 2 out of the 3 cases were on the same patient who had a relapse of symptoms. The Trust continues to review all cases through a post-infection review process; to establish areas of good practice, lapses in care and also identify improvements. Both cases of CDI were found to have significant risk factors; which contributed to the infection. The cases were managed in a timely manner, with no evidence of cross-infection. The IPC fayre in January 2023 rasied awareness to the importance of following enteric precautions for patients with suspected CDI. The IPC team have since introduced a new bowel chart to aid staff in making decisions around when to send stool samples upon suspecting CDI.



Infection Prevention & Control Ward/Department Audits

Wards and departments complete a package of infection prevention and control audits across the year in order to show continouous monitoring of standards. The suite comprises of environmental auditing, hand hygiene, and bare below the elbows (BBE).

The following graph shows the Trust's compliance for each audit.
The results show that the Trust consistently achieved above the 95% target in all areas for IPC General Inspection, Hand Hygiene and Bare Below the Elbow (BBE).



IPC Quality Assurance Walks

The IPC team undertake regular audits called Quality Assurance Walks. The walks enable us to monitor standards of IPC within the wards/departments, such as hand hygiene, patient placement, cleanliness of the patient environment, linen management, waste management, and other standard infection control precautions.

Since introduction of the IPC Quality Assurance Walk system in August 2021, the team continue to undertake a rolling programme of assurance audits driven by a Red Amber Green (RAG) rated escalation process, with frequencies set in line with functional risk categories (National Standards of Cleanliness).

The IPC team priorities going forward include alignment of all audit toolkits to the National Infection Prevention and Control Manual for England (NIPCM); which will provide further assurance around standard infection control precautions.

This year a total of 66 walks were undertaken that identified common themes such as patient equipment not always being labelled as clean, and some non-conplinace of cleanliness around shared equipment such as commodes and toilet seat raisers. Quality assurance walks are documented using an electronic programme that enables actions to be idenfied to the responsible ward/dept manager straight away. All actions are monitored through an Infection Prevention and Control & Cleanliness Working Group (IPCWG) on a bi-weekly basis for oversight, to ensure that actions are dealt with in a timely manner.

This year, the IPC team are pleased to report 100% compliance to the IPC QA walk plan.

OneTogether

OneTogether is a partnership between leading professional organisations with an interest in the prevention of surgical site infection (SSI). The partnership has been initiated as a quality improvement collaborative with the aim of promoting and supporting the adoption of best practice to prevent SSI throughout the patient's surgical pathway.

The OneTogether assessment tool has been designed to demonstrate compliance across the surgical pathway and is set out in 7 standards:

1. Skin preparation
2. Prophylactic antibiotics
3. Patient warming
4. Maintaining asepsis
5. Surgical environment
6. Wound management
7. Surveillance of surgical site infection

In November 2021, we completed the OneTogether assessment as it gave us the opportunity to assess and monitor standards of practice along the patients' surgical journey. This has enabled us to identify areas for improvement; and with the implementation of a surgical site infection prevention working group (SSIPWG), actions were identified and completed.

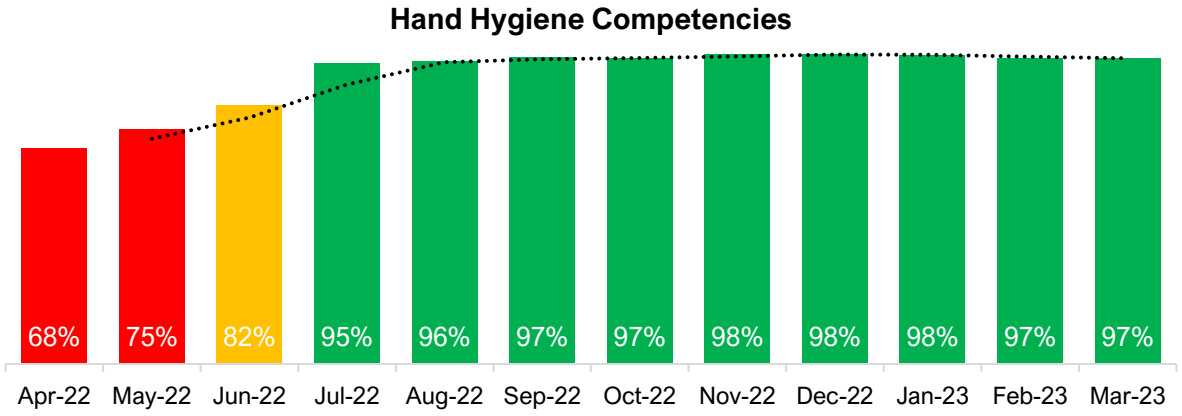
The Trust showed remarkable improvements in its compliance to the IPC led OneTogether assessment of the surgical pathway, with a compliance score of 95% compared to 63% in 2021. Improvements have been made in relation to standard operating procedures that clearly define expected standards. This accounted for the majority of the increased compliance scores, as standards in practice were consistently high in both 2021 and 2023 assessments. General findings included from the assessment in 2023 included improvements had been made around the monitoring of patient temperature during the intra-operative phase with some improvements required around documentation of temperatures during surgery.

The SSIPWG continued to meet bi-weekly throughout 2022/23 with meetings being chaired by the MSK Matron to maintain pace on action completion.

Hand Hygiene & Bare Below the Elbow

In May 22 hand hygiene training was uploaded to ESR as a mandatory module for all staff in order to monitor hand hygiene competencies. Compliance to this training was monitored in line with all other mandatory training modules by the Learning & Development Team. Staff training compliance is circulated to managers and full report is presented to the Infection Control & Cleanliness Committee.

In response to low compliance reported for 2021-22 relating to hand hygiene technique, our IPC Support Worker Will Walter implemented a programme of hand washing assessments to suport staff to obtain full hand hygiene competency.
Since commencement in post in May 22, The Trust began to report a significant increase in compliance scores for this module. As shown in the graph below the Trust continued to maintain and report a positive trajectory to hand hygiene training for clinical and non clinical staff throughout the year. Will continues to support clinical areas in leading on their hand hygiene competencies to maintain excellent compliance to our high standards.



Criterion 2: Provide and maintain a clean and appropriate environment

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

Cleanliness

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

Following a successful business case, which included a review of current standards and practices in line with NHSE/I action plans, a benchmarking exercise with reference peer Trusts and an options appraisal, in December 2022 ward housekeepers were introduced to the Trust. A hybrid role, new to RJAH, these staff professionally report to facilities and have been seen as a key enabler to maintaining a tidy clinical environment which facilitates effective cleaning. In addition to ward housekeepers, investment in the deep cleaning Patient Environment Action Team (PEAT) afforded 2 additional members of staff, with the team now covering 7am – midnight, supporting cleanliness technicians with enhanced cleaning, ad hoc response and periodic equipment cleaning.

Outcomes for cleaning continued to be monitored internally throughout the year. External and patient led monitoring, including PLACE assessment, returned following a National pause of assessments during the pandemic.

Cleanliness – Deep Cleaning

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

The Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment in certain circumstances, as specified by the Infection Control Policy, room cleaning is completed as below:

- Green – Standard daily clean using detergent
- Amber – Terminal clean using 1000 ppm Chlorine Based Agent
- Red – Terminal clean using 1000 ppm Chlorine Based Agent followed by HPV fogging

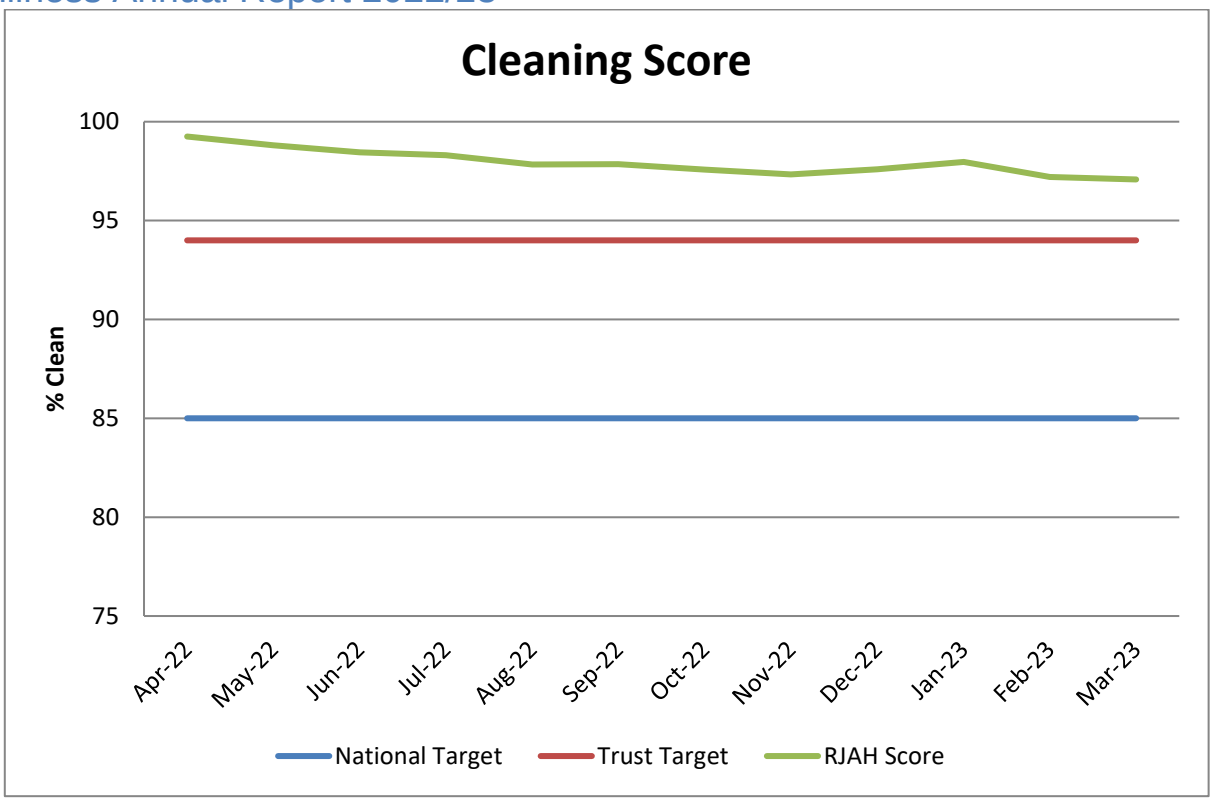
This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

The Trust employed an external contractor to complete HPV fogging; responses to date have been quick, effective, and professional.

29 individual rooms and 1 complete bay and a full ward have required a red terminal clean in 2022/23; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion. This represents a significant increase from 2021/22 (130%); with all red cleans this year being performed on MCSI – the Trust is now undertaking a review of options to ensure this enhanced cleaning remains fit for purpose, supported by both the Decontamination Group & IPC Working Group.

Cleanliness – Internal Monitoring

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



Internal monitoring is carried out every day, visiting all areas on a rolling programme according to their risk. All cleanliness matters are issued within 24 hours to the relevant team, assurance is provided in relation to resolution through signed off completion. All required improvements identified by the audits are acted upon by the internal team and the results are reported to the Infection Prevention & Control Committee on a quarterly basis, with specific action plans or failure themes managed through the Infection Prevention & Control Working Group.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2022/23 the Trust achieved an average score of 97.85%.

National Standards of Cleanliness 2021

The National Standards of Healthcare Cleanliness were published in May 2021, and following a collaborative implementation process, launched at the Trust in April 2022.

Cleanliness and Environment - Kitchen

The Trust kitchen retained its 5-star food hygiene rating at last inspection in November 2022, which in particular, called out the high standards of cleanliness within the Trust kitchens and maintenance of assurance records in line with HACCP principles.

Recommendations highlighted as part of the 2022 inspection included structural improvements within the kitchen – this was escalated through IPC working group for funding, which was approved in January 2023.

The onsite nursery is registered with Shropshire Council environmental health, and retained its 5-star food hygiene rating in June 2022.

CQC Inpatient Survey

The CQC Inpatient Survey 2022 results were published in September 2022, with the Trust scoring top in the country under the metric 'how clean was the hospital room or ward that you were in' with an average score of 98.87%. The consistently good results achieved through this survey are a testament to the dedication and exacting standards shown by the entire housekeeping team.

PLACE – Patient Led Assessment of the Care Environment

In 2022, the National PLACE assessment programme was reinstated following a pause in inspections during the pandemic.

PLACE captures responses to questions on cleanliness; food; privacy, dignity and wellbeing; condition, appearance and maintenance; dementia and disability. Each year questions are updated/added to reflect what is deemed as best practice – therefore careful consideration must be given when making any comparison to previous years responses, however this patient led assessment provides vital insight into the patient's perspective of the environment.

Domain	2022 Score	Status since last assessment	2022 National Average
Cleanliness	99.91%	→	98.0%
Food	93.85%	↓	90.2%
Privacy, Dignity & Wellbeing	92.38%	↓	86.1%
Condition, Appearance & Maintenance	99.04%	↑	95.8%
Dementia	83.11%	↓	80.6%
Disability	83.21%	↓	82.5%

Cleaning Standards – Triangulation of Audits

Trust audits have been consistently providing assurance internally that a high standard of cleanliness is maintained. Whilst these audits provide the core information for assurance, confidence in the internal audit is bolstered by the triangulation of external review, including the CQC inpatient survey (the largest survey relating to the patient perspective of hospital standards) and PLACE (a survey led by patients).

All information from independently gathered reviews of cleanliness point to a high assurance of cleanliness in the Trust.

Linen

Quarterly review meetings continued to ensure standards relating to the provision of linen were monitored.

Linen services are provided by an alternative external supplier, who continues to provide assurance to the infection control working group through monthly compliance reporting against National Guidance standards.

In May 2022, an on-site audit of the linen contractor was undertaken, attended by both facilities and IPC colleagues from across the consortium.

The contractor was able to provide assurance of the decontamination process of linen, in line with National Guidance, however concerns were raised regarding the cleanliness of the working environment, and some basic infection prevention protocols, including adequate access to hand hygiene facilities.

A formal audit report was issued on behalf of the consortium, and actions monitored through infection prevention & control working group, with a re audit in September 2022 providing comprehensive assurances that actions had been resolved, and further evidence of ongoing improvements and monitoring shared. The Trust will continue to undertake annual on-site reviews as part of its contract management process.

Clinical Waste

Quarterly review meetings continued to ensure standards relating to the provision of clinical waste were monitored.

Clinical waste services are provided by an alternative external supplier. Assurance this waste is being managed, both at Trust level and by the external contractor, in line with National Guidance is provided to the infection control working group though annual pre acceptance audits.

In line with NHS England requirements, the Trust has continued to work collaboratively with all waste contractors servicing the site to ensure the ability to flex to relevant pandemic guidance and changes in activity has been maintained.

Estates Department Contribution to the Clean and Appropriate Work Environment

Estates department activity is essential in delivering the IPC agenda, it is delivered under the principles outlined in National Guidance, which covers the importance of a clean, safe environment for all aspects of healthcare.

Matters of Estate that impact the clean environment are escalated through the IPC working group for prioritisation and oversight. This year, projects have included:

- Refurbishment of heavy workshop including creation of dedicated clean wheelchair store.
- Completion of the installation of bay doors across the Trust (facilitating the ability to adequately cohort patients in any ward)
- Refurbishment of ultrasound rooms
- Refurbishment of cleaning cupboards across the Trust
- Refurbishment of children's outpatients clinic rooms
- Full refurbishment of Clwyd ward, completion of ongoing refurbishment of Powys ward
- Various wall and corner protection works across the Trust

Water

The control of water is a legal requirement; the Estates Deparmtent work to National Guidance to mitigate risks from exposure to legionella.

The Estates department continues to employ a third-party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years, or where required following incidents or significant infrastructure changes.

There is a written site-specific scheme of control for each inpatient premises. Eurofins provide the Trust an internet-based water testing database storage and reporting for statutory test results. There is also a three-monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control Working Group.

In line with National Guidance. The Trust has an Authorising Engineer for Water AE (W), appointed in writing. The AE(W) is a 'independent advisor,' who offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

The Estates Department continually undertake water tests throughout the Trust estate. This water testing is carried out in line with legislation and guidance. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as legionellosis; it is a method of using qualitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. The Trust conducts Water sample tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to out of parameter results, the mechanical team within the Estates department continue to employ an effective method of thermal disinfection. This process increases efficacy and reduces costs because of the in-house delivery of such works. Disinfection is often employed to manage domestic water hygiene.

The Trust is therefore assured that the Water Safety of the site is compliant in-line with current Legislations and guidance.

Ventilation

It is a legal requirement to provide adequate Ventilation in enclosed areas of a workplace.

Ventilation is led and monitored by the Estates Department, supported by an Authorising Engineer for Ventilation AE(V), appointed in writing. The AE(V) is a 'independent advisor,' a requirement of National Guidance and offers technical advice to the Trust, auditing the Specialised Ventilation and increasing the Trust's resilience.

The Trust conducts monthly air velocity tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

The RJAH Estates team conduct Quarterly PPM's on all Air Handling units (AHU's) to ensure they are clean, fully functional, and proactively manage any issues that should arise.

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

The Trust is therefore assured that the sites Ventilation Systems are compliant in-line with current Legislations and guidance.

Decontamination Group

Decontamination, which covers the theatre and sterile services environment, is led and monitored by the Estates department supported by their third party accredited Authorising Engineer for Decontamination AE(D), who is appointed in writing. The AE(D) is a 'independent advisor,' a requirement of National Guidance who offers technical advice to the Trust, auditing the Decontamination equipment and increasing the Trust's resilience.

The RJAH Estates team maintain a local testing regime of Decontamination equipment on a monthly basis and proactively manage any issues that should arise. Reports are produced for Quarterly and Annual Testing. These reports are then reviewed by the Trusts Authorising Person (AP(D) and the AE(D)

The Trust is therefore assured that the Decontamination of Theatre Surgical equipment is compliant in-line with current Legislations and guidance.

Personal Protective Equipment (PPE)

The department took responsibility for control of PPE, to ensure the Trust benefited from sufficient stock of appropriate PPE; responsibilities included:

- Management of Trust stock through the National PUSH model and consideration of mutual aid requests to support the wider region.
- Installation of PPE stations across site & daily top up service of these, alongside ensuring adequate PPE is available at point of care for clinical teams.
- Provision of FFP3 fit testing & supporting clinical teams to ensure staff are protected with masks in line with the most up to date guidance.

Enhanced Cleaning

National SOPs for cleaning in line with risk level were stood down, although the Trust continued to utilise these checklists for cleaning in cases of COVID outbreaks.

Successful business cases supported the continued provision of touch point cleaning throughout public areas, with the Trust recognising that the National Standards for Healthcare Cleanliness recommended increased frequency of cleaning these as a business-as-usual task. Work schedules for this team incorporated supporting a second daily clean for isolation rooms, as specified by the National Infection Prevention & Control Manual.

IPC Related Estates & Facilities Improvements

Following substantial works completed in 2021/22, focus shifted this year to ensuring estates and facilities processes were aligned to the IPC governance framework, and that appropriate escalation routes were in place to identify where clinical environments fell below expected standards.

Continued collaboration, through the IPC working group, has facilitated further refurbishments, promoted respect in subject specialists, and fostered an open and honest approach to auditing and inspection where teams are proud to be held to account.

During a year where the Trust has learned many lessons, in relation to maintaining an evolving environment in a clean and safe manner, learnings have been passed on to our ICS partners via process sharing, site visits and regular catch ups.

Moving into 2023/24, an emphasis on ensuring processes are efficient and sustainable.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

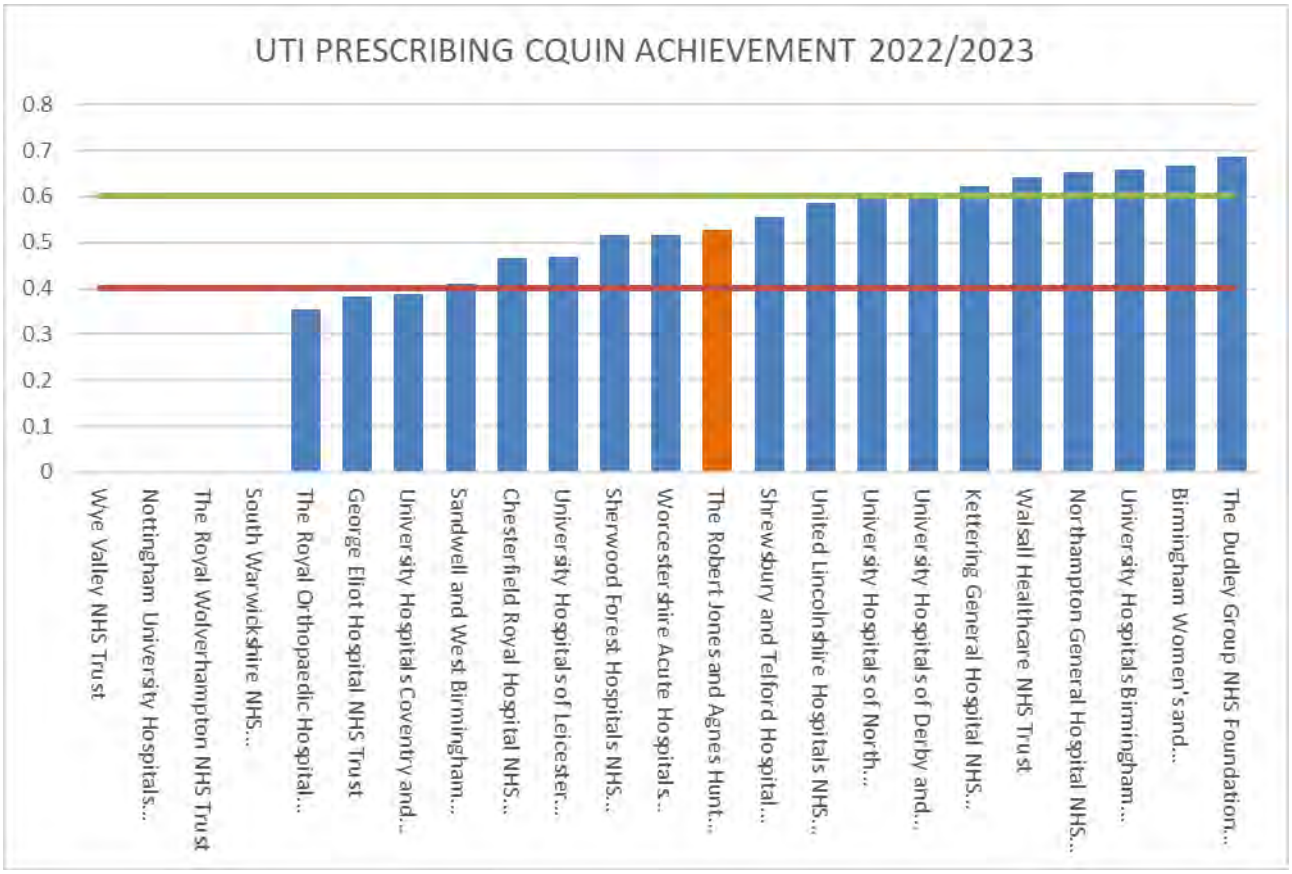
Antimicrobial Stewardship (AMS)

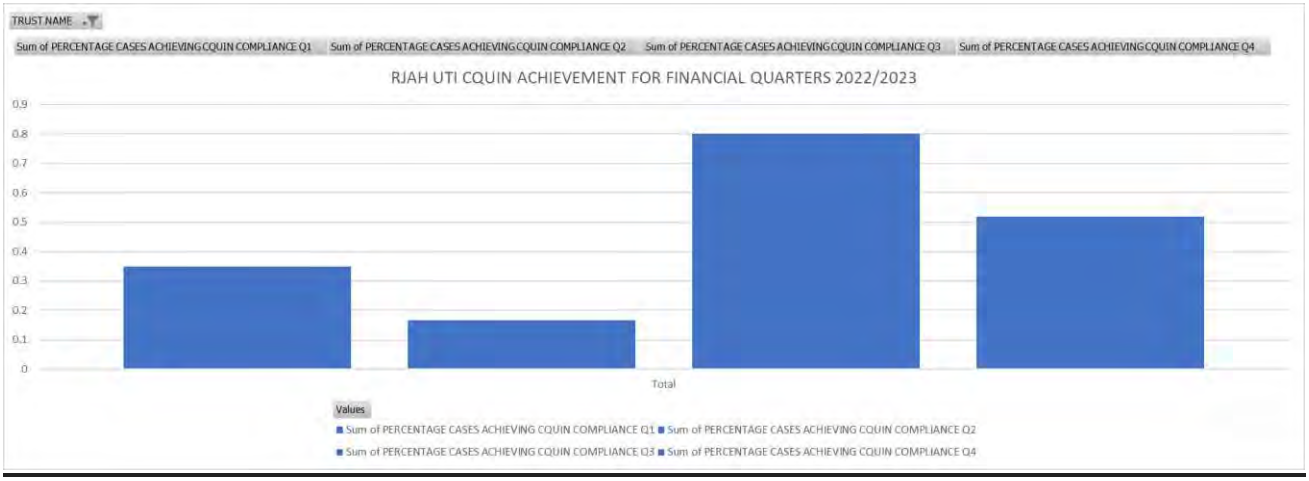
The Trust antimicrobial management group (AMG) comprised representatives from pharmacy, microbiology, nursing and medical staff. This group managed and formulated policy with regard to antimicrobial stewardship, and responded to concerns in this area. Attendance was a challenge to the group and following agreement at Committee, antimicrobial stewardship is now embedded as a standing agenda item of the monthly Drug and Therapuetics Committee to ensure the right representation and to avoid duplication of meetings. The group's responsibility includes

monitoring antimicrobial prescribing and usage, feeding back actions and concerns to the Executive Board through a quarterly AMS report to the Infection Prevention and Control Committee.

CQUIN 2022/2023

The CQUIN SCHEME for 2022/23 included an antimicrobial target regarding urinary tract infection recognition, treatment and management. Pharmacists were tasked with completing a rolling audit which included proactively influencing prescribing and retrospective data collection to ensure quality and activities around antimicrobial stewardship were achieved. The Trust achieved the CQUIN target with significant improvement in prescribing during the final two quarters of 2022/23.





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

Communication Programme

The Trust has a dedicated Communication Team. The IPC team informs the Communications Team, via email, of all outbreaks. Where these may result in media interest because of the nature or impact of the outbreak, the Communications Team is invited to meetings to provide support and guidance and to prepare proactive and reactive media statements.

In the past 12 months The IPC and Communications Teams have worked together to:

- Promote IPC events by providing online flyers
- Facilitate updated national guidance messages to staff
- Collate and disseminate a Trust wide bi-monthly IPC Bulletin
- Issue media statements during outbreaks.
- Support the annual campaigns such as Hand Hygiene day

IPC Bulletin

In May 22 the IPC bulletin was introduced to provide effective communication to staff. The bulletin is managed by the Communications team but led by the Chief Nurse and Chief medical Officer. Content is provided bi-monthly by both IPC and executive level teams.
The bulletin became an essential communication tool throughout the transition of improvements undertaken during the year. It features a spotlight of the week for areas of good practice and specific IPC focus.

Trust Website and Information Leaflets

The Trust webpage continued to be reviewed and improved following its redesign in February 2022. The page now provides information to patients and visitors informing them of the required IPC precautions, aligned to national guidance.

The webpage will continues to be updated by the Communications Team in collaboration with IPC as new information becomes available.

IPC now has a dedicated intranet page whereby the newly appointed IPC Administrator/Support Secretary takes lead on the design, upload and update of content.

Medical Illustration Team

The IPC team have strong links to the Medical Illustration team who have provided much help and support this year to enable us to deliver key information to staff and patients. Examples include:

- Bare below the elbow posters
- COVID-19 related information
- Outbreak signage
- Re-branding logos
- Driver diagram design

We continue to be supported by the team who provide us with a prompt service; enabling us to relay information in a professional, and timely manner.

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

The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at a local level; alert organism surveillance and managing outbreaks of infection.

Oswestry Infection Control (OIC)

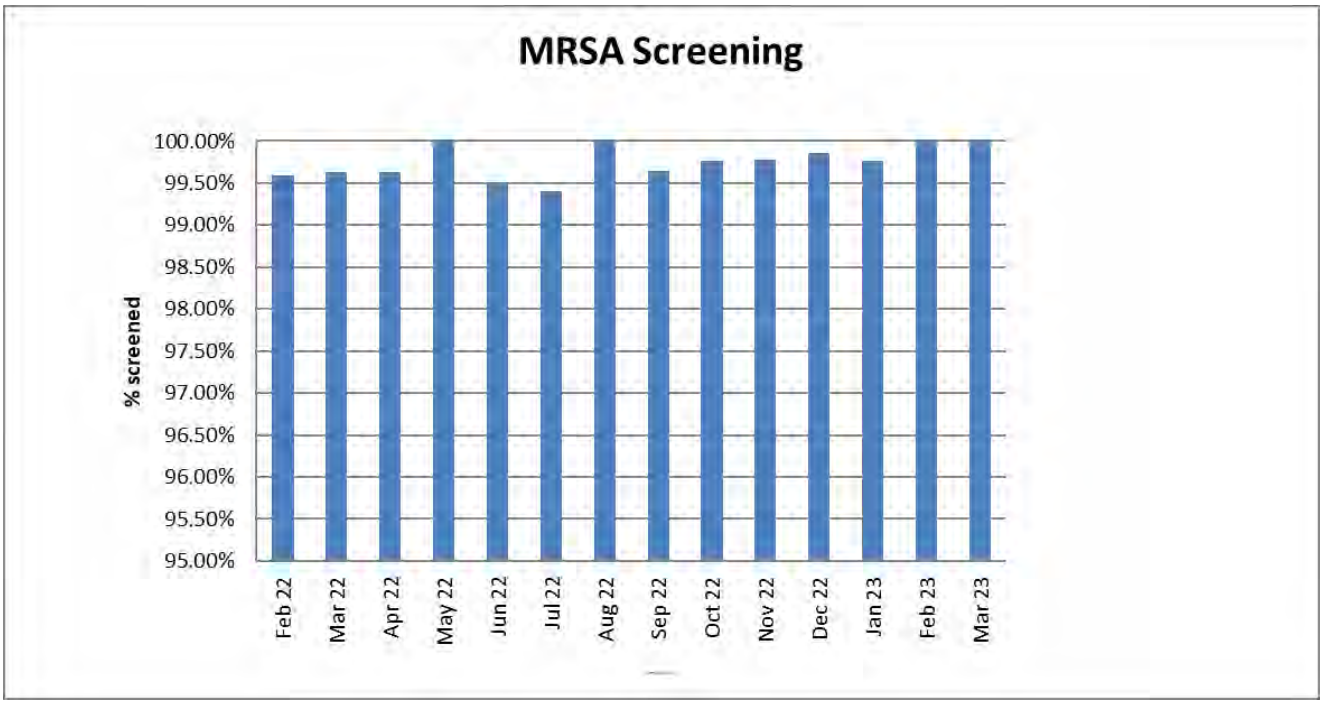
The IPC team receive a daily report (between Mon-Fri) which identifies all positive samples sent to the laboratory as part of the Oswestry Infection Control (OIC) reporting system. This system enables the IPC team to advise and support on the management of patients' infections; including patient placement, in order to reduce risk of cross-infection.

MRSA screening

Meticillin-Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that usually lives harmlessly on the skin, but if it gets into the body, it can cause serious infection that needs immediate treatment with antibiotics.

All elective surgical patients undergo screening for MRSA, and positive cases are alerted to the IPC team on a daily basis as part of the OIC reporting system. This enables prompt recognition of MRSA so that decolonisation treatment can be offered to the patient; preventing potential postponements of surgery.

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



	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Eligible patients	739	800	533	841	777	844	845	836	858	928	711	827	762	787
Screened for MRSA	736	797	531	841	773	839	845	833	856	926	710	825	762	787
% achieved	99.59%	99.63%	99.62%	100.00%	99.49%	99.41%	100.00%	99.64%	99.77%	99.78%	99.86%	99.76%	100.00%	100.00%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Surgical Site Infection Surveillance Service (SSISS)

Infections acquired in hospital are recognised as being associated with significant morbidity. They can result in extended length of hospital stay, pain, discomfort and sometimes permenant disability. Infections of the surgical site account for approximately 16% of all hospital acquired infections, are estimated to double the length of post-operative stay in hospital and significantly increase the cost of care.

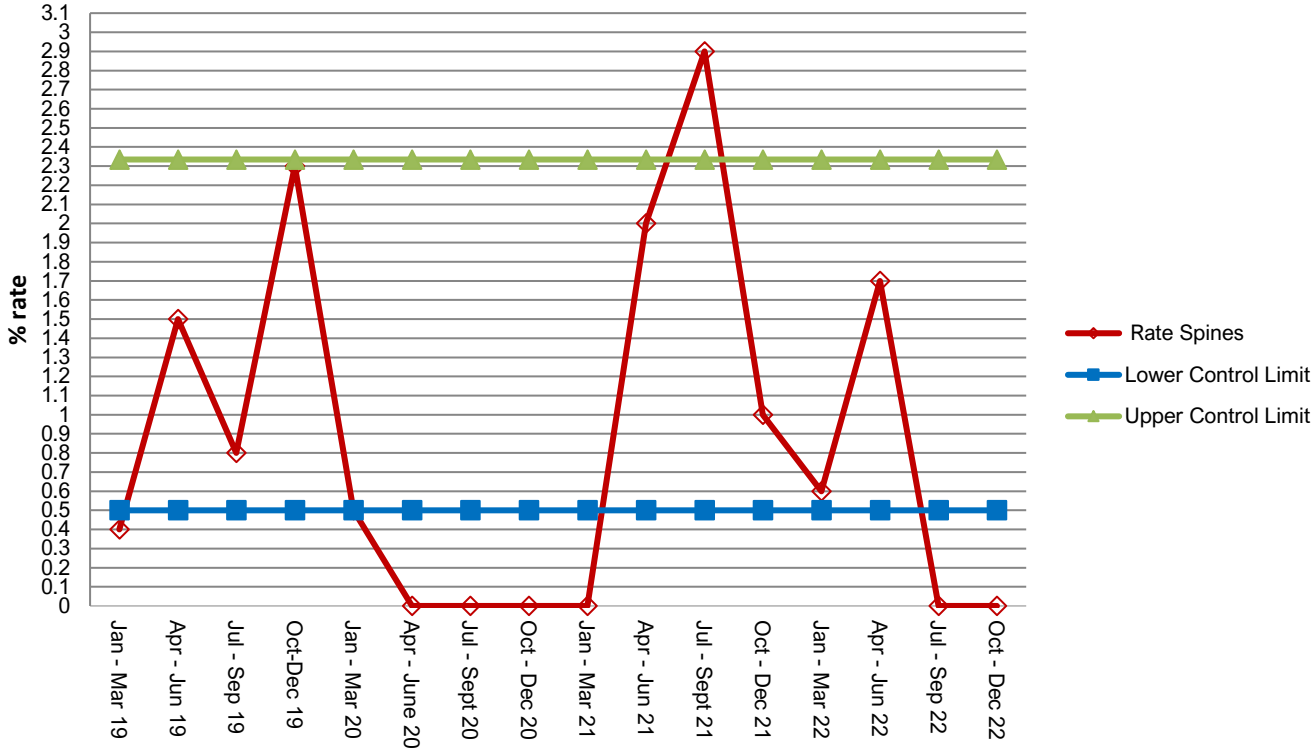
In April 2004, surveillance of surgical site infections (SSIs) in orthopaedic surgery became mandatory for all English NHS Trusts. RJAH submits surgical site infection data to the UK Health Security Agency (UKHSA) database on a quarterly basis.

The UK Health Security Agency (UKHSA) analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence may be high or low, enabling the Trust to benchmark against the national rate of infection.

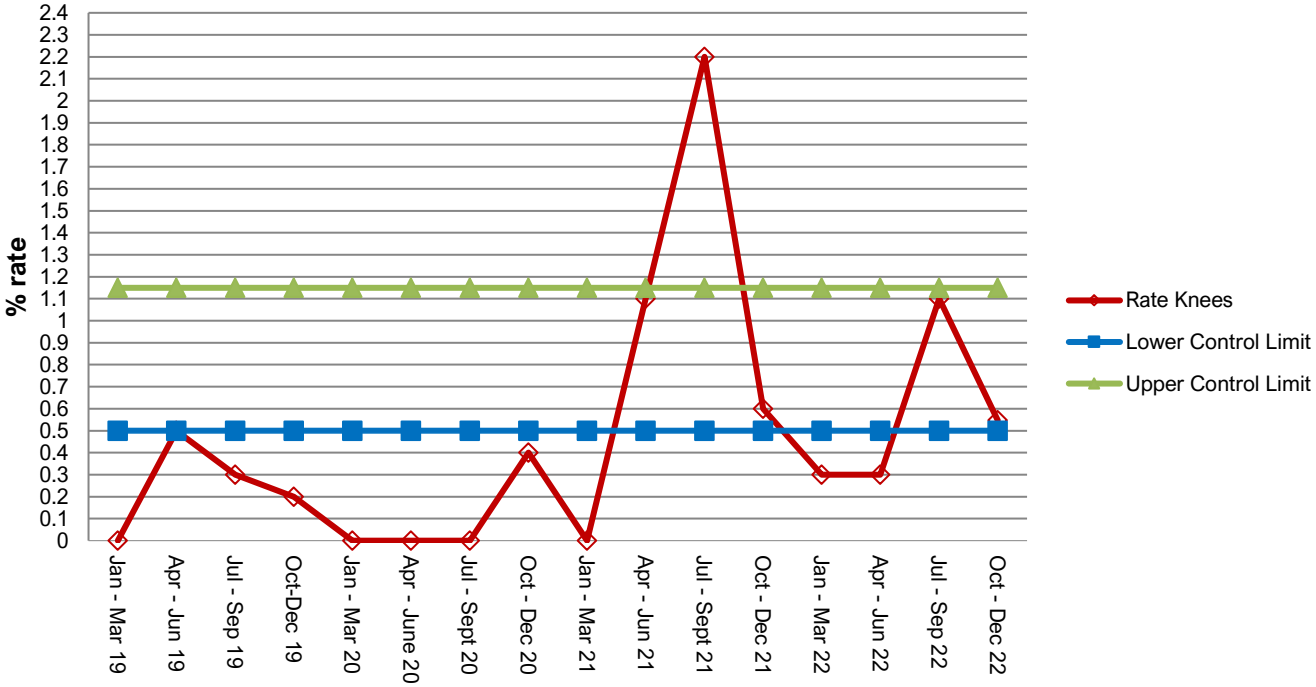
From April 2022 – October 2022, RJAH submitted data to SSISS on total of 2961 operations – 1271 Total Hip Replacements (THR), 1056 Total Knee Replacements (TKR) and 934 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 28 SSIs reported, 15 THR, 9 TKR, and 4 spinal surgeries.

The following graphs show the breakdown in RJAH rate of surgical site infections reported to UKHSA between January 2019 and December 2022. At the time of writing this report, UKHSA have not yet reconciled SSI data for Jan-March which is why it is not shown below.

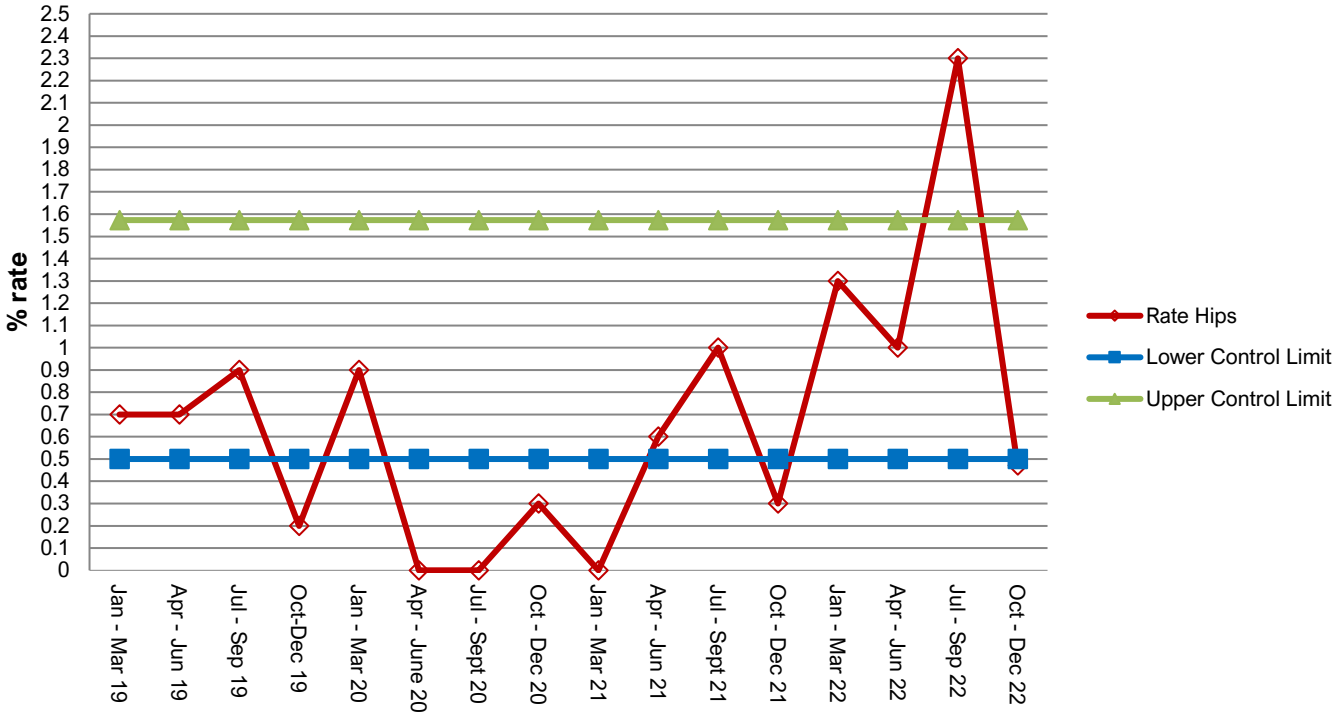
Rates of RJAH Spinal Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



Rates of RJAH Total Knee Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



Rates of RJAH Total Hip Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



Further to an investigation into the reported rise in surgical site infections (SSI) for the July – September 22 period, outlier letters were received from UKHSA for Total Hip Replacements (THR) and Total Knee Replacements (TKR) for this period.

An investigation was instigated with a tabletop exercises undertaken 4th and 18th November 2022 looking into cause and contributory factors using OneTogether audit framework.

Procedures to prevent SSI are aimed at:

- Minimising the number of microorganisms introduced into the incision site, for example removing microorganisms that normally colonise the skin of patient, maintaining asepsis and managing air quality.
- Enhancing the patients' defences against infection, for example by minimising tissue damage and maintaining normal body temperature during the procedure.
- Preventing the multiplication of microorganisms at the incision site, for example using prophylactic antibiotics.
- Preventing access of microorganisms into the incision site, for example postoperatively by use of a wound dressing

Pathogens that cause SSI may originate from:

• the patient's own microbial flora present on skin and in the body

• the skin or mucous membranes of operating personnel

• the operating room environment

• instruments and equipment used during the procedure

Upon completion of the SSI investigation, no singular root cause was identified, however a number of recommendations were made, including the introduction of a skin decolonisation regime (see below) and a review of the SSI process, to improve the monitoring of SSI and prompt identification of issues. It was agreed that the OneTogether toolkit provides a structured approach to assessing standards across the patient's surgical pathway, and it has been agreed that this will be used periodically to provide continuous cycle of assessment and improvement.

A report was presented to the IPC&C Committee in March detailing findings of the investigation and circulated to medical/surgical teams for wider learning.

MSSA decolonisation

Meticilin- Senstive Staphylococcus Aureus (MSSA) is a bacteria commonly found living harmlessly on the skin. Through the investigation of SSI during 2021-2022, we identified MSSA as the most common micro-organism found in wounds. In response to this, and to attempt to minimise future surgical site infections, the Trust introduced an MSSA decolonisation regime for all elective patients undergoing hip, knee and spinal surgery. Since 21/11/22, patients receive a decolonisation regime pack with instructions delivered by the Pre-op Assessment Team.

Infection Multi-Disciplinary Team (MDT)

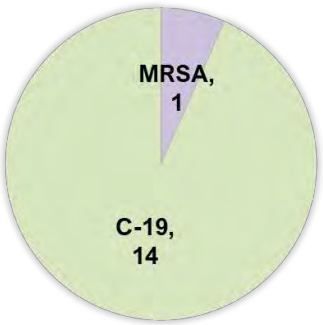
The MDT meet weekly to discuss infections and make recommendations for treatment. The Infection MDT is attended by Consultant Surgeons, a Consultant Microbiologist, an Antimicrobial Pharmacist, the Infection Prevention & Control Team, and a Consultant Radiologist.

UKHSA Surgical Site Surveillance System requirements are to report hip, knee and spinal surgery, howeverthe Infection MDT reviews patients from all orthopaedic specialities, including upper limb, lower limb, sports & spinal injuries.

Outbreaks

An outbreak of infection is described as two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample and are linked through a common exposure, personal characteristics, time or location. Each outbreak was investigated by a multi-disciplinary Outbreak Control Team, that reviewed all available evidence, and reported to UKHSA and the CQC.

The Trust managed a total of 15 outbreaks from April 22 – March 23:



A summary of outbreaks is tabled below:

Dept	Month Declared	Outbreak Type	How many involved (staff and pts)
Gladstone Ward	April 22	COVID-19	2 Patients 2 Staff
Sheldon Ward	June 22	COVID-19	1 Staff 2 Patients
Estates Dpt	June 22	COVID-19	4 Staff
Kenyon Ward	July 22	COVID-19	2 Staff 4 Patients
Powys Ward	July 22	COVID-19	3 Staff
Gladstone Ward	July 22	MRSA	5 Patients
Admisisons	July 22	COVID-19	2 Staff
Theatres	July 22	COVID-19	2 Staff
Clwyd Ward	July 22	COVID-19	1 Staff 3 Patients
Gladstone Ward	August 22	COVID-19	1 Staff 2 Patients
Sheldon Ward	August 22	COVID-19	5 Staff 5 Patients
Kenyon Ward	November 22	COVID-19	3 Patients
Sheldon Ward	November 22	COVID-19	1 Staff 6 Patients

Sheldon Ward	December 22	COVID-19	8 Patients 8 Staff
Sheldon Ward	March 23	COVID-19	2 Staff 4 Patients

After action reviews were implemented in July 22. The reviews are structured tofind cause and contributory factors and to share lessons learned.

The reviews were led by the IPC Team in collaboration with the Matron and Ward/Departmental Manager. Feedback takes the form of a poster for areas to display. The following info graphic captures all actions and outcomes identified:

Serious Incidents/ Periods of Increased Incidence

On 20 July 2021 an outbreak of Methicillin Resistant Staphylococcus Aureus (MRSA) was declared on Wrekin ward, which met the criteria of a Serious Incident. A total of ten patients tested positive for MRSA and it has been determined with evidence of transmission that eight of these patients contracted MRSA whilst admitted under the care of RJAH. The outbreak led to the closure of the Midland Centre for Spinal Injuries Unit (MCSI) on 26 July 20210 to further admissions until 23 August 2021.

Twice-weekly outbreak meetings were held that included ICS, UKHSA and NHSE. Audits were undertaken by the IPC team which showed issues relating to cleanliness, estates, clutter, and usage of PPE; and an initial audit showed a score of 79% compliance. External audits were undertaken by NHSE and a peer review by SaTH which showed similar findings. Over a period of two months, compliance scores improved to 98.5% which reflects the hard work and collaboration between the teams to improve standards.

In May 2022 a breach of license was confirmed and Trust were to be moved to segment 3 on the single oversight framework (SOF3). Over the course of 2022/23 the Trust made significant improvements and successfully implemented actions, providing assurance that sustainable changes have been embedded across the Trust. The Trust met the objectives set by NHS England, resulting in the Trust being moved from “red” to “green” on the Infection Prevention Control risk matrix and the removal of formal undertakings. The Trust also regularly received positive feedback that the improvements have been embedded and sustained across the organisation.

Actions were identified and included:

- Review of theTrust MRSA policy
- Clear cleaning responsibilities between clinical and domestic to be defined
- Introduction of a Trustwide Improvement Plan where actions were monitored weekly to ensure oversight
- Improvements made to clinical areas such as new flooring, wall coverings, door protection, bathroom facilities, cleaning cupboards and kitchens
- Introduce groin swabbing as part of all patients medical/surgical pathways
- Immediate identification and resolution of all environmental and estates repairs

- Regular peer and external departmental audits of compliance with IPC
- IPC quality walkabout audits undertaken using the Red Amber Green rating system to determine frequency of audits dependant on the overall score
- Develop avenues to check on understanding of IPC guidance and consider different ways of disseminating information.
- Audit of MRSA decolonisation regimes
- Shared learning from outbreaks cascaded through clinical leads and ACNs

In March 2023, the Board agreed that the Committee had delivered its purpose. The dedicated committee was therefore disestablished and oversight of the residual actions, and the wider IPC agenda, were transferred back to the Quality and Safety Committee. This arrangement was to be reviewed in six months' time, to ensure sufficient focus was still being paid to the IPC agenda

Moving forward, the focus for MCSI is on the maintenance and sustainability of the standards that have been achieved since the outbreak. The ward will continue to follow their standard auditing process; along with a programme of IPC quality assurance walks that will include collaboration with the Facilities team.

It was important that we shared the learning around the outbreak across the Trust. We were creative in the way we spread the important message that IPC is everybody's business; which is what inspired us to hold the IPC fayre (see our key achievements). We continue to include our journey of improvement (see below graphic) in training sessions, including doctor's inductions, HCSW sessions, orthopaedic course teaching sessions. We were able to reach a wide audience at the IPC Summit held in January, which offered attendees the opportunity to make their pleadge to infection prevention and control.


IPC Timeline & Journey of Improvement 2022-23
Q1
Q2
Q3
Q4
April
• Business case approval B5 SSI Practitioner & B3 IPC Support Worker & IPC Secretary.
• Truswide IPC Improvement Plan created to monitor and oversee all required improvements.
May
• Appointment of IPC Support Worker
• Appointment of SSI Practioner
• Training needs analysis undertaken
• Promotion of Glove awareness and Hand Hygiene week with competitions and prizes for staff
June
• Development IPC training report for IPC&C Committee.
• IPC Fayre provided training sessions on IPC areas of focus.
• Hand Hygiene competencies added to ESR.
July
• IPC Re-Brand
• MRSA Outbreak MCSI
• Increased IPC focus, support & engagement from NHSE & UKHSA
• Management of actions via audit reporting system.
• Increased QA Walks for high risk areas.
August
• Bespoke Quality Assurance Walk audit for Theatres uploaded to auditing system.
September
• Trust Reporting/Auditing System designed & Implemented by IPC Assurance Lead to analyse audit scores.
October
• Rise in SSI for July – Sept 22 Investigation.
November
• Implementation of pre-op MSSA decolonisation
• SSI review
• Appointment of IPC admin assistant/support secretary
• Reintroduction of face to face meetings IPC Link Practitioners
December
• IPC Assurance Lead appointed permanent.
• NHSEI visit confirmed sustained improvements. Maintained Green status on the SOF matrix.
• Post discharge surveillance commenced for spinal surgery.
January 23
• IPC Summit – launch of strategy
• IPC Quality Improvement plan realigned to HSCA and merged actions. Upodaded to MS Teams
February 23
• OneTogether re-audit shows improved scored of 95% compliance
March 23
• NHSE monitoring visit

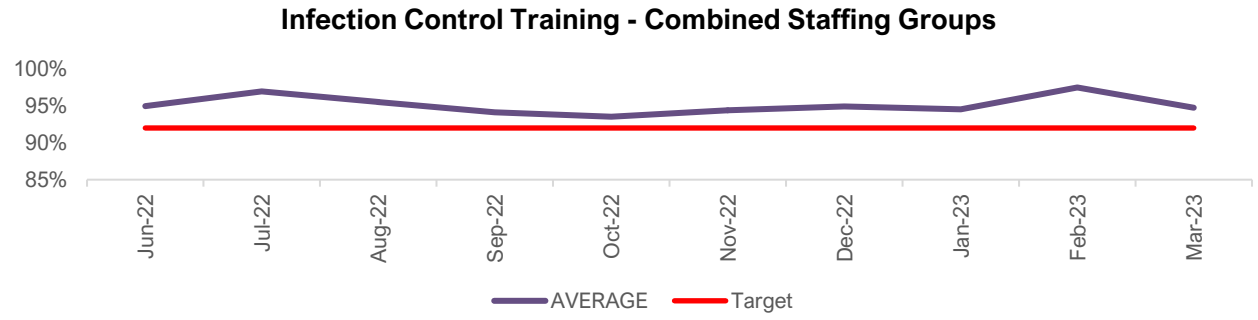
Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

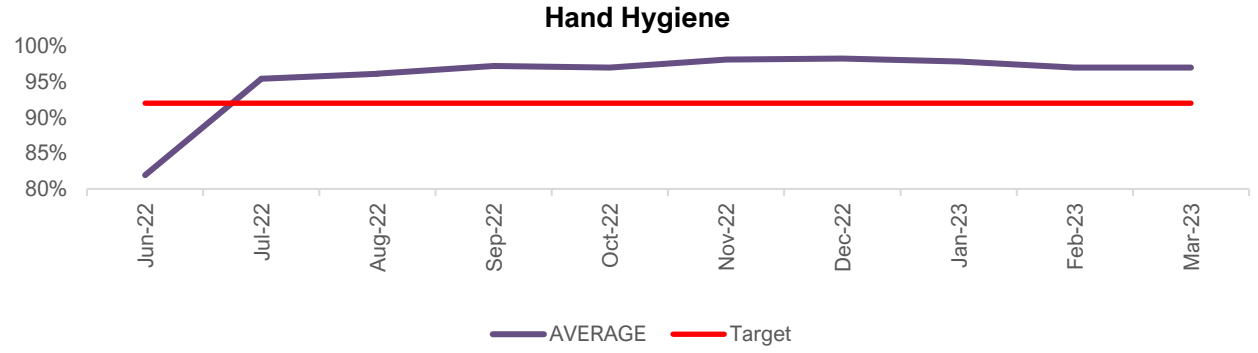
The following IPC modules are monitored via ESR and mandatory for staff to completed:

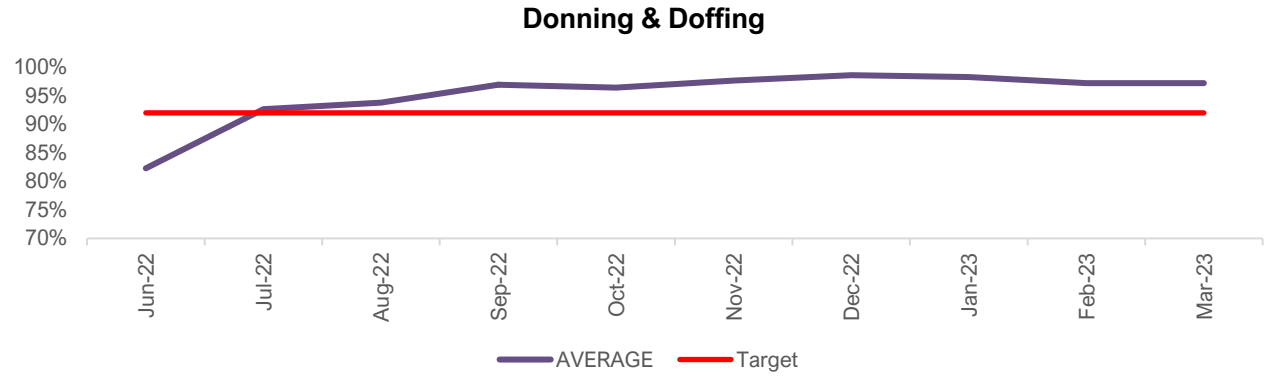
- Infection Control Training Clinical & Non Clinical
- Hand Hygiene
- Donning & Doffing
- Aseptic Non Touch Technique
- Cleaning for Confidence Intensive Care Units
- Cleaning for Confidence: Introduction

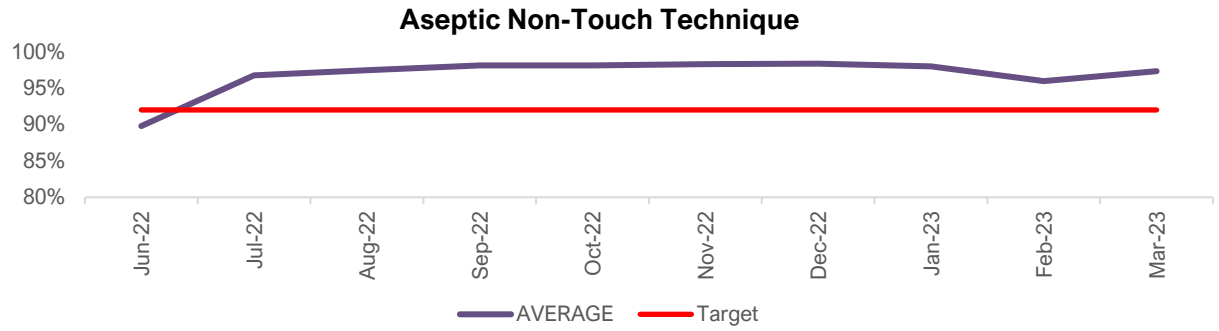
The IPC QMS was expanded in June to monitor the trajectory of compliance to these training modules.

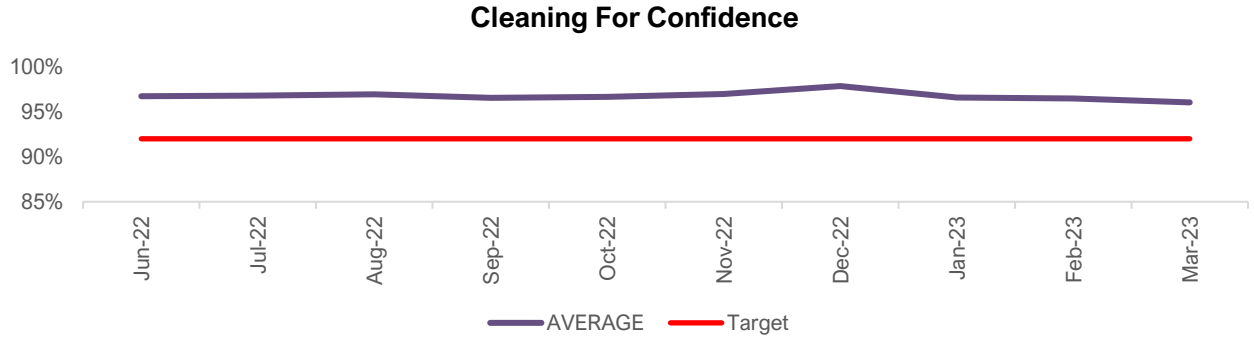
Graphs below evidence the continued upward trend to the compliance of each training module throughout the year.











Additonal to the mandatory suite of IPC modules managed via ESR, the following training is delivered by the IPCN and IPC Support Worker.

- Induction training for all clinical and non-clinical staff and rotational doctors
- Hand washing assessments to clinical staff to ensure staff obtain full hand hygiene competency.
- All volunteers receive a training presentation and hand hygiene education.

The IPC team have provided a number additional of education sessions throughout the year including:

Orthopaedic course – The Orthopaedic/Spinal Injuries course is delivered at RJAH through Staffordshire University. As part of the programme, the IPCN provides an educational session for delegates around the importance of practising standard infection control precautions to prevent infection.

CPE staff information leaflet – The IPCN developed a Carbapenemase-Producing Enterobacteriacae (CPE) leaflet for staff on the Midlands Centre for Spinal Injuries (MCSI) unit in response to a period of increased incidence. This has been shared Trust-wide and is located on the Learning & Development Team's digital displays around the Trust.

CPE education for doctors – The IPCN and Consultant Microbiologist gave CPE education to the medical workforce on the MCSI unit during the period of increased incidence within the unit.

HCSW training sessions – The IPCN has delivered several teaching sessions to Healthcare Support Workers to aid their understanding around the chain of infection and measures that we practice to ensure that pateints are cared for in a clean, safe environment. We have collaborated with the wider System and provide regular teaching sessions for HCSWs outside of the RJAH community.

Criterion 7: Provide or secure adequate isolation facilities

The Trust has isolation policies in place and has single side room accommodation with en-suite facilities to isolate patients when required. We learned lessons through the COVID-19 pandemic around the ability to cohort patients who were either COVID-19 positive or contacts of a positive patient; and to enable effective cohorting of patients, the Estates team fitted doors to bays around the Trust. This has improved our ability to provide a safe environment whilst mitigating some risk of cross-infection.

The Trust Isolation Policy includes a risk assessment tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case by case basis. In rare cases where there has been no side room available; the IPC team have assisted the ward area with mitigations dependent upon the organism – this is documented in a risk assessment template and kept in the patient's notes.

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

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. The ICD is a Consultant Microbiologist at SaTH who is contracted to work at RJAH as a specialist. Medical microbiology support is provided 24 hours a day, 365 days a year.

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

A review of all IPC policies was carry out in January 2023. The IPC Team will continue to ensure all policies align to the NIPCM and will include the following steps into the IPC programme of works for 23/24:

- Step 1: Continue to assess and align all IPC Policies to the NIPCM
- Step 2: Align Quality Assurance Walks question sets to the NIPCM to provide a robust and regular monitoring system to the effectiveness of IPC audits Trustwide.

Policies Reviewed/Published in 2022- 23	
Cleaning & Decontamination Policy	Infection Prevention & Control Policy
MRSA Policy	Influenza Policy
Surgical Site Infection Policy	Tuberculosis Policy
Isolation Policy	Management of Sharps Injuries and Exposure to Blood Bourne Virus Policy
Hand Hygiene & Personal Protective Equipment	Carbapenemase Producing Enterobacteriaceae (CPE)
Coronavirus /Seasonal Respiratory Policy	Multiply Resistant Gram Negative Organisms
Legionella Policy	Streptococcal Infections
Diarrhoea and or vomiting - Management of affected patients and staff including Norovirus	

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

<u>TP Health Occupational Health & Employee Well-Being</u>

TP Health is committed to the protection of all Trust employees as an essential part of Infection Control policies and guidance. In line with the Health and Social Care Act and Department of Health Guidelines, TP Health have arrangements in place for assessing the immunisation status of all Trust employees as well as regularly reviewing the immunisation status of existing healthcare workers and providing vaccinations as necessary and in accordance with the Green Book and Joint Committee on Vaccination and Immunisation to reduce the risk and spread of vaccine-preventable disease. There are currently two days per week at RJAH of Occupational Health clinics, which are mainly filled with new starter immunisations. RJAH are able to utilise the OH facility at SaTH for convenience.

Blood Borne Virus Exposure

Blood borne virus exposure incidents or injuries may represent a significant risk to staff working in healthcare environments. Under Health and Safety Legislation, TP Health work collaboratively with the Trust to ensure their responsibility for the health and safety of staff in relation to preventing, reducing, and controlling the risks of healthcare associated infection and management of occupational exposure to blood borne viruses and post exposure prophylaxis. TP Health are responsible for the assessment and follow up of all blood borne virus exposure incidents occurring during departmental opening hours and for the follow up of those exposure incidents occurring out of hours in emergency departments.Between April 2022 to March 2023 exposure incidents reported to TP Health was a total of 18 incidents. Of these 18 incidents, 13 of these were percutaneous.

Flu Campaign 2022/2023

This year's flu campaign was led by the Trust Medicines Management Lead Nurse. Staff uptake was lower than expected this year at 56.9%, however this low uptake was reflected nationally. Drive for COVID-19 vaccinations were throught to be a contributory factor to the low uptake figures.

Moving Forward

Our drivers (mentioned in our key achievements) have led us to create structure to our ambitions (see below graphic) which will be monitored through the IPC Team annual plan:

Integrated Working – we will collaborate with other providers across the System to consolidate our approach to IPC

Education and Training – we will innovate our approach to IPC educations and training by empowering staff to check and challenge IPC practices. We will engage staff with national IPC initiatives and campaigns

Digital Technology – We will introduce technology to enhance our surveillance of Alert organisms

Enhanced Engagement and Involvement – We will innovate and revise IPC data collection, analysis and reporting to improve all staff understanding of IPC quality metrics.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
IPC Quality Improvement Ambitions

Integrated working

Collaborate with other providers across Shropshire Telford and Wrekin, to consolidate our approach to IPC

- Work collaboratively to deliver the ICS IPC Strategy
- Drive sustainability and build resilience of IPC by developing new ways of working with other provider IPC Teams
- Develop peer support processes for IPC audit

Education and Training

Innovate our approach to IPC education and training

- We will empower staff to check and challenge poor adherence to IPC practice
- Provide a central space for IPC information
- We will engage staff with National IPC initiatives and campaigns

Digital Technology

Harness technology to make IPC accessible and responsive

- The Trust will introduce technology to enhance our surveillance of Alert Organisms
- We will review our Surgical Site Infection Surveillance systems and introduce new ways of data capture and more accurate reporting

Enhanced Engagement and Involvement

Ensure IPC has Board to Floor engagement and involvement

- We will improve and review IPC data collection, analysis and reporting to improve all staff understanding of IPC quality metrics
- Promote a robust governance structure with clearly defined roles, responsibilities and accountability for IPC

Conclusion

This year has continued to be challenging as we have worked through our improvement journey. However, we have embraced this extraordinary challenge and are proud to be able to demonstrate our collaborative approach across the Trust. The IPC Team are excited to move into the next year with a more proactive approach to the prevention and control of infection, in line with our vision of a zero tolerance approach to noscomial infections. Over the last year the IPC has grown, and with increased visibility around the Trust and our passion to help our staff provide the highest levels of patient care, we are seeing increased ownership and engagement.

We are committed to our vision and look forward to moving back into 'business as usual' approach after the COVID-19 pandemic, with a focus on sustaining and further improving the standards we have reached.

We would like to express thanks to all of the hard working, committed RJAH family for embracing this journey with us, and very much look forward to celebrating our sustained improvements throughout the next year.

Samantha Young	Director of Infection Prevention and Control (DIPC)
Anna Morris	Clinical Lead for Infection Prevention & Control
Hayley Gingell	IPC Assurance Lead

June 2023

Controlled Drug Accountable Officer Annual Report 2022/23

Committee / Group / Meeting, Date

Board of Directors (Public), Wednesday 08 November 2023

Author:

Name: Caroline Jenkins,
Title: Interim Chief Pharmacist

Contributors:

Maryse Mackenzie, Medicines Safety Officer
Paul Kavanagh-Fields Chief Nurse and Patient Safety Officer

Report sign-off:

Paul Kavanagh – Fields, Chief Nurse and Patient Safety Officer
Quality and Safety Committee, October 2023

Is the report suitable for publication?:

No

Key issues and considerations:

The purpose of the report is to provide the committee with assurance that the Trust meets its obligations regarding the use and management of controlled drugs within the organisation. The report provides an update on monitoring and auditing of CDs, medication incidents involving CDs and the investigation and actions following these.

The Controlled Drugs incidents trajectory currently indicates that the numbers of incidents reported are constant. This report provides assurance that we are aware of the main issues and continue to work to improve areas around Controlled Drug local intelligence network categories. Our key areas of concern are discrepancies and accounted for losses.
In 2022/23, there were no critical incidents reported.

Attendance at the Controlled Drug Local Intelligence Network is 100% and staff training for processes pertaining to Controlled Drug medication is 90.23%. This is monitored quarterly and ward, theatre and departmental managers are contacted regarding compliance. Attendance for CD destruction can be challenging requiring non-pharmacy staff engagement

In conclusion, this report demonstrates assurance that there are effective processes in place and remedial actions are taken to address any concerns raised in relation to the handling/management of Controlled Drugs at RJAH.

Strategic objectives and associated risks:

Coporate Objective -'deliver high quality clinical services'
CQC – safer management of controlled drugs
Patient Safety and experience - Safer management of Controlled Drugs improves patients' safety and therefore experience
Financial - Investment in new technology to underpin safe medicines processes
Workforce - An appropriately trained workforce is essential for the safe management of all drugs.
Equality, Diversity and Inclusion - Improving patient safety by reducing avoidable harm from controlled drugs has the potential to reduce inequalities as harm from Controlled Drugs may be variably distributed between groups with different protected characteristics.
Legal - The Misuse of Drugs Act 1971; The Misuse of Drugs Regulations 2001; The Controlled Drugs Regulations 2013

Recommendations:

Continue with current monitoring and audit patterns.
The Board are asked for their support to look at investment in technology to assure safety for CD and wider medication management.
The Board of Directors is asked to accept the contents of this report and to consider the risks detailed.

Next steps:

Develop paper for capital investment to support the installation of automated medicines units for ward areas.
Escalate CD destruction commitment to relevant areas.

Acronyms

Glossary

BNF – British National Formulary
CD – Controlled drug(s)
CDAO – Controlled Drug Accountable Officer
CDLIN – Controlled Drug Local Intelligence Network
CLDO - controlled drug liaison officer
CQC – Care Quality Commission
Datix – incident reporting database software
EU – European Union
IG – Information Governance
MDA - misuse of drugs act 1971
MDR - misuse of drugs regulations 2001
MSO – Medicines Safety Officer
NHS – National Health Service
RJAH- The Robert Jones and Agnes Hunt Orthopaedic Hospital
RN – Registered Nurse
SNAHP – Senior Nurse and Allied Health Professional
SOP – Standard Operating Procedure
Tendable® - audit software for point prevalence monitoring

Appendices

Appendix A	Controlled Drug Accountable Officer Annual Report

Controlled Drugs Accountable Officer (CDAO) Report

1. Section 1: Analysis and supporting detail.

1.1. Background

1.1.1. Purpose of the report

To ensure that "safe management of controlled drugs" is maintained as an organisational priority.
To provide assurance on the systems and processes within RJAH Orthopaedic Hospital Foundation Trust that led to the safe management of controlled drugs.
To update the Board of Directors on any concerns raised in last year's (2021/22) report.
To highlight the recommendations from the Care Quality Commission (CQC) annual report on controlled drugs (CD) (published July 2022).

1.1.2. Background to CDAO

In January 2000, Doctor Harold Shipman was convicted of the murder of 15 of his patients using the drugs diamorphine (heroin) and morphine. Reports also suggest that he may have used these drugs to kill many more of his patients, possibly around 250.

Between 2002 and 2005 six reports were published under the chairmanship of Dame Janet Smith. These led to the legislative changes which were introduced in the 2007 Health Act to strengthen the governance arrangements surrounding the use of controlled drugs by "relevant people".

As part of the statutory requirements contained within the 2007 Health Act organisations such as NHS trusts were required to appoint a CDAO, who was responsible for the assurance of safe use of controlled drugs throughout the organisation. Other requirements included the sharing of information (or intelligence) across organisational boundaries and a duty to collaborate. Where there are strong grounds for concern a CDAO must share intelligence with other bodies such as the police, the NHS counter fraud service, the CQC or registering bodies such as the General Medical Council, the Nursing and Midwifery Council, and the General Pharmaceutical Council.

In 2013 new legislation was introduced (The Controlled Drugs [Supervision of Management and Use] Regulations 2013) which brought the previous medicines and CD legislation in Line with the NHS organisational changes. This legislation was put in place to ensure that the overriding aim of the CDAO continued to be to protect the public from harm in relation to controlled drug use by relevant people.

The CDAO is responsible for coordinating the sharing of information through Local Intelligence Networks (LINs). To support the CDAO in this task the MSO and Chief Pharmacist attend and share via reporting to the local LIN. Information concerning all incidents relating to controlled drugs is reported by the RJAH CDAO to the Midlands CD LIN on a quarterly basis.

1.1.3. Controlled Drugs

In August 2012, the legislation covering medicines for human use was revised and consolidated into a new act – The HUMAN MEDICINES REGULATIONS 2012. This legislation updated the 1968 Medicines Act and incorporated various changes introduced by EU legislation together with all the updates and variations to the original act. There is a degree of complexity surrounding the laws relating to medicines and CDs but in general terms the main legislative points to note are:

1.1.4. The Misuse of Drugs Act 1971 (MDA 1971)

This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

1.1.5. The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments)

Covers the medical use of those drugs listed within the MDA 1971. Within the context of MDR 2001 the classification system for the medical use of these drugs, defines the drugs by a different system of

schedules (1, 2, 3, 4 & 5). Within this context these drugs are classified according to their likelihood of harm vs therapeutic benefit. With Schedule 1 drugs being the most tightly controlled in terms of prescribing, dispensing, storage & transportation and Schedule 5 having the least control. Schedule 4 also includes anabolic steroids.

The British National Formulary (BNF) gives details of the legal status of most of the medicines used in the UK. The Chief Pharmacist/CDAO would be expected to intervene in all cases where there may be a concern about the use of these drugs by relevant people. Further details can be found on the home office website http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-licences/controlled-drugs-list.

1.1.6. Management of Controlled Drugs (CD's)

Following the activities of Dr Harold Shipman in the 1990's, it became clear that the systems and process of control that were in place at the time to govern the use of CDs were inadequate. Following the fourth report of the Shipman enquiry in 2004, the chairman Dame Janet Smith concluded that the governance arrangements for these drugs needed to be strengthened.

Many of her recommendations from the enquiry were incorporated into part three of the 2007 Health Act and statutory instrument No. 3148 The Controlled Drugs (Supervision of Management and Use) Regulations.

http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf
http://www.legislation.gov.uk/uksi/2006/3148/pdfs/uksi_20063148_en.pdf
One of the key changes introduced by the 2007 Health Act was the statutory requirement for NHS trusts (and other relevant bodies) to appoint an Accountable Officer for Controlled Drugs (CDAO).

1.1.7. Statutory role of the Controlled Drugs Accountable Officer (CDAO)

The requirement for designated bodies to appoint a CDAO was made in the 2007 Health Act and has been reiterated in subsequent legislation. The CDAO must ensure that their designated body has adequate arrangements for the safe and legal management and use of controlled drugs throughout the organisation.

The overriding concern of the CDAO is to protect the patients and public from harm due to controlled drugs by relevant people. There are several specific duties of the CDAO. Full details of the duties of the CDAO are laid down in Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (http://www.legislation.gov.uk/uksi/2013/373/part/2/made).

The CQC are required to hold a record of all CD accountable officers (and ensure all relevant organisations are registered with them. See http://www.cqc.org.uk/content/controlled-drugs-accountable-officers)

Duties of the CDAO include ensuring that:

- The organisation is following "adequate and up to date" Standard Operating Procedures (SOPs).
- Appropriate arrangements for monitoring and auditing the management and use of controlled drugs.
- Systems exist to alert the accountable officer of any complaints or concerns involving the management or use of controlled drugs.
- The incident reporting system captures untoward incidents involving the management or use of controlled drugs.
- Appropriate arrangements in place for analysing and responding to untoward incidents involving the management or use of controlled drugs.
- Relevant individuals receive appropriate training in relation to controlled drugs.
- Arrangements are appropriate for monitoring and auditing the management and use of controlled drugs by relevant individuals and assessing their performance.

- The recording of any concerns raised in relation to the management or use of controlled drugs by a relevant individual.
- The assessment and investigating of any concerns raised regarding the management or use of controlled drugs by a relevant individual. The CDAO must determine whether these concerns should be shared with a responsible body.
- Appropriate action is taken to protect patients or members of the public in cases where concerns in relation to the management or use of controlled drugs by a relevant person appear to be well-founded.
- Appropriate arrangements for ensuring the proper sharing of information.

The designated body (Board of Directors) has a responsibility to ensure that they notify the CQC of the name of the CDAO and that they are a "fit, proper and suitably experienced person" who does not 'routinely supply, administer or dispose of controlled drugs as part of their duties'.

Notification to the CQC should be done through the relevant section of the CQC website (http://www.cqc.org.uk/content/controlled-drugs-accountable-officer-notifications) -This notification section is password protected.

The Trust can be assured that the CQC hold details of the CDAO for RJAH 2022/2023 as follows:

2022/2023	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Sara	Ellis-Anderson	Sara.ellis3@nhs.net	01691 404358	Oswestry	SY10 7AG

Designated bodies are required to ensure that the CDAO is provided with the necessary funds and resources to carry out their responsibilities.

1.1.8. CD Recommendations from the Care Quality Commission (CQC)

The CQC scrutinise and report on how well NHS trusts and other agencies work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people.

In July 2022, the CQC published their latest annual report.
The safer management of controlled drugs: Annual update 2022 - Care Quality Commission (cqc.org.uk)

The board of directors are advised the following recommendations relate to RJAH:

Table 1. CQC recommendations relevant to RJAH Orthopaedic Hospital Foundation Trust

Make sure your governance processes are up-to-date and fit for purpose	
• Areas remain where improvements can be made. • Particularly where there are complex commissioning arrangements for services. For example, where several providers are involved in delivering a person's care, it's important to have clear roles and responsibilities in relation to controlled drugs, such as reporting incidents. • All parties involved must understand and agree these so that people receive safe care. Local intelligence networks can provide examples of good governance processes, which providers can adopt and tailor to their own services.	Compliant through Medicines policy and CD policy. Addressed through this document. Assured through CD LIN and ICS medicines safety forums.
Make sure prescribing at transfer of care is completed safely	
• Clinicians must have the relevant medical and medication history before prescribing controlled drugs to patients.	Assured through access to SCR and medicines reconciliation activities.
Know the identity of your local controlled drugs accountable officer (CDAO) and police-controlled drug liaison officer CLDO.	

• Any organisation with a responsibility around controlled drugs must have these details and know how to report controlled drugs incidents. • CDAOs and CDLOs are important partners and can provide help, support, and advice on a wide range of controlled drugs issues, as well as for reporting incidents.	Assured through MSO and CDAO training and participation in regional meetings.
Work collaboratively to improve the prescribing, managing and monitoring of controlled drugs.	Compliant through medicines management activities

1.1.9. RJAH Assurance relating to Trust CD Policy

1) Any serious concerns relating to controlled drugs are investigated and actions taken to prevent recurrence.

2) All reported losses/discrepancies are reviewed, investigated, and followed robustly with teams and managers according to the Trust CD Policy.

3) The CDAO will share any serious concerns relating to controlled drugs and relevant people with NHS England, Midlands LIN and CDAO.

4) The CDAO or appropriately trained deputy (Chief Pharmacist or Medicines Safety Officer) attends the Regional CD LIN meetings.

1.1.10. Update on issues reported to the Committee in the previous annual CDAO reports (2021-2022)

No concerns/outstanding issues.

1.1.11. Review of reported incidents involving all controlled drugs

RJAH monitors and audits the management, prescribing and use of CDs. Discrepancies/incidents are reported via Datix® and subsequently to the CD LIN. The Controlled Drug Accountable Officer (CDAO) would be informed in person or by e-mail if concerns are noted/raised. Pharmacy completes monitoring of CDs and other abusable medicines monthly. Data is then reviewed and reported to the Trust Medicines Safety Officer (MSO). Any anomalies or changes in patterns noted are then reported via Datix® investigated and appropriate action taken.

For 2022-2023 any noted anomalies or changes were attributed to increases in hospital activity. The Trust has a defined audit process for CDs. The West Midlands Audit tool is used for all audits undertaken. The audit results go to Matrons, Ward Managers and MSO via Tendable®. Ward level action plans are produced to address any issues identified and followed up at the subsequent re audit.

1.1.12. Reporting of Incidents

The general trend for reported incidents is static, see Figure 1. There have been no serious untoward incidents reported involving schedule 2 and 3 CDs for 2022-2023. The Trust has reported 32 incidents via Datix® that are reportable out to the CD LIN. All 32 of the reported incidents were rated as low risk. See Figure 2 below.

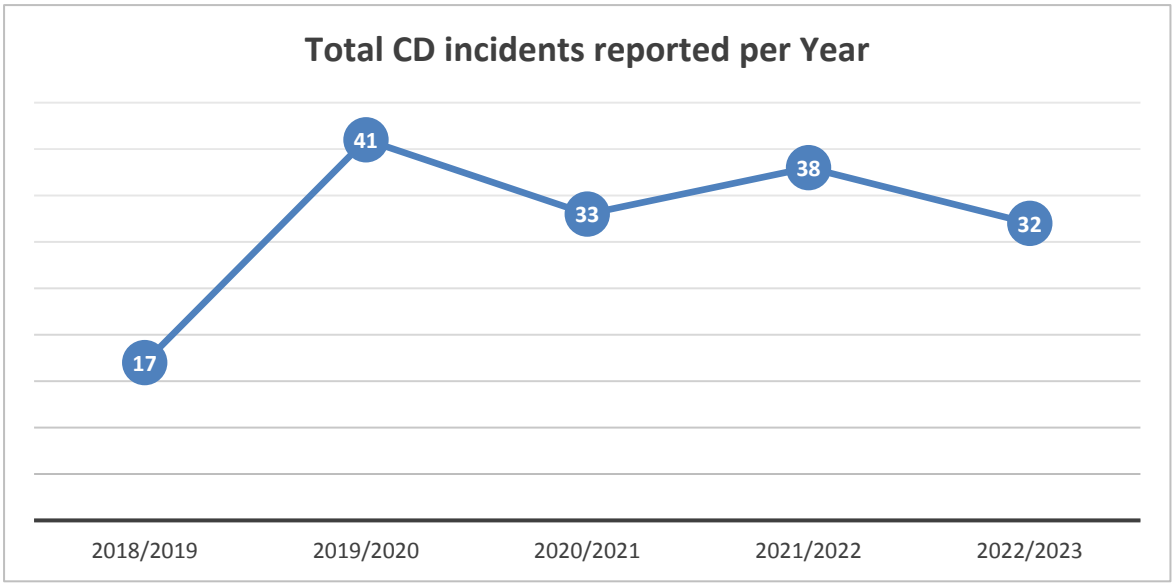


Figure 1. Trend of number of incidents reported each year.

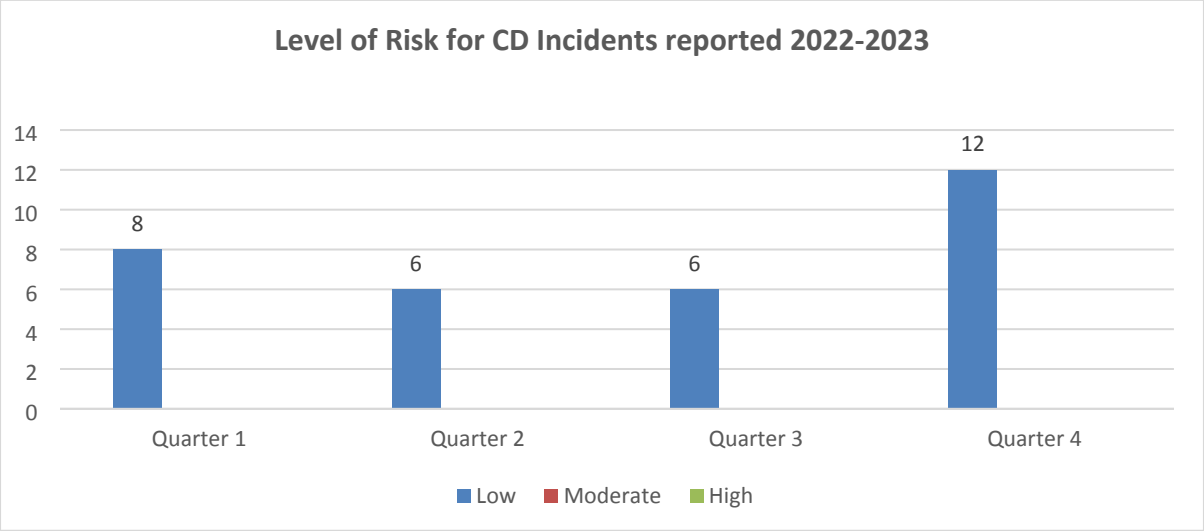


Figure 1 - The annual number of reported incidents involving all controlled drugs (Apr 2022 to Mar 2023)

1.1.13. Review and investigation of incidents

Incidents were reported to the CDAO through the trust electronic incident reporting and management system called “Datix®”.

In cases of known or suspected serious or major concern, the CDAO will act immediately and inform the Chief Executive and Medical Director and will put systems in place to prevent further harm. If the CDAO believes that there are strong grounds for major concern they will share information with other relevant bodies e.g., LIN bodies, Police, CQC etc.

All reported CD incidents are subject to a brief initial assessment by the MSO, ward manager and pharmacist as a triaging process for the CDAO. A prioritised investigation is triggered if the CDAO or others suspect that the incident may be a major concern.

In cases where the investigation of a reported incident is considered insufficient, the MSO will oversee a more granular investigation and interview the staff involved, their manager and any other relevant people to triangulate and verify the information received. Details of individuals’ behaviour in relation to relevant SOP’s, their medicines related training and their involvement with other CD or medicines related incidents are all considered and recorded as part of the investigation process.

There are cases where there is insufficient information, or it is impractical to gather more details. Rather than leaving these as open, or on-going, but where there is little prospect of gathering more detailed information e.g., staff leaving, then these incidents will be classed as “technically closed” but would be re-opened if further information comes to light through other incidents. Details of all incidents and subsequent investigation are held by the trust incident recording system. A summary of the incidents reports is shown in table 2 below.

1.1.14. Issues of serious or major concern (April 2022 to March 2023)

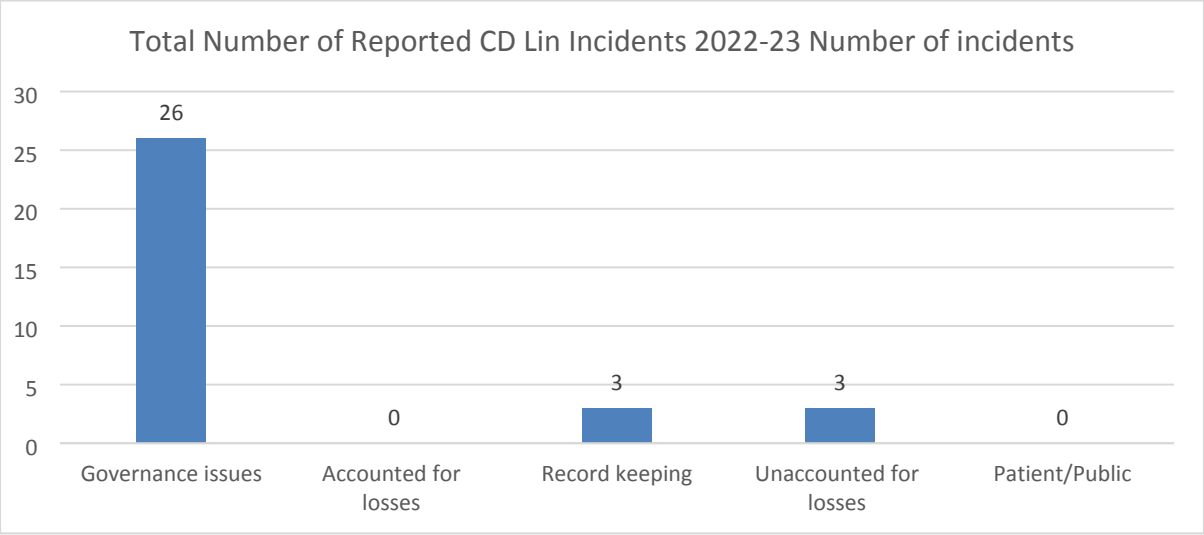
No issues of serious concern were reported between April 2022 – March 2023.

1.1.15. Other issues (April 2022 to March 2023)

Nil

1.1.16. CD Discrepancies

32 incidents via Datix® were reported to the CD LIN.



Graph 2 RJAH reported CD incidents by CD LIN Category.

CD LIN reporting categories:

- Accounted for losses.
- Unaccounted for losses
- Patient/Public
- Governance issues
- Record keeping
- Other

To Note: though not required by the CD LIN the Trust report locally on all CD incidents regardless of the schedule they may come under. Below is a brief description of the incidents reported to the CD LIN for each quarter. The incidents have been classed as low harm. Standards for CD processes are monitored through the CD audits completed by medicines management personnel. Learning from CD incidents is communicated via groups and meetings such as patient safety and SNAHP and disseminated to ward staff.

Table 2. Brief overview of CD incidents reported to CD LIN for each Quarter 2022/2023

Quarter	Ward	Brief description of CD discrepancy incident – low harm
1	Gladstone	Inaccurate stock balance not noticed for 24hr. Prescribed Tramadol not administered pt asleep. Patient prescribed 200mg of Gabapentin was administered 100mg Gabapentin.
	Wrekin	Incorrect dose of Morphine Sulphate administered and taken by the patient.
	Clwyd	Incomplete documentation of administration of Gabapentin.
	HDU	2ml underage of oral morphine solution
	Sheldon	Oxycodone 20mg administered instead of 25mg prescribed. Ampoule of Morphine Sulphate 10mg/ml found broken in new pack.
2	Pharmacy	Zomorph capsule missing.
	Kenyon	Accidental Breakage of oral morphine solution bottle.
	Wrekin	Gabapentin 300mg found on pts table. Not observed taking. CD keys could not be located.
	Gladstone	Patient own Tramadol entered into the CD register incorrectly.
	Oswald	Inaccurate documentation against the incorrect preparation of oxycodone.
3	Sheldon	Accidental breakage of vial of midazolam whilst performing the CD daily check. Purple bug became dislodged when preparing a dose of oxycodone liquid.
	Ludlow	Pregabalin administered but not document in the CD register.
	Kenyon	Accidental spillage oral morphine solution whilst drawing up a dose.
	HDU	Two capsules found to be damaged within the foils outer packaging.
	Main Recovery	The stock CDs for Menzies were handed over and taken back to main recovery.
4	Wrekin	Discharge TTO of Pregabalin not given to the patient on discharge. Patient missed a dose of Pregabalin on four consecutive days.
	Powys	Oxycodone administered but not documented in CD register. CD register balance for Tramadol MR incorrect by one tablet. Multiple doses of Pregabalin missed with no code used.
	HDU	Oxycodone 20mg MR x 1 lost after removal from the CD cupboard.
	Gladstone	Pregabalin capsule found on the counter hidden beside a bag. Multiple CDs prepared taken to incorrect pt not taken.
	Pharmacy	Alfentanyl required Remifentanyl issued and taken to theatres.
	Oswald	Potential Underdose and/or documentation error oral morphine solution.
	Sheldon	Empty box of oral morphine solution transferred from another Trust. Oxycodone dose required part oral morphine used to make a full, dose not administered to patient.

1.1.17. Ongoing Actions Trust wide for assurance:

- Medicines management administrators in co-ordination with Ward managers and Trust induction processes maintain an up-to-date record of staff CD counter signatories' records.
- Ward managers will continue to ensure that all RNs have completed the CD training. The online training and documentation of competency will be completed and shared with the medicines management administrator.
- Face to face training is available to support good CD management where additional training is identified.
- Daily task checklists are available in clinic areas as a visual reminder of tasks including when CD stock checks are due to take place.
- Feedback following Medicines management audits is given directly to the nurse in charge and a Datix recorded so that ward managers may implement relevant steps and record these in a systematic way.

1.1.18. Attendance of Controlled Drug Local Intelligence Network (CD LIN) meetings

It is a statutory requirement of the Trust's CDAO that a quarterly report is provided to the CDLIN. Regulation 29 requires the CDAO to give an occurrence report to the accountable officer for the local area team that is leading their LIN.

This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report).

RJAH have recorded 100% attendance at the CD LIN regional meetings for 2022-2023.

1.1.19. Conclusion

- The overall pattern of incidents involving CDs within the Trust is generally low.
- Attendance at the CD LIN is 100% and helpful for shared learning.
- CD incidents continue to be reported within the trust supporting an open and honest reporting culture to learn from incidents and improve.
- CD training and achievement for the trust is 90.23% including bank staff.

2. Risks

Investment in technology to support ward activities around selection and counting discrepancies would help to mitigate further risks and incidents.

3. Assurance

3.1. Benchmarking and improvement

Benchmarking regarding the number of controlled drugs incidents can be challenging to interpret and a decrease in reports of incidents does not always confer a positive correlation or development. Themes in medicines incidents will be monitored and interpreted using the PSIRF methodology when launched later in 2023/24.

Data and actions reflected in this report is a triangulation of information and experience relating to Patient Safety, Medicines Optimisation, Medicines Safety and Learning from Incidents.

Data is regularly provided to Quality and Safety committee regarding controlled drugs incidents through the Quarterly Medicine Safety Report.

Evidence of ward CD audits, staff attainment of CD training, improvements into practice following thematic deep dives into areas of concern through the patient safety group.

Working robustly with the Medicines Safety Officer, ward pharmacists and ward managers to address issues and support reporting into the patient safety group to enable improvements.

3.2. Destruction of Controlled Drugs

There are authorised witnesses for the destruction of controlled drugs.

Appointments are made with the authorised staff to attend pharmacy to support the safe destruction of CDs.

Pharmacy have struggled with attendance at times due to other competing pressures across the Trust, but we have maintained a safe storage and destruction over the last twelve months.

3.3. Controlled Drugs Policy and supporting procedures.

Over this twelve-month period, there has been no changes within legislation and as such no legislation changes to policy at RJAH.

4. Implications

4.1. Strategic Aims and Board Assurance Framework

Improved CD safety supports our strategic aims of delivering outstanding care and maintain patient safety.

4.2. Equalities, diversity, and inclusion

Strategic aims and ambition regarding equality, diversity and inclusion are considered when developing and implementing improvement actions.

Reducing avoidable harm from controlled drugs has the potential to reduce inequalities as harm from CDs may be variably distributed between groups with different protected characteristics.

4.3. Culture and people

Maintain a robust, open and transparent culture of reporting incidents ensuring that every opportunity is taken to learn and improve from incidents.

4.4. Training and competency

Maintain high attainment of CD training and competency through regular training and shared learning from incidents in appropriate forums. This will lead to a more competent and able workforce.

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	20-10-2023
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Quality and Safety	Paper FOIA Status:	Full / Partial / Non-disclosure Delete as appropriate

1. Purpose of Paper

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

Learning from Deaths summary report to Q and S.

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

A structured judgement review is carried out in timely manner using the SJR Plus methodology developed by NHSE.

Deaths are reported through the Board of Directors.

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

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

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q2 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns or trends identified.

Learning from deaths (see below).

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	ME review/Family feedback.	Coroner review.
July 2023	1	0 (SI)	0	ME suggested learning related to completion of MCCD.	Coroner issued form B after PM. No need for inquest. Natural causes.
August 2023	0	0	0	n/a	n/a
September 2023	1	1	0	SJR awaited.	Coroner issued form 100A. No concerns.

3.3. Associated Risks.

None.

3.4. Next Steps

Discussions complete with SATH concerning a link with their Medical Examiner and Bereavement system. This service commenced June 2023.

LFD lead now working as a Medical Examiner at SATH.

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

1st Death using ME service processed late June.

Also attends Shropshire LFD group and West Midlands LFD forum (currently west midlands only due to staffing issues at ICS in Shropshire). (This meeting has been stood down by ICS due to lack of staff).

3.5. Conclusion

Positive learning:

Nil for these cases. (SJR/SI may pick up learning in due course).

Negative learning:

SI report awaited from July death which may have learning.

ME service picked up poorly completed MCCD, so I have arranged to perform some teaching to patient team and to wider SPR group in October.

SJR awaited for September death (very recent).

Plan going forward to use NHSE dashboard to generate LFD reports, although these are not designed for our limited numbers per se. (Not currently available due to change in IT system over December).

Appendix 1: Acronyms

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

Chair's Assurance Report
Quality and Safety Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	08 November 2023
Executive Sponsor:	Paul Kavanagh Fields, Chief Nurse and Patient Safety Officer	**Paper written on:**	30 October 2023
Paper Reviewed by:	Lindsey Webb, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Private	**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 20 October 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

Although work is ongoing to identify patients receiving metal on metal implants the Committee required further assurance on the completion of appropriate follow up in line with MHRA guidance from 2017. The concern has been recorded on the risk register and a regular assurance report will be presented to the Committee.

The Committee reviewed the register and noted the Metal-on-Metal risk would be updated to reflect the fact that not all patients had yet been reviewed in line with the MHRA guidance. Further detail on this is being provided to the next meeting.
A new risk is being added with regards to potential compensation claims arising from the historical hand vibration cases. Assurance has been given that no staff are currently working with equipment that may cause this moving forward.

Board Assurance Framework
The Committee reviewed the document and agreed for BAF 4 – high levels of community infection that the score be reduced as supporting policies and mitigation have been embedded to address the risk. This is in line with the national guidance.

IPC Q2 Report
The Trust has breached the CDI target with a further 2 CDI cases This is in line with the picture nationally currently under investigation by the UKHSA. The rise seen at RJAH is mainly due to numerous recurrences in one patient.

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:

Medicines Safety
A number of observations of practice have been carried out across August and September where key themes had been identified and safety actions agreed. These actions will be monitored through the patient safety improvement plan and through Patient Safety Meeting. The Trust confirmed training issues would be picked up through the context of PSIRF and assurance was provided this does not take away from individual investigations. The PSIRF response would be theming these to identify improvements.

MSCI Peer Review
Although the full report is yet to be received, the review team flagged a concern relating to a dedicated confidential space for the psychology support for patients on the ward. This was addressed with immediate effect. The Committee asked for the terms of reference of the review to be presented to the next meeting along with the full report and action plan.

CQC Action Plan (Paediatric Peer Review)
There is one outstanding action aligned to the out of hours arrangements which have also been flagged within the Paediatric Peer Review. The Committee requested greater clarity on how all clinical service strategies were shared with Board members.

Paediatric Peer Review
The Committee asked for further assurance on the actions and improvements implemented following the peer review therefore the action plan will be presented at future meetings.

Legal Claims Q2 Report
The Committee considered the report which in summary outlined:

- No new CNST claims in Q2.
- 1 CNST has been closed in A2.
- The Trust has been advised to settle 3 CNST claims in Q2.
- There have been no new ELPL claims in Q2.
- The Trust has been advised to settle 2 ELPL claims, one of which was due to go to trial in October 2023 with the probability of claimant being successful high and therefore to settle to minimise costs.

Policy Tracker
The Committee noted the policy tracker and the process in place to review and receive overdue policies. A number of documents were added to the workplan for the next meeting.

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.

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

- a reduction in MCI patient awaiting admission,
- a reduction in medications errors,
- 1 patient breached the cancer target due to administrative oversight and processes have been put in place to ensure this does not recur,
- Levels of theatre cancellations are lower than last year despite the impact of industrial action.

CIP QIA Q2 Report
Assurance was provided on the continuing process. The process for 2023/24 will be timelier to ensure completion and sign off before delivering programmes next year. The enhanced quality element of the paper alongside the financial elements was welcomed.

PSIRF/SI Update
It was noted that there have been no serious incidents or never events within month and good progress have been made on current actions. The Committee acknowledged that the report will be presented differently next month with the transition to PSIRF, focusing on improvement and actions being taken forward as part of the patient safety improvement plan. To provide further assurance on the duty of candour, the Committee asked for the table to be reviewed which will support identifying gaps.

Quality Priorities Update
All priorities remain on track. There is no risk to delivery except around end-of-life care which was rolled over from the previous year. Different streams are being investigated to recruit an end-of-life facilitator into the Trust. A request was made to quantify success measures for each priority which will be included in future reports.

Quality Spot Checks (Internal Audit Report)
Assurance was given that the remaining actions will be completed by the end of October as planned, and that an update will be provided at the next Committee.

Learning from Deaths Q2 Report and Mortality Review
No concerns have been raised within Q2 and is shared with the Board of Directors for oversight. The Committee noted the Q2 report and are waiting the SI outcome following a death in July.

In relation to the review, the Trust were assured with the processes in place however, the flowchart of the death review process does not show notification for patients who have a learning disability or autism, and assurance was provided that the flowchart will be updated to reflect this as well as the transition to PSIRF.

Hand Vibration Report
The Committee were assured with the process and support offered to staff following the alert. 4 members of staff have been diagnosed with having hand arm vibration syndrome which has been reported under the RIDDOR regulations. The Trust will complete another assessment in 6months, training has been scheduled and exposure to the equipment has been restricted. The Committee will continue to gain assurance via the Chairs Report from the Health and Safety Meeting.

Controlled Drug Accountable Officer Annual Report
The Committee considered and reviewed the annual report which is shared with the Board of Directors for oversight. Increased reporting has been introduced with quarterly reports being presented to the Patient Safety Meeting. As part of surveillance and adherence to Controlled Drug

legislation, support is being asked to automate processes and enhance safety at ward level which will be taken through Capital Management Group.

Chair Reports
The Committee noted the chairs assurance report from the Patient Safety Meeting and the IPC Meeting – no concerns were raised.

The following items were **deferred** to the next meeting:

- Safeguarding Priorities
- Patient Experience Q2 Report
- CQUIN Q2 Report

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 - People & Workforce
September 2023 – Month 6

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.

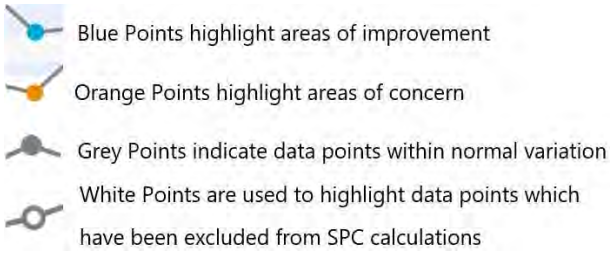
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

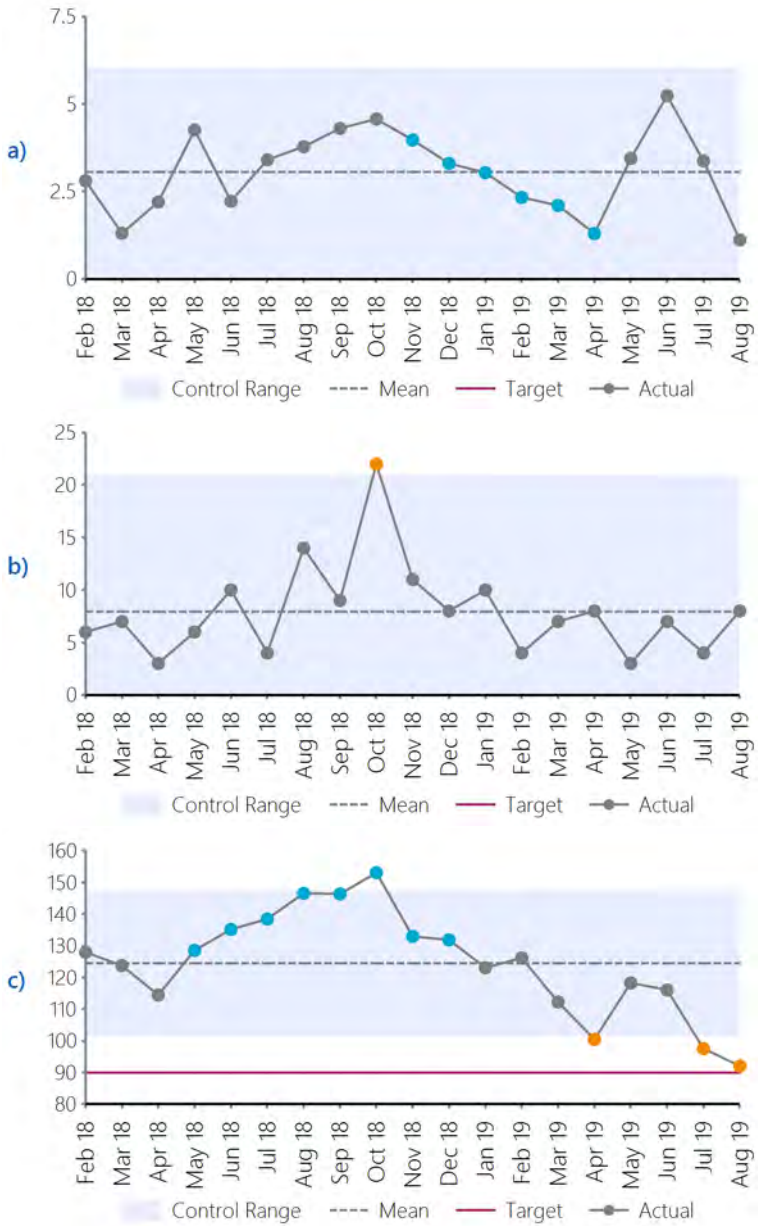


Some examples of these are shown in the images to the right:

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.



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	5.69%	4.73%		L	Moving Target	+	
Staff Turnover - Headcount	12.00%	9.07%		L	Moving Target	+	
In Month Leavers	10	12			Moving Target	+	
Vacancy Rate	8.00%	5.30%		L	?	+	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	185		N/A to SPC	Moving Target		
Agency Core - Off Framework	0	64		N/A to SPC	F	+	

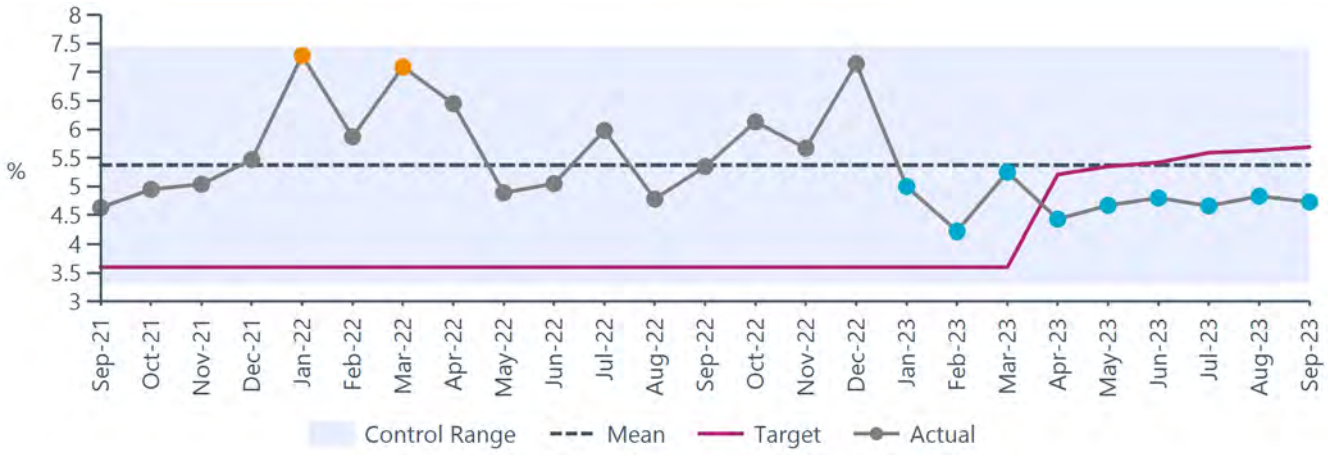
Sickness Absence

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

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
5.69%	4.73%	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 September is reported at 4.73%. It is included as an IPR exception this month as the SPC graph indicates special cause variation of an improving nature with the last nine data points, since January, all consecutively below the mean.

The top three reasons for absence Trust-wide were:
* Anxiety/stress/depression/other psychiatric illnesses
* Other musculoskeletal problems
* Back Problems

Actions

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
5.35%	6.13%	5.67%	7.15%	5.00%	4.22%	5.25%	4.43%	4.67%	4.80%	4.66%	4.83%	4.73%

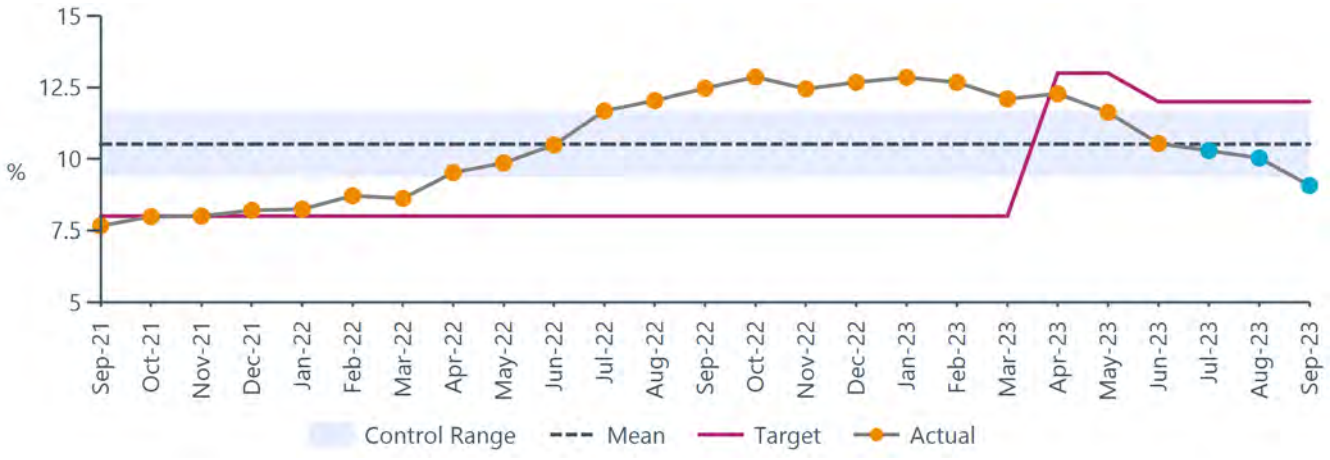
Staff Turnover - Headcount

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
12.00%	9.07%	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 9.07% for September and included as special cause variation due to the improved position. This metric relates to the leavers over the past twelve months. For the period of October-22 to September-23 there have been 160 leavers as a proportion of the month end headcount of 1764.

Actions

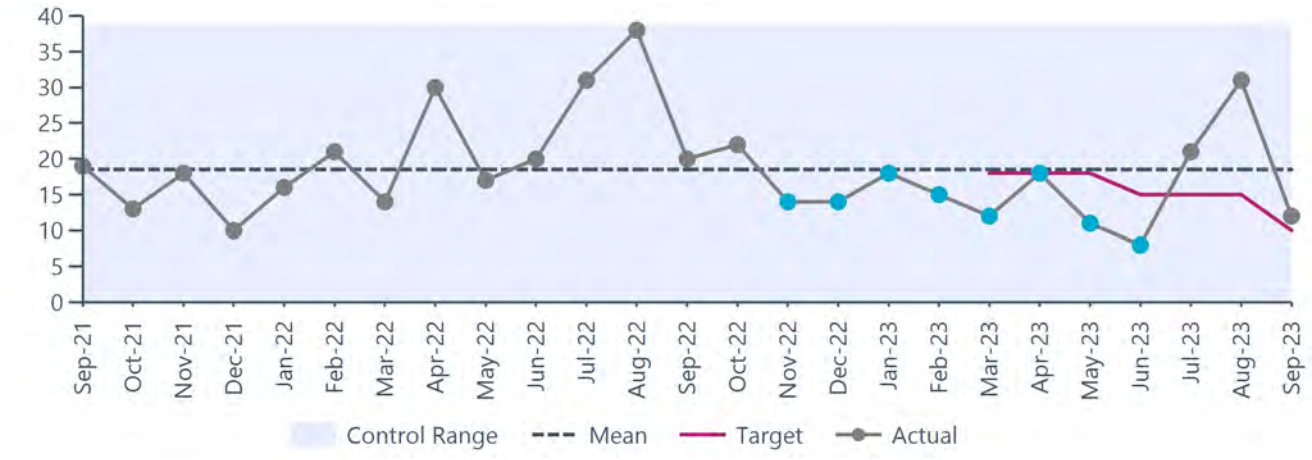
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
12.47%	12.87%	12.45%	12.68%	12.85%	12.68%	12.10%	12.28%	11.63%	10.54%	10.29%	10.03%	9.07%

In Month Leavers

Number of leavers in month 217809

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
10	12		Moving Target



Trajectory

What these graphs are telling us

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

Narrative

There were 12 staff that left the Trust in September. 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 new target.

The September leavers were from the following areas: MSK Unit (6) and Specialist Unit (6).

The reasons for leaving were:
* Flexi retirement (2)
* End of fixed term contract (1)
* Dismissal - Capability (1)
* Voluntary resignations - Relocation (2), Other/Not Known (2), Work Life Balance (2), To undertake further education or training (1), Promotion (1)

Actions

* Focussed effort on developing role competencies and career pathways for progression to agenda for change. This work will commence in Theatres and MCSI. Within Theatres, work has begun on developing career pathways for bands 2/3/4 and remains in progress. Within MCSI a business case is in progress.
* Trainee Nurse Associates; First cohort complete in September-23, second cohort in April-24. Further cohort commenced in September-23; recruitment to backfill has commenced, only Clwyd & MCSI outstanding to fill, utilising recruitment day.
* 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.
* 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 three.
* Collaborative working with System to maintain the preceptorship springboard programme and further development underway to align with new AHP standards. Preceptorship is now offered as a joint programme integrating nursing and allied health professions. Risk associated with facilitator resource from across the System; mitigations being discussed and negotiated.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
20	22	14	14	18	15	12	18	11	8	21	31	12

Vacancy Rate

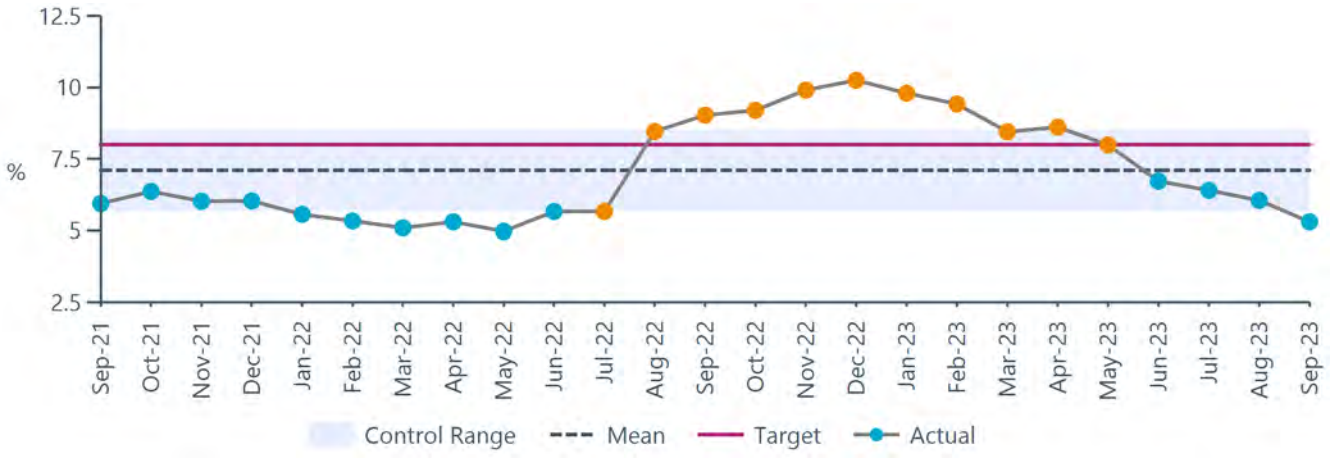
% of Posts Vacant at Month End 211183

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	5.30%	L	?

Trajectory

Actual
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 September month-end is reported at 5.30%. It is included as an exception due to showing special cause variation of an improving nature. As shown in the SPC above, there has now been nine consecutive months of steady reduction.

Actions

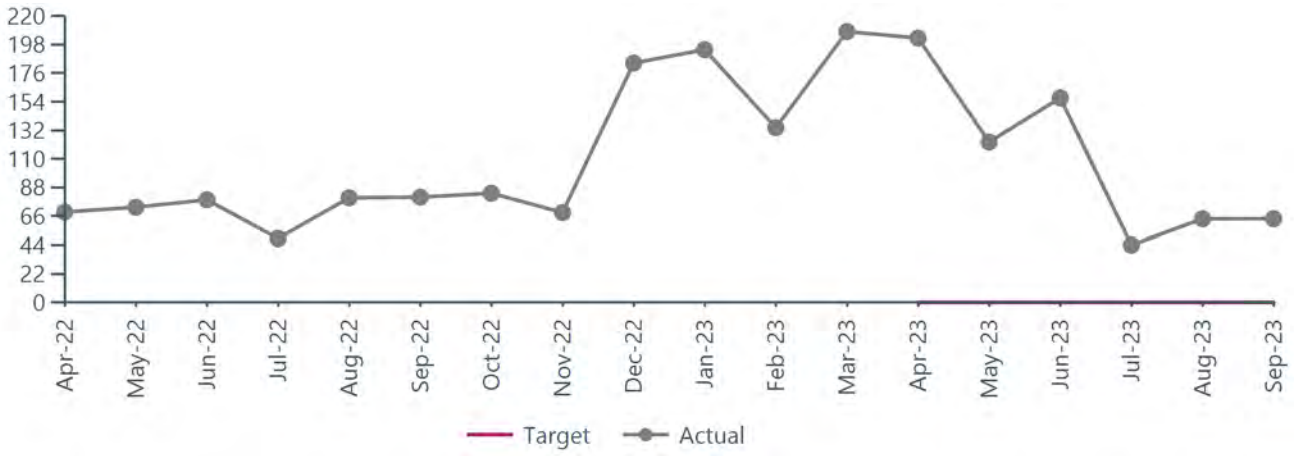
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
9.03%	9.20%	9.91%	10.25%	9.80%	9.42%	8.45%	8.61%	7.99%	6.72%	6.40%	6.05%	5.30%

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	64	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 26%, no increase in spend and 2% reduction from month 5.

Actions

Enhanced sign off arrangements for off framework agency shifts'. Task and Finish group established to oversee agency reduction plan.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
80	83	68	183	194	134	208	203	123	157	44	64	64

ImproveWell.

A NEW WAY TO IMPROVE

ImproveWell is a digital engagement solution for improvement in healthcare.
Giving everyone a voice, the ImproveWell solution helps your organisation to improve staff experience *and* the quality of patient care from the ground up.

Create the right environment for wellbeing at work and continuous improvement with ImproveWell

Give everyone a voice:

Foster a culture that enables the frontline to feel heard and be involved in designing better teams, workplaces and care.

Empower local leadership:

Allow group and organisational leads to run programmes that support goals and challenges specific to their area.

Create a culture of collaboration:

Collaborate across teams, departments and stakeholder groups, to share feedback, ideas and best practice.

Instant feedback & learning 24/7:

Enable diverse teams and key stakeholders to feed back any time, anywhere. Unlock continuous learning on what is and isn't working.

Create a funnel of improvement ideas:

From the ward to the board, everyone can be involved in driving change by offering a simple way to suggest ideas for improvement.

Enable data-driven decisions:

Ask the right questions and make data-driven decisions in a rapidly-changing, high-pressure environment.

#ENGAGETOIMPROVE

Patient Outcomes

Quality Improvement

Frontline innovation
Collective intelligence | Multidisciplinary alliance | Continuous improvement

Staff Experience

Wellbeing at work
Autonomy | Belonging | Contribution

ImproveWell.

Real-time insights
Two-way feedback | Informed decision-making | Demonstrable change

HIGH ENGAGEMENT ORGANISATIONS SHOW*

21% increase in productivity

22% increase in profitability

41% decrease in patient incidents

37% decrease in absenteeism

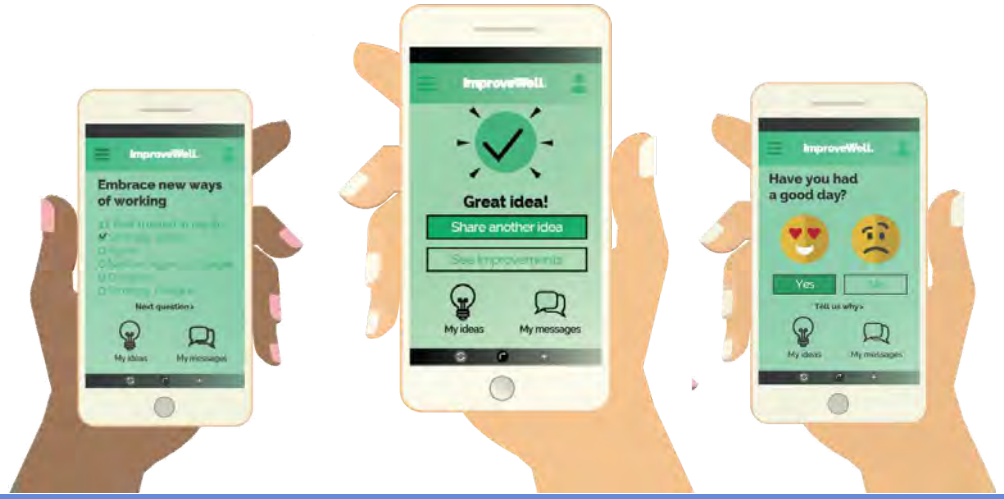
*source: Gallup, High Engagement Drives Growth, 2013

ImproveWell.

HOW IT WORKS

Make change simple with 24/7 real-time feedback and actionable insight from the frontline.

THREE FEEDBACK SYSTEMS
JOIN A COMMUNITY OF IMPROVERS
CPD-ACCREDITED ONBOARDING & TRAINING



SENTIMENT TRACKER

Track and boost morale and wellbeing at work with real-time insights, by asking your team how their workday is going.

IDEA HUB

Gather ideas for improvement, discuss or refine collaboratively, and keep everyone up to date with progress and implementation.

PULSE SURVEYS

Understand what matters and see where improvements are needed with swift and straightforward survey creation.

IMPROVEWELL INSIGHTS

Capture real-time feedback from expert patients, regular service users or partner organisations via customisable online portals.

DATA DASHBOARD

Detect trends and pressure points, prioritise improvement efforts, measure change and publish reports to close the feedback loop.

"There is no other option for me – we are so pleased to be using ImproveWell."
DR AMAR SHAH, Chief Quality Officer, East London NHS Foundation Trust

"ImproveWell enabled us to gather real-time insights; to feedback to staff what we're doing; and to access data for use in decision-making." **DR DOMINIQUE ALLWOOD, Medical Director, NHS Nightingale Hospital London**

Guardian for Safe Working Hours Q2 Report

Committee / Group / Meeting, Date

Board of Directors (Public), Wednesday 08 November 2023

Author:

Name: Chris Marquis
Role/Title: Guardian for Safe Working Hours

Contributors:

Report sign-off:

Ruth Longfellow, Chief Medical Officer
People and Culture Committee, Thursday 26 October 2023

Is the report suitable for publication?

Yes

Key issues and considerations:

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

The Trust has in place a Guardian of Safe Working and this paper presents the October 2023 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

Strategic objectives and associated risks:

Aligned to the Trusts Corporate Objectives; Deliver high quality clinical services / Grow our services and workforce sustainable.

Recommendations:

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

Report development and engagement history:

The paper was presented to the People and Culture Committee on 26 October 2023 – assurance was noted.

1. Background

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

Work scheduling – junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments, and the training opportunities available during the post or placement.

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

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

2. Guardians of Safe Working Hours Report

2.1 **High level data** – for the reporting period of October 2023 (data not updated by People Services)

Specialty	Contract	Headcount
Orthopaedics	Training posts	18
	Of which Doctors in training on 2016 contract	17
Rehabilitation/Spinal Injuries	Training posts	2
	Of which Doctors in training on 2016 contract	0

2.2 **Exception reports (regarding working hours)**

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

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

We have received two exception reports.

The recent exception reports received, relate to a trainee on an English contract, working in North Wales, with RJAH as the central contract holder. As Wales does not have the role of GJDWH, there is no system to address the issues raised at the placement hospital. We are actively engaging with all concerned to address the issues raised. This has instigated a diary exercise to ensure on call hours paid reflect accurately, work done. It has also required a review of working practices, whereby, the Juniors are swapping shifts in an unsafe manner.

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

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

2.3 **Working schedule reviews**

Please see above.

Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. With no exception reports, no work schedule reviews should be expected.

2.3.1 **Junior Doctor Agency and Locum usage and Rota Vacancy Report**

Please see Appendix 1

Trauma and Orthopaedics - **Number of Vacancies (28 posts)**	
July 2023	0
August 2023	1
September 2023	1
Vacant shifts	
July 2023	6
August 2023	5
September 2023	4
Total Cost - £9,075.00	

Medicine - **Number of Vacancies (12 posts)**	
July 2023	0
August 2023	0
September 2023	2
Vacant shifts	
July 2023	5
August 2023	18
September 2023	15
Total Cost - £20,080.00	

MSCI - **Number of Vacancies (9 posts)**	
July 2023	0
August 2023	2 (1 clinical fellow & 1 SAS)
September 2023	2 (1 clinical fellow & 1 SAS)
Vacant shifts	
July 2023	8
August 2023	8
September 2023	8
Total Cost - £6,737.60	

Long Term Vacant Shifts

- MCSI (Midlands Centre of Spinal Injuries) has two vacancies.
- T&O has one vacancies.
- Medicine has a single vacancy.

2.3.2 Fines

None – please see exceptions report section 2.2.

2.4 Challenges

Trainees placed in North Wales

As discussed above, this situation is a challenge, but one all users are actively engaged with. There is a clear shared purpose to address the issues raised (effectively working hours and appropriate payment) to ensure we are not having the same issues moving forward with future placements. The TPD, HR and relevant parties from North Wales are involved. This will require a diary exercise repeated which will be over a 20-week period to ensure information is captured for two rota cycles. Future updates on the situation will be included in future reports.

Software System

We still do not have a go live date. Funding is an issue.

3. Associated Risk

As previously discussed, appropriate focus on training needs to be ensured. Cancelled lists with sickness and staffing issues have significant impact not only on activity and waiting list issues, but also surgical training.

Central contracting has led to the complex situation I have discussed in this paper. We are seeking an active solution.

We desperately need to establish an electronic reporting system. Funding needs to be allocated for this.

4. Conclusion

The Trust has received its first exception reports. These do not relate to issues within the Trust.

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

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

Christopher Marquis
Guardian of Safe Working

Workforce Disability Equality Standard Annual Report

Meeting, Date

Board of Directors, 8th November 2023

Author:	**Contributors:**
Name: Caroline Nokes-Lawrence Role/Title: Associate Chief People and Culture Officer	OD and Inclusion Team

Report sign-off:

Denise Harnin, Chief People and Culture Officer

The WDES 2022/3 summary data has been presented to the EDI Committee on 17th August 2023 whose remit is to *provide strategic direction, leadership and support for promoting and maintaining equality, diversity and human rights issues throughout the Trust* and the People and Culture Committee on 21st September 2023

Is the report suitable for publication:

The WDES annual report for 2023 is mandated to be published on the Trust's website by 31st October 2023 following approval from Board. The report and action plan will be submitted within the timescales subject to approval.

Key issues and considerations:

The Board are asked to receive the following highlights from the Trust's annual WDES data report.

i) The data provides findings in relation to the ten reporting metrics as of March 2023
ii) There is **a zero percent representation** at Board declaring a disability or long-term condition.
iii) Percentage of disabled staff saying that the employer has made an adequate adjustment(s) to enable them to conduct their work has increased from 71.2% in 2021 to 80.4% from the national staff survey data.
iv) Reporting last incident of harassment, bullying or abuse has increased from 39.2% to 47.9% although still appears below the national average figure of 51.3% this remains unacceptable for our workforce

Strategic objectives and associated risks:

The Board Assurance Framework risks / corporate risks overseen by the Meeting are:

- Effectiveness of engagement with the workforce
- Workforce capacity and capability
- EDI capacity and capability

Strategic objectives;

- Caring for staff

Recommendations:

The Committee are asked to.

i) Note the contents of the report and WDES annual analysis and Action Plan (Appendix A and Appendix B)
ii) Note that the EDI Committee will continue to monitor and review the relevant data analysis in line with the Trust's Inclusion Strategy
iii) Approve the annual report for inclusion on the Trust's website.

Workforce Disability Equality Standard
Annual Report

Report development and engagement history:

The information and analysis were shared with the Equality, Diversity, and Inclusion meeting on 17th August for information and the People and Culture Committee on 21st September 2023.

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever EDI improvement plan.

Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool, and provide sustainable careers.

Next steps:

The EDI meeting members, Disability and Neuro-Diverse Group will continue to monitor the data analysis and actions. In addition, the OD and Inclusion Team will work in conjunction with the newly formed Disability and Neuro-Diverse Staff Network Group to review the contents of the Action Plan

Information from the NHS national Staff Survey for 2023 will also provide valuable information regarding the workforce responses and analysis.

This data is normally released around March of the following year of the survey taking place in October and November 2023.

i) The WDES report and Action Plan should be published on the Trust's website, so that the data is available and clear to all stakeholders within the mandated timescales.
ii) The Trust's analysis and data will be shared with the wider ICS EDI network.
iii) The Action Plan will be reviewed in tandem with the Inclusion Strategy Action Plan to ensure delivery of objectives

Acronyms

EDI	Equality, Diversity and Inclusion
WDES	Workforce Disability Equality Standard

Appendices

Appendix A	*WDES Annual Report 2023*
Appendix B	*WDES Action Plan 2023*

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHS Workforce Disability Equality Standard (WDES) Annual Report – 2023

Aspiring to deliver world class patient care

Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever EDI improvement plan.

Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers.

Making a difference for disabled staff

The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES puts data into the hands of people in NHS organisations who best understand the experiences of their disabled staff and how to make positive change. A more inclusive environment for disabled people working and seeking employment in the NHS is better for our people, for teams and for patients.

WDES 2023 data collection and the reporting framework

The WDES 2023 reporting timeline ran from 1 May until 31 May for NHS provider trusts and required metrics and narrative data to be reported via the WDES data collection framework (DCF) introduced in 2021. By 31 October 2023, trusts must publish their board ratified 2023 WDES annual report on their website.

Mandatory coverage of the WDES

The WDES is mandated through the NHS Standard Contract under Service Condition 13.8 for trusts

SC13 Equity of Access, Equality and Non-Discrimination

13.8 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must implement and comply with the National Workforce Disability Equality Standard and submit an annual report to the Co-ordinating Commissioner on its compliance.

Introduction

The data for indicators 1 to 3 and 10 are from the Trust's workforce data as of 31 March 2023. This includes information on disability-related demographics, workforce representation, and disability declaration rates. Indicators 4 to 9 have been obtained from the Trust's National Staff Survey results for the year 2022. These measures cover aspects such as workplace adjustments, perceived discrimination, bullying and harassment, career development opportunities, and satisfaction levels among disabled staff.

The data presented provides a better understanding of the experiences of our disabled workforce and highlights areas of success and areas requiring further attention. The Action Plan will include specific objectives, initiatives, and review of policies to further support disabled staff, promote inclusivity, and further develop a positive work environment.

The WDES Annual Report 2023 demonstrates the Trust’s commitment to disability equality and improving the work experience of disabled staff. We will aim to create an environment that promotes equal opportunities and positive change for all staff.

WDES 2023 Data Summary Table

Metrics derived from data collected directly from organisations as at 31st March 2023

Overall rank compared to 212 Trusts nationally = 139

Metric number and description			Trust Values					Nat. Av.	Rank	RAG
			2019	2020	2021	2022	2023	2023		
Metric 1: Disabled representation in the workforce by pay band										
Disabity declaration rate in the workforce		Overall	**3.0%**	**2.8%**	**2.7%**	**3.0%**	**4.0%**	**4.9%**	**148**	✖
		Non-clinical	3.7%	4.0%	4.1%	4.1%	4.7%	5.8%	158	✖
		Clinical	2.4%	2.3%	2.2%	2.8%	3.9%	5.0%	144	✖
		Medical/Dental	0.0%	0.0%	0.0%	0.0%	0.7%	2.2%	184	✖
Pay band at which Disabled under-representation first occurs	Non-clinical	Band 4 -					Proportional			
		Band 5 +					Proportional			
	Clinical	Band 4 -					Proportional			
		Band 5 +					Proportional			
	Medical/Dental						Proportional			
Disability disparity ratios	Non-clinical	Lower:middle	0.88	0.57	0.63	0.99	0.76	0.98		!
		Middle:upper	0.58	1.63	2.63	2.36	2.55	1.26		!
		Lower:upper	0.51	0.93	1.65	2.35	1.94	1.23		!
	Clinical	Lower:middle	1.30	1.03	0.75	0.90	0.63	0.94		!
		Middle:upper	0.46	0.91	0.53	0.62	0.83	1.22		!
		Lower:upper	0.94	0.40	0.00	0.56	0.53	1.16		!
Metric 2: Likelihood of appointment from shortlisting										
Likelihood ratio Non-disabled / Disabled				1.97	1.58	1.07	1.74	0.99	201	!
Metric 3: Likelihood of entering formal capability process due to performance management										
Likelihood ratio Disabled / Non-disabled				0.00				2.17		
Metric 10: Disabled representation on the board										
	Overall	Members	0	0	0	0	0			
		Proportion	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%	212	✖
	Exec	Proportion	0.0%	0.0%	0.0%	0.0%	0.0%	5.4%		✖
	Non-exec		0.0%	0.0%	0.0%	0.0%	0.0%	6.0%		✖
	Voting		0.0%	0.0%	0.0%	0.0%	0.0%	5.6%		✖
	Non-voting		0.0%	0.0%	0.0%	0.0%	0.0%	6.1%		✖

Key

- **Key to rank colour coding (1=best, 212=worst)**

In top 10% of trusts nationally.

In bottom 10% of trusts nationally.

WDES 2023 Data Summary Table

Metrics derived from NHS Staff Survey 2022 (published March 2023)

Metric number and description	Trust Values 2018	2019	2020	2021	2022	Nat. Av. 2022	Rank	RAG
Metric 1 (equivalent): Proportion with a long-term condition or illness								
Disabled	15.0%	16.5%	18.6%	22.1%	21.0%	23.6%		✗
Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months								
Disabled	26.0%	20.4%	21.7%	23.5%	22.4%	33.2%	8	✓
Non-disabled	16.9%	14.4%	13.7%	16.2%	15.2%	26.0%		✓
Metric 4b: Harassment, bullying or abuse from line managers in last 12 months								
Disabled	21.1%	18.0%	18.7%	15.8%	18.3%	16.1%	148	✗
Non-disabled	11.1%	11.0%	9.7%	9.2%	9.6%	9.2%		!
Metric 4c: Harassment, bullying or abuse from other colleagues in last 12 months								
Disabled	30.5%	27.0%	34.1%	28.0%	26.9%	24.8%	142	✗
Non-disabled	20.3%	18.6%	16.8%	17.3%	18.4%	16.5%		✗
Metric 4d: Reporting last incident of harassment, bullying or abuse								
Disabled	53.7%	53.4%	62.5%	39.2%	47.9%	51.3%	149	✗
Non-disabled	46.5%	44.8%	43.2%	46.3%	48.5%	49.5%		!
Metric 5: Career progression								
Disabled	55.2%	52.0%	58.8%	59.6%	47.4%	52.1%	167	✗
Non-disabled	62.5%	58.4%	61.5%	62.4%	59.5%	57.7%		!
Metric 6: Presenteeism								
Disabled	33.9%	16.2%	35.2%	25.8%	27.0%	27.7%	105	!
Non-disabled	18.8%	21.9%	13.5%	15.8%	13.0%	19.9%		✓
Metric 7: Feeling valued								
Disabled	43.2%	39.3%	43.0%	37.2%	26.6%	35.2%	197	✗
Non-disabled	58.0%	55.4%	54.9%	44.0%	47.3%	45.0%		✓
Metric 8: Reasonable adjustments								
Disabled	75.4%	75.3%	79.2%	71.2%	80.4%	73.4%	34	✓
Metric 9a: Staff engagement								
Disabled	7.15	7.15	7.20	6.90	6.71	6.42	57	!
Non-disabled	7.68	7.58	7.56	7.23	7.23	6.93		!

Key to RAG rating

Key to RAG rating. (N.B. These only consider data from the latest year.)	
Metric 1 declaration rates and all metrics derived from the NHS Staff Survey (4, 5, 6, 7, 8 and 9a)	
✔	More than 5.0% better than national average (proportion, not percentage points).
!	Within +/-5.0% of national average (proportion, not percentage points).
✖	More than 5.0% worse than national average (proportion, not percentage points).
Please note, for the metrics derived from the NHS Staff Survey, these RAG ratings are applied separately for disabled and non-disabled staff. In subsequent tabs in this file, the results of statistical tests are shown which compare the results for disabled staff against the results for non-disabled staff to see if there is a difference.	
Metric 1 disparity ratios, metric 2 and metric 3	
✔	The results shown are significantly better for disabled staff based on evaluation of likelihood ratios.
!	The result show no significt difference between disabled and non-disabled staff based on evaluation of likelihood ratios.
✖	The results shown are significantly worse for disabled staff based on evaluation of likelihood ratios.
Historically, metrics 2 and 3 have been evaluated using the "4/5ths rule". This is a simple statistical method but lacks analytical vigour. The tests used here (and on subsequent tabs) are much better at identifying potential issues and not flagging issues that do not exist (especially when numbers are small). Further information can be found at https://www.medcalc.org/calc/relative_risk.php. Discussions have started regarding which statistical tests it would be most appropriate to use for the WDES and the WRES, and full details will be given if any change is agreed.	
Metric 10	
✔	More than 5.0% more than propotion with long-term condition or illness in Staff Survey (proportion, not percentage points).
!	Within +/-5.0% of propotion with long-term condition or illness in Staff Survey (proportion, not percentage points).
✖	More than 5.0% less than propotion with long-term condition or illness in Staff Survey (proportion, not percentage points).

WDES priorities

Each metric was ranked against all other trusts nationally. The following metrics are the ones ranked lowest.
A minimum of 3 metrics are shown: additional metrics are included if there is a tie in the rankings.
All metric ranks which are in the bottom 10% nationally are also included and shown in purple text

	2023					
			Rank			
Metric	Trust	National Average	National	Type Specialist	Size Small (1 to 4,999 staff)	Region Midlands
Metric 10: Disabled representation on the board	0.0%	5.7%	212	16	92	41
Metric 2: Likelihood of appointment from shortlisting	1.74	0.99	201	13	85	40
Metric 7: Feeling valued	26.6%	35.2%	197	16	87	39

WDES priorities

The following metrics are in the top 10% nationally.

Metric	2023					
	Trust	National Average	Rank			
			National	Type	Size	Region
				Specialist	Small (1 to 4,999 staff)	Midlands
Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months	22.4%	33.2%	8	6	7	2

Key findings for 2023 (1 of 2)

Disability declaration in the workforce is 4% an improvement on 2022 with 3%

The overall relative likelihood of non-disabled staff being appointed from shortlisted compared to disabled staff ratio is 1.74% which is a decline from 1.07% in 2022

There is no disabled representation at Board level which has remain unchanged for a number of years

Proportion of staff with a long term condition or illness has decreased from 22.1% to 21%

Harassment, bullying or abuse from patients, relatives or the public in last 12 months for disabled staff has decreased from 23.5% to 22.4%

Harassment, bullying or abuse from line managers has increased in the last 12 months for disabled staff from 15.8% to 18.3%

Key findings for 2023 (2 of 2)

Harassment, bullying or abuse from other colleagues in last 12 months for disabled staff has decreased from 28% to 26.9%

Reporting last incident of harassment, bullying or abuse has increased from 39.2% to 47.9% which is below the national average figure

Equal opportunities for career progression or promotion - In 2022 47.4% of disabled staff (compared to 59.6% in 2021) believed they had equal opportunities for career progression. This compares to 59.5% of non-disabled staff

Percentage of disabled staff saying that the employer has made an adequate adjustment(s) to enable them to carry out their work. Staff experience has increased from 71.2% in 2021 to 80.4%

Staff Engagement score for disabled staff has scored slightly lower year on year. The 2022 staff engagement score for disabled staff was 6.71; this compares to the non-disabled staff rate of 7.3

Executive Summary (1 of 2)

The Trust continues to commit to being a more inclusive place to work , ensuring equal opportunities and celebrating our diversity. We support and encourage staff to share their experiences through a variety of feedback resources and in line with our Inclusion Strategy

Through 2022 / 2023, we have achieved;

- The launch of our Inclusion Strategy and Action Plan 2023-2026
- Appointed a staff Chair for our Disability and Neuro-Diverse Staff Network
- Appointed an Executive Sponsor for the Disability and Neuro-Diverse Staff Network
- Reviewed the Terms of Reference of our monthly EDI meetings so that they are more inclusive for members to attend
- Joined the NHSE Diversity in Health and Care Partners programme, which commenced in September 2023 and is a year-long programme that includes, supporting health and care organisations to create more inclusive workplace cultures, where difference is welcomed and celebrated, with access to leading industry experts, good practice, guidance, resources and networking opportunities.

Executive Summary (2 of 2)

Through 2022 / 2023, we have achieved;

- Received 52% response for our Staff Survey 2022
- Continuing to review our progress and delivery against statutory requirements, such as the public sector equality duty
- Published WRES, WDES, Workforce Report and Gender Pay Gap report
- Developed EDI mandatory training on e-learning modules
- Held Staff listening events to help shape the Inclusion strategy and a platform for staff to share experiences
- Signed the NHS Confederation Inclusive Leadership pledge

Our Inclusion Vision

We hold the principles of equality and inclusion at the heart of everything we do and all that we stand for.

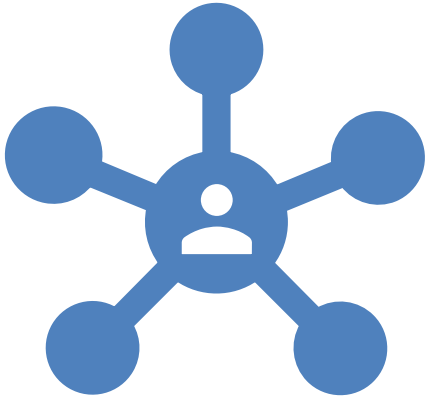
We will connect and align our vision and ethics to everyone.

We want under-represented groups at senior levels (such as women, people with disabilities, ethnic diverse and LGBTQ+ communities) to realise their potential in a sustainable way

NHS People Plan 2020

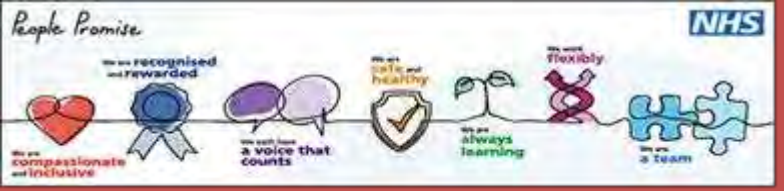
The NHS must welcome all, with a culture of belonging and trust…

We must understand, encourage and celebrate diversity in all its forms



Staff Network

The results of the WDES data for 2023 will be shared with our newly formed Disability and Neuro-Diverse Staff Network and the subsequent action plan will be shared for input and feedback. Amendments to the action plan will be made in line with the network recommendations



Further enquiries

RJAH would welcome any enquiries about the details of our WDES and Action Plan

please contact
Caroline Nokes-Lawrence, Associate Chief People and Culture Officer
caroline.nokes-Lawrence@nhs.net

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

WDES ACTION PLAN 2023

WDES Metric	Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
1,2	**Inclusion Strategy and Action Plan launched September 2023**	Action Plan to be reviewed at each EDI monthly meeting	Ongoing March 2024	Launched ongoing	People & Culture	CPO & Associate CPO
9a, 9b	**NED EDI lead**	To be agreed by Board	Dec-23	In Progress	Board	Chair
All	**Dedicated EDI Lead, resource and expertise**	Trust People Services structure revisited to include EDI lead and OD and Inclusion Team	Complete Review 31.08.24	Appointment of Associate CPO on secondment for 12 months Workstream lead on EDI for Trust and with ICS	People	CPO/ CEO
9a, 9b	**EDI Committee**	Review of Terms of Reference Representation across Trust on monthly meetings. Chaired by Associate CPO	Complete	In Progress	People & Culture	CPO
7	**System EDI network**	Associate CPO attends System EDI network meeting for the Trust Link in with System Disability network group	Ongoing	In Progress	People & Culture	CPO

WDES Metric	Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
4,8,9a, 9b	**Set up Disability and Neuro-Diverse Staff Network**	Set up to meet monthly Staff Chair appointed Executive sponsor/ally Deputy Chief Executive Encourage allies to join the network	Complete	Ongoing	People & Culture	CPO
5, 9b	**Staff Listening Events to develop Inclusion Strategy and Action Plan**	Staff attending events to provide ideas and views for the Inclusion Strategy Action Plan Guest speaker ICS Disability Network Chair	Jun-23	Completed	People & Culture	CPO
2,5	**Leadership development programme**	A Leadership Development Programme with various cohorts, and staff with protected characteristics encouraged to attend	Mar-24	In Progress	People & Culture	CPO
2	**Review of Induction process**	Ensure induction process has sufficient focus on E,D&I	Dec-23	Under Review	People & Culture	CPO
9b	**Review calendar of events to celebrate**	Communications team and OD and Inclusion Team have developed relevant national and local events relating to protected characteristics.	Mar-24	Ongoing	People & Culture	CPO
1,2,3,5,6	**Improve recording of disability data**	Trust Workforce Information Lead has identified actions to improve capture of disability data.	Mar-24	In Progress	People & Culture	CPO
5,6,9a, 9b, 10	**Encourage staff to complete Staff Survey**	Improve on 52% completion rate of 2022 staff survey. Associate CPO visiting teams and managers Drop in sessions for staff to complete during work time Looking for improvement rate on staff engagement score	Nov-23	In progress	People & Culture	CPO

WDES Metric	Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
9b	**EDI newsletter**	Draft in place for roll out to staff Links to ICS newsletter and events	Mar-24	First newsletter due in November 2023	People & Culture	CPO
8,9a, 9b	**Social Re-charge battery badges**	to be discussed further with network if this is an initiative to take forward on awareness and understanding.	Mar-24		People & Culture	CPO
10	**Disabled representation at Board**	Currently 0% Review turnover and where vacancies exist, ensure adverts have a statement of welcome of applicants with protected characteristics	Mar-24		People & Culture	CPO
9b	**Celebrate Disability History month**	November to December 2023 Include in newsletter Encourage staff sharing stories in lived experiences Explain reasonable adjustments and what it means Stories of valuing differences	Dec-23		People & Culture	CPO

WDES metrics

Metric 1

Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Metric 2

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Metric 3

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.

NHS Staff Survey

The question or theme from the NHS Staff Survey which is used to calculate each metric is shown in brackets underneath the title.

Metric 4

(Relates to Q14a-d in the NHS Staff Survey)

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

1. Patients/Service users, their relatives or other members of the public
2. Managers
3. Other colleagues
4. **Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

Metric 5

(Relates to Q15 in the NHS Staff Survey)

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Metric 6

(Relates to Q11e in the NHS Staff Survey)

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Metric 7

(Relates to Q4b in the NHS Staff Survey)

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Metric 8

(Relates to Q30b in the NHS Staff Survey)

Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

Metric 9a

(Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey)

The staff engagement score for Disabled staff, compared to non-disabled staff.

Disabled staff engagement

Metric 9b

Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes or No)?

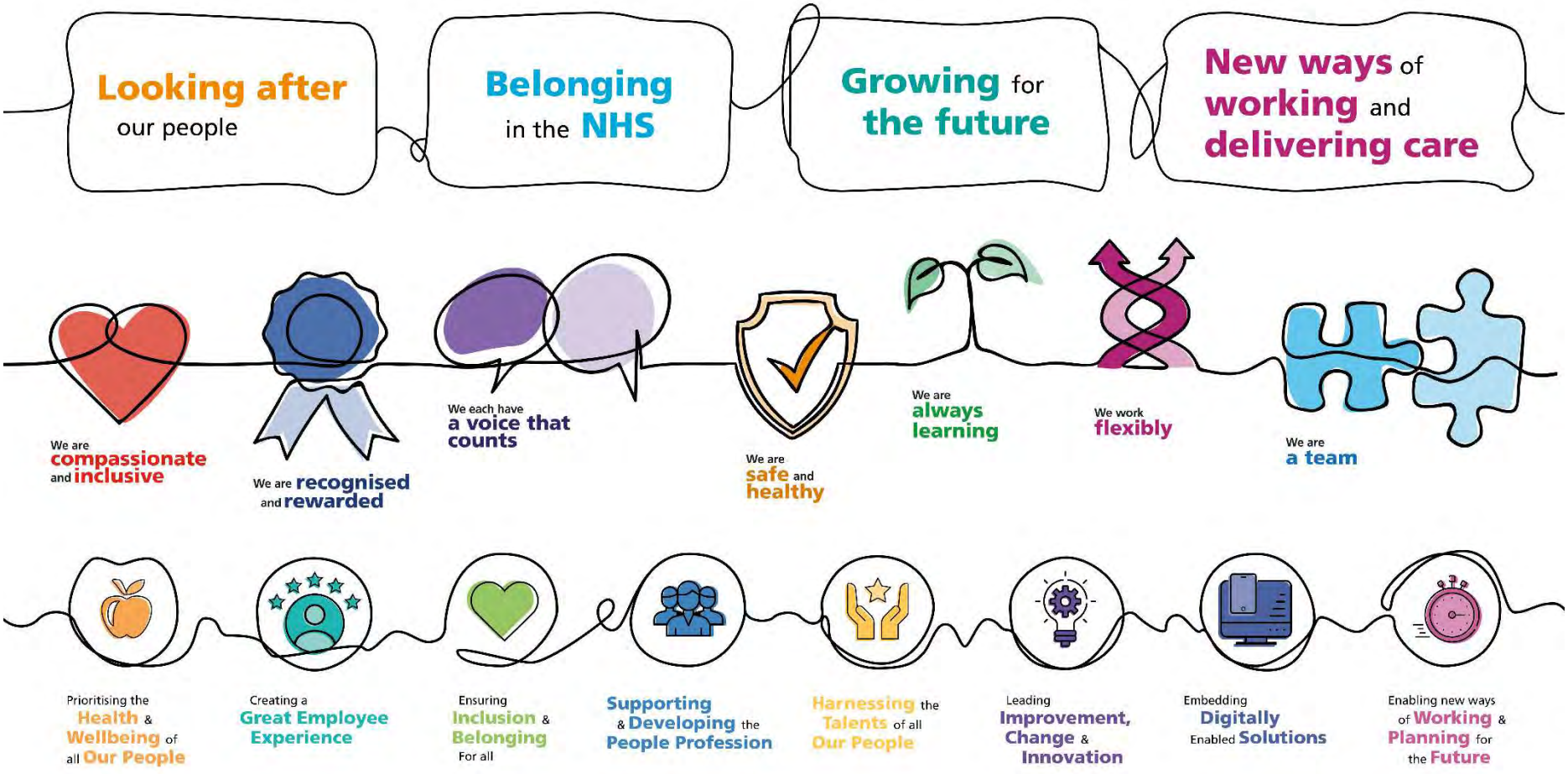
Board representation

For this metric, compare the difference for Disabled and non-disabled staff.

Metric 10

Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated:

- by voting and non-voting membership of the board
- by executive and non-exec membership of the board.


Looking after our people
Belonging in the NHS
Growing for the future
New ways of working and delivering care
We are compassionate and inclusive
We are recognised and rewarded
We each have a voice that counts
We are safe and healthy
We are always learning
We work flexibly
We are a team
Prioritising the Health & Wellbeing of all Our People
Creating a Great Employee Experience
Ensuring Inclusion & Belonging For all
Supporting & Developing the People Profession
Harnessing the Talents of all Our People
Leading Improvement, Change & Innovation
Embedding Digitally Enabled Solutions
Enabling new ways of Working & Planning for the Future

Workforce Race Equality Standard Annual Report

Committee/Meeting, date

Board of Directors, 8th November 2023

Author:	**Contributors:**
Name: Caroline Nokes-Lawrence Role/Title: Associate Chief People and Culture Officer	OD and Inclusion Team

Report sign-off:

Denise Harnin, Chief People and Culture Officer

The WRES 2022/3 summary data has been presented to the EDI Committee on 17th August 2023 whose remit is to *provide strategic direction, leadership and support for promoting and maintaining equality, diversity and human rights issues throughout the Trust* The report will be sent to the next People and Culture Committee in November.

Is the report suitable for publication:

The WRES annual report for 2023 is mandated to be published on the Trust's website by 31st October 2023 following approval from Board. The report and action plan will be submitted within the timescales subject to approval.

Key issues and considerations:

The WRES requires NHS trusts to self-assess against nine indicators of workplace experience and opportunity for organisations to compare the workplace and career experiences of ethnic diverse and white staff. Four indicators relate specifically to workforce data, four are based on data from the national NHS staff survey questions, and one considers ethnic diversity representation on boards.

As a Trust, we are using the term ethnically diverse rather than Black and Minority Ethnic (BME)

The Board are asked to receive the following highlights from the Trust's annual WRES data report.

i) The data provides findings in relation to the reporting metrics as of March 2023
ii) The report generates three areas for improvement which are included in the Action Plan
   1) likelihood of appointment from shortlisting
   2) Improve career progression in clinical roles (lower to middle levels)
   3) Experience of discrimination from a manager/team leader or other colleagues

Strategic objectives and associated risks:

The Board Assurance Framework risks / corporate risks overseen by the Meeting are:

- Effectiveness of engagement with the workforce
- Workforce capacity and capability
- EDI capacity and capability

Strategic objectives;

- Caring for staff

Workforce Race Equality Standard
Annual Report

Recommendations:

The Committee are asked to.

i) Note the contents of the report and WRES annual analysis and Action Plan (Appendix A and Appendix B)
ii) Note that the EDI Committee will continue to monitor and review the relevant data analysis in line with the Trust's Inclusion Strategy
iii) Approve the annual report for inclusion on the Trust's website

Report development and engagement history:

The information and analysis were shared with the Equality, Diversity, and Inclusion meeting on 17th August for information and will be shared with the People and Culture Committee in November.

The Workforce Race Equality Standard (WRES) is a set of nine specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever EDI improvement plan.

Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool, and provide sustainable careers.

Next steps:

The EDI meeting members, Ethnic Diverse Staff Network Group, will continue to monitor the data analysis and actions. In addition, the OD and Inclusion Team will work in conjunction with the newly formed network to review the contents of the Action Plan

Regular updates will also be shared with the Board.

Information from the NHS national Staff Survey for 2023 will also provide valuable information regarding the workforce responses and analysis.

This data is normally released around March of the following year of the survey taking place in October and November 2023.

i) The WRES report and Action Plan should be published on the Trust's website, so that the data is available and clear to all stakeholders within the mandated timescales.
ii) The Trust's analysis and data will be shared with the wider ICS EDI network.
iii) The Action Plan will be reviewed in tandem with the Inclusion Strategy Action Plan to ensure delivery of objectives

Acronyms

EDI	Equality, Diversity and Inclusion
WDES	Workforce Race Equality Standard

Appendices

Appendix A	*WRES Annual Report 2023*
Appendix B	*WRES Action Plan 2023*

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHS Workforce Race Equality Standard (WRES) Annual Report – 2023

Aspiring to deliver world class patient care

Workforce Race Equality Standard

WRES focuses on enabling people to work comfortably with race equality. Through communications and engagement, we will work to change the deep rooted cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability to work with race.

Continuous embedding of accountability to ensure key policies have race equality built into their core, so that eventually workforce race becomes everyday business.

The WRES will continue to work to evidence the outcomes of the work that is done, publishing data intelligence and supporting the system by sharing replicable good practice.

With over one million employees, the NHS is mandated to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of ethnic diverse board members across the organisation.

A fair experience for all

To enable organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice

To provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda

The WRES 2023 reporting timeline ran from 1 May until 31 May for NHS provider trusts and required metrics and narrative data to be reported by 31 October 2023, trusts must publish their board ratified 2023 WRES annual report on their website.

The current reporting year for the purposes of this report is 2023. Data for indicators 1 to 4 are taken from WRES data portal submissions relating to the workforce as at the end of March 2023. Data for indicators 5 to 8 come from the NHS Staff Survey run in 2022

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

Introduction

The WRES requires NHS trusts to self-assess against nine indicators of workplace experience and opportunity for organisations to compare the workplace and career experiences of ethnic diverse and white staff . Four indicators relate specifically to workforce data, four are based on data from the national NHS staff survey questions, and one considers ethnic diversity representation on boards

As a Trust, we are using the term ethnically diverse rather than Black and Minority Ethnic (BME)

Indicator 1
Non-clinical staff on AfC paybands

BME staff were represented at 1.2% in all non-clinical AfC roles.
At Band 4 and under (e.g., administrative and technical support roles, estates officer):
- BME representation was 1.2%, overall.
- BME staff were proportionately represented by pay band.

At Band 5 and over (graduate and management level roles):
- BME representation was 1.2%, overall.
- BME staff were proportionately represented by pay band

Indicator 1

Clinical staff on AfC paybands

BME staff were represented at 5.8% in all clinical AfC roles.
At Band 4 and under (e.g., clinical support workers and healthcare assistants):
- BME representation was 5.4%, overall.
- BME staff were proportionately represented by pay band.

At Band 5 and over (e.g., clinical roles requiring professional registration including nurses):
- BME representation was 6.1%, overall.
- BME staff were underrepresented at Band 6 and above, 3.6%

Indicator 1

Medical staff

BME representation was 40.8% in all medical and dental roles.

Amongst medical and dental staff:

- BME staff were underrepresented at Consultant level and above, 34.3%.

Indicator 1

Race disparity ratios for non-clinical staff on AfC paybands

Lower to middle: 0.77; not significantly different from "1.0" (or equity).
The Trust performed better than 55% of Trusts and worse than 45% of Trusts

Indicator 1

Race disparity ratios for clinical staff on AfC paybands

Lower to middle: 2.60; higher than "1.0" (or equity) to a medium degree.
The Trust performed better than 30% of Trusts and worse than 70% of Trusts.
Middle to upper: 0.39; not significantly different from "1.0" (or equity).
The Trust performed better than 13% of Trusts and worse than 87% of Trusts.
Lower to upper: 1.00; not significantly different from "1.0" (or equity).
The Trust performed better than 100% of Trusts and worse than 0% of Trusts.

Indicator 2

The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

The Trust performed better than 5% of Trusts and worse than 95% of Trusts.

11

Example: a value of "2.0" would indicate that White candidates were twice as likely as BME candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as BME candidates to be appointed from shortlisting.

At March 2023 the likelihood ratio was 3.49; higher than "1.0" or equity to a large degree. Specifically, 257 out of 824 white candidates were appointed from shortlisting (31.2% of white candidates) compared to 17 out of 190 BME candidates (8.9% of BME candidates).

Indicator 3

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff

the likelihood ratio was 0.00; Specifically, 0 out of 120 BME staff entered formal disciplinary proceedings (0.00% of the BME workforce) compared to 5 out of 1512 white staff (0.33% of the white workforce)

Indicator 4

The relative likelihood of white staff accessing non–mandatory training and continuing professional development (CPD) compared to BME staff

the likelihood ratio was 0.22; lower than "1.0" or equity to a large degree. Specifically, 86 out of 1512 white staff undertook non-mandatory training (5.7% of the white workforce) compared to 31 out of 120 BME staff (25.8% of the BME workforce).

The Trust performed better than 3% of Trusts and worse than 97% of Trusts

Indicator 5

The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

The percentage of staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months was similar for BME staff, 14.6%, and for White staff, 16.9%.

In terms of the percentage of BME staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, the Trust performed better than 99% of Trusts and worse than 1% of Trusts

Indicator 6

The percentage of staff who experienced harassment, bullying or abuse from other staff in the last 12 months

The percentage of staff who experienced harassment, bullying or abuse from other staff in the last 12 months was similar for BME staff, 20.8%, and for White staff, 24.7%

In terms of the percentage of BME staff who experienced harassment, bullying or abuse from other staff in the last 12 months, the Trust performed better than 87% of Trusts and worse than 13% of Trusts

Indicator 7

The percentage of staff who believed that the trust provided equal opportunities for career progression or promotion

The percentage of staff who believed that the trust provided equal opportunities for career progression or promotion was similar for BME staff, 54.2%, and for White staff, 57.0%

In terms of the percentage of BME staff who believed that the trust provided equal opportunities for career progression or promotion, the Trust performed better than 91% of Trusts and worse than 9% of Trusts

Indicator 8

The percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleagues

The percentage of staff who personally experienced discrimination from other staff in the last 12 months was significantly higher for BME staff, 17.0%, than for White staff, 6.6%

in terms of the percentage of BME staff who personally experienced discrimination from other staff in the last 12 months, the Trust performed better than 39% of Trusts and worse than 61% of Trusts.

Indicator 9

Overall board membership

At March 2023, the difference between BME representation on the board and in the workforce was -0.4%. The degree of BME underrepresentation equated to less than half a member in terms of a headcount.

The Trust performed better than 99% of Trusts and worse than 1% of Trusts.

a negative value means that the percentage of BME members on the board of directors is lower than in the workforce

Indicator 9

Voting board membership

At March 2023, the difference between BME representation on the board and in the workforce was +2.0% amongst voting members. BME members were at least proportionately represented on the board in terms of a headcount of voting members. The Trust performed better than 92% of Trusts and worse than 8% of Trusts

Indicator 9

Executive board membership

At March 2023, the difference between BME representation on the board and in the workforce was -7.1% amongst executive members.

The degree of BME underrepresentation equated to less than half an executive member in terms of a headcount. The Trust performed better than 78% of Trusts and worse than 22% of Trusts

WRES priorities

High priority areas for improvement

Indicator 2: likelihood of appointment from shortlisting

Indicator 1: Career progression in clinical roles (lower to middle levels)

Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against ethnic diverse staff

WRES priorities

Areas of best performance

Indicator 1: Career progression in clinical roles (lower to upper levels)

Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months against ethnic diverse staff

Indicator 9: Board representation (overall and voting members)

Executive Summary (1 of 2)

The Trust continues to commit to being a more inclusive place to work , ensuring equal opportunities and celebrating our diversity. We support and encourage staff to share their experiences through a variety of feedback resources and in line with our Inclusion Strategy

Through 2022 / 2023, we have achieved;

- The launch of our Inclusion Strategy and Action Plan 2023-2026
- Reviving our Ethnic Diverse Staff Network
- Appointed an Executive Sponsor/ally for the Ethnic diverse Staff Network
- Reviewed the Terms of Reference of our monthly EDI meetings so that they are more inclusive for members to attend
- Joined the NHSE Diversity in Health and Care Partners programme, which commenced in September 2023 and is a year-long programme that includes, supporting health and care organisations to create more inclusive workplace cultures, where difference is welcomed and celebrated, with access to leading industry experts, good practice, guidance, resources and networking opportunities.
- Promotion of the National NHS Muslim Network

Executive Summary (2 of 2)

Through 2022 / 2023, we have achieved;

- Received 52% response for our Staff Survey 2022
- Continuing to review our progress and delivery against statutory requirements, such as the public sector equality duty
- Published WRES, WDES, Workforce Report and Gender Pay Gap report
- Promoted the Visible Leaders Network https://midlands.leadershipacademy.nhs.uk/our-offers/visible-leaders-network/
- Celebrated Inclusion Week in September 2023
- Held a Come Dine with me event in October 2023
- Celebration and staff stories through Black History Month
- Developed EDI mandatory training on e-learning modules
- Held Staff listening events to help shape the Inclusion strategy and a platform for staff to share experiences
- Signed the NHS Confederation Inclusive Leadership pledge

Our Inclusion Vision

We hold the principles of equality and inclusion at the heart of everything we do and all that we stand for.

We will connect and align our vision and ethics to everyone.

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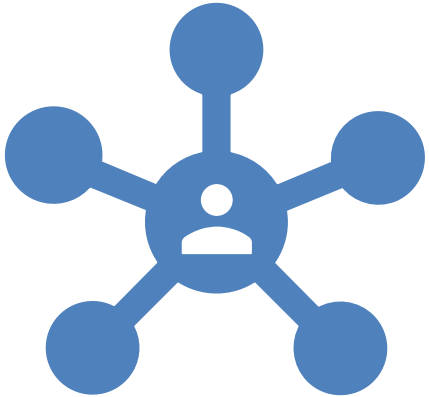
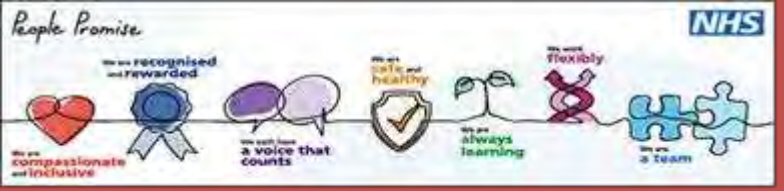


Staff Network

The results of the WRES data for 2023 will be shared with the Ethnic Diverse Staff Network, once it has been set up again. The subsequent action plan will be shared for input and feedback. Amendments to the action plan will be made in line with the network recommendations



Further enquiries

RJAH would welcome any enquiries about the details of our WRES and Action Plan

please contact
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caroline.nokes-Lawrence@nhs.net

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

WRES ACTION PLAN 2023

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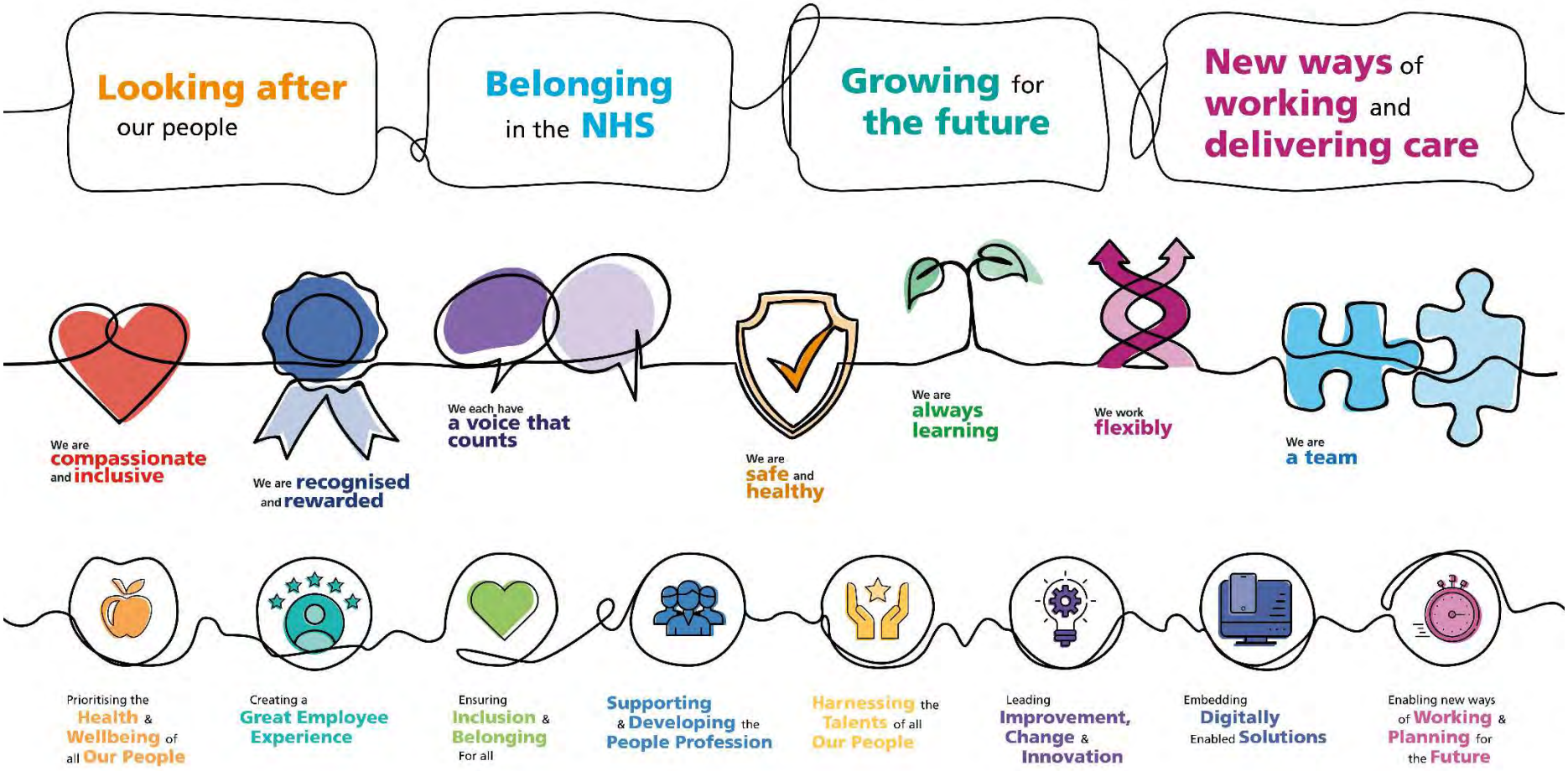
Inclusion Strategy and Action Plan launched September 2023	Action Plan to be reviewed at each EDI monthly meeting	Ongoing March 2024	Launched ongoing	People & Culture	CPO & Associate CPO
NED EDI lead	To be agreed by Board	Dec-23	In Progress	Board	Chair
Dedicated EDI Lead, resource and expertise	Trust People Services structure revisited to include EDI lead and OD and Inclusion Team	Complete Review 31.08.24	Appointment of Associate CPO on secondment for 12 months Workstream lead on EDI for Trust and with ICS	People	CPO/ CEO
EDI Committee	Review of Terms of Reference Representation across Trust on monthly meetings. Chaired by Associate CPO	Complete	In Progress	People & Culture	CPO
System EDI network	Associate CPO attends System EDI network meeting for the Trust Link in with System Ethnic Diverse network group	Ongoing	In Progress	People & Culture	CPO

Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
Set up Ethnic Diverse Staff Network	Set up to meet monthly Executive sponsor/ally appointed Encourage allies to join the network	Mar-24	Ongoing	People & Culture	CPO
Staff Listening Events to develop Inclusion Strategy and Action Plan	Staff attending events to provide ideas and views for the Inclusion Strategy Action Plan Guest speaker ICS Equality Network Chair	Jun-23	Completed	People & Culture	CPO
Leadership development programme	A Leadership Development Programme with various cohorts, and staff with protected characteristics encouraged to attend	Mar-24	In Progress	People & Culture	CPO
Review of Induction process	Ensure induction process has sufficient focus on E,D&I and promotion of Staff Network Groups	Dec-23	Under Review	People & Culture	CPO
Review calendar of events to celebrate	Communications team and OD and Inclusion Team have developed relevant national and local events relating to protected characteristics.	Mar-24	Ongoing	People & Culture	CPO
Encourage and improve recording of ethnic diverse data	Trust Workforce Information Lead has identified actions to improve capture of ethnic diverse data.	Mar-24	In Progress	People & Culture	CPO
Encourage staff to complete Staff Survey	Improve on 52% completion rate of 2022 staff survey. Associate CPO visiting teams and managers Drop in sessions for staff to complete during work time Looking for improvement rate of staff experiences who have an ethnic diverse background	Nov-23	In progress	People & Culture	CPO

Action	Progress/ Issues/ Risks	Target date	Status	Committee	Lead
EDI newsletter	Draft in place for roll out to staff Links to ICS newsletter and events	Mar-24	First newsletter due in November 2023	People & Culture	CPO
Ethnic diverse representation at Board	Review turnover and where vacancies exist, ensure adverts have a statement of welcome of applicants with protected characteristics	Mar-24		People & Culture	CPO
ImproveWell app	Launch of digital engagement solution app, to capture real time staff feedback of experiences. Pilot in Theatres November/December 2023	Mar-24		People & Culture	CPO
likelihood of appointment from shortlisting	Continually review and monitor our recruitment processes to ensure they are accessible for all. Continue with Recruitment Open days to assist communities in applying for Trust vacancies and understanding what the barriers might be	Mar-24		People & Culture	CPO
Improve career progression in clinical roles (lower to middle levels)	Understanding any barriers to progression through feedback and discussion with Ethnic Diverse Staff network group Review framework and opportunities to progress	Mar-24		People & Culture	CPO
Experience of discrimination from a manager/team leader or other colleagues	The Trust recognize this is unacceptable, and will continue to promote all Freedom to speak up processes, review staff survey feedback, and regularly communicate with staff that the Trust and ICS has a zero tolerance policy to discrimination	Mar-24		People & Culture	CPO


Looking after our people
Belonging in the NHS
Growing for the future
New ways of working and delivering care
We are compassionate and inclusive
We are recognised and rewarded
We each have a voice that counts
We are safe and healthy
We are always learning
We work flexibly
We are a team
Prioritising the Health & Wellbeing of all Our People
Creating a Great Employee Experience
Ensuring Inclusion & Belonging For all
Supporting & Developing the People Profession
Harnessing the Talents of all Our People
Leading Improvement, Change & Innovation
Embedding Digitally Enabled Solutions
Enabling new ways of Working & Planning for the Future

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
People and Culture Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	08 November 2023
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	31 October 2023
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 26 October 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.

Board Assurance Framework

The Committee agreed that it is an appropriate time for the document to be reviewed to align with the recently approved corporate objectives. The members of the meeting discussed and acknowledged the phenomenal work which has been undertaken by the Trust to reduce the risks aligned to workforce, recruitment, wellbeing and EDI. The Committee welcomed a refresh perspective on the BAF and agreed the current position.

Corporate Risk Register
The Committee noted and agreed the corporate risk register. The movement of risks were welcomed and noted.

Chair Report ICS People Committee
It was noted that there was no formal paper available from the System and therefore a verbal update was provided via the Chief People Officer. Following a discussion, concerns were raised relating to the risk (to both the Trust and the System) regarding there being no central people relating leadership which subsequently has led to additional pressures being shared across the System. The Committee agreed to raise the concern with the Board of Directors with a suggestion that the risk is highlighted and discussed at the ICB.

WDES Annual Report
The Committee received the annual report which is required to be published by the Trust on 31 October 2023. The report has an associated action plan which will be monitored through the Committee. Concerns were raised in relation to comparative data provided regarding harassment and bullying which will be investigated as part of the action plan. The Committee agreed for the draft report to be made available on the Trust website and recommend the approval of the report by the Board.

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 key performance indicators. The Committee asked consideration to be given to the following to provide further assurance at the next meeting:

- Deep dive of high long-term sickness to be completed and improvement actions to be presented.
- Review internal heath and wellbeing services available due to the imminent ceasing in the current counseling services.
- Personal development reviews review – the committee discussed the reduction in PDR compliance rates and were provided assurance that the Trust has a current focus on this. The committee will be more assured when the compliance levels are seen to have increased in the monthly performance report.

Guardian of Safe Working Hours Q2 Report
The Committee were informed that the Trust has reported 2 exceptions within Q2 however exceptions were not directly related to the Trust. The exceptions relate to two trainees who the Trust hold central contracts for who are working in Wales where there is no guardian in place. The Committee were assured on the processes in place to support the staff and engage with neighboring providers. There is a requirement for the Trust to source funding for the electronic reporting system, the Committee were re-assured that the Trust is currently reviewing options.

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. The Trust reported a sustained improvement for month 6. MSCI remains the highest reliance upon agency but noted this is due to the high level of one-on-one care provided to the patients.

Nursing Safe Staffing Report
The Committee were assured that the Trust are compliant with the safe staffing levels. Concerns were raised in relation to medication incidents and staff behaviors but assurance was provided that

these areas are being overseen by the Quality and Safety Committee via the medication incident improvement work and patient experience report.

EDI Report
The Committee are assured with the actions implemented to improve the overall EDI agenda for the Trust and agreed for the reporting to be bi-monthly. The Committee asked for an assurance report to allow reflection on the internal audit recommendations from 2022/23 review.

Education Contract Self-Assessment
The committee were provided with an overview of the self assessment which covered the contractual key performance indicators in relation to NHS education contract. To improve the Trusts position the following actions are required; internal governance and assurance process to ensure quality improvement and educational supervisor to support the practice appropriately. The Committee supported and approved the self-assessment.

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

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

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

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

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

- Medical Staffing Rostering Policy
- Non-Medical Job Planning Policy

The following papers were **deferred** to the next meeting:

- Freedom to Speak Up Q2 Report and Action Log
- Responsible Officer Revalidation Report
- Powys Assurance Update (verbal) – it was noted this was deferred due to the update meeting being rearranged to 2nd November.

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps :-
   - To consider the approval of the WDES report
   - To consider the concerns raised in relation to the lack of ICB people related leadership
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 - Performance
September 2023 – Month 6

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.

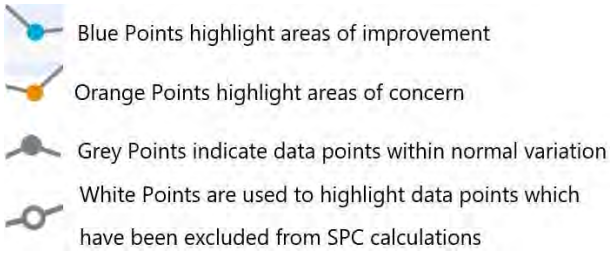
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

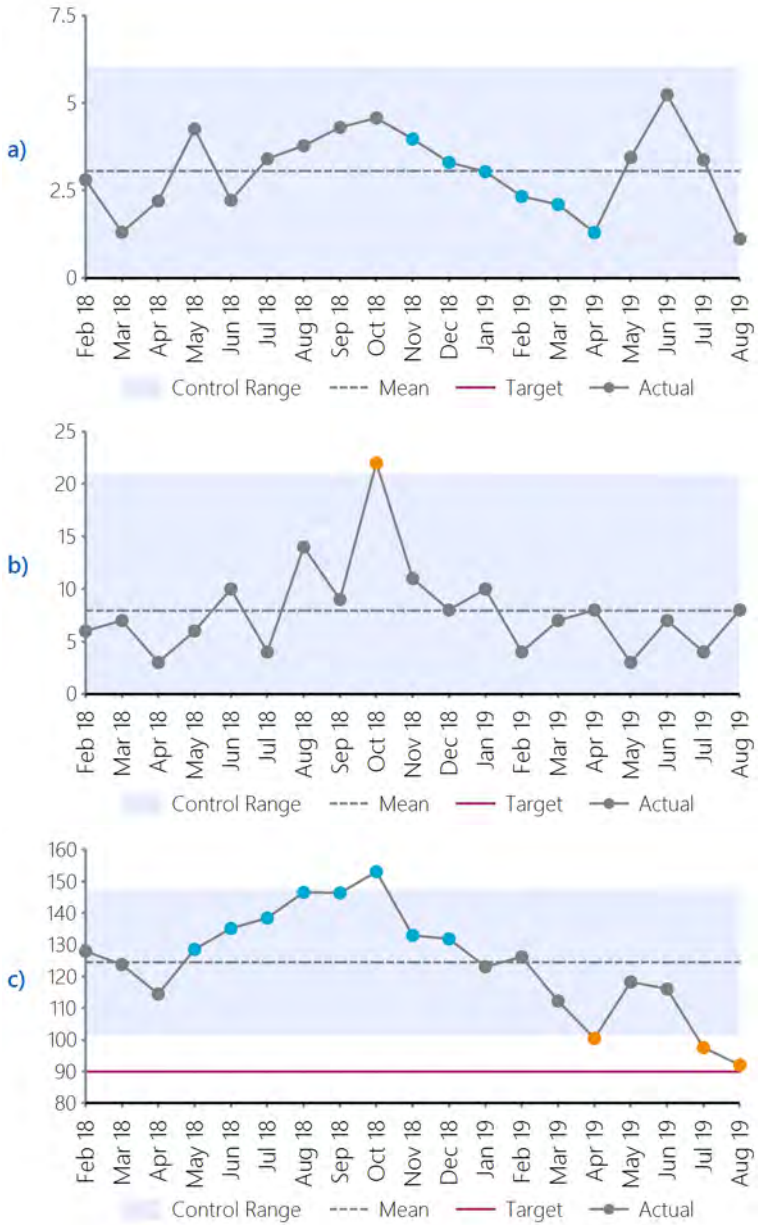


Some examples of these are shown in the images to the right:

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.



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
Cancer Plan 62 Days Standard (Tumour)*	85.00%	0.00%			?	+	12/09/23
28 Day Faster Diagnosis Standard*	75.00%	94.74%			?		12/09/23
18 Weeks RTT Open Pathways	92.00%	50.57%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,177	1,265	L	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		911			No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	12	0	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		223		L	No Target	+	
Patients Waiting Over 104 Weeks - English	0	1		L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		53		L	No Target	+	
Overdue Follow Up Backlog	5,000	11,710		L	F	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
6 Week Wait for Diagnostics - English Patients	85.00%	77.97%				+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	88.06%				+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,081	916			Moving Target	+	24/06/21
Overall BADS %	85.00%	79.43%			?	+	
Total Outpatient Activity against Plan (volumes)	15,453	12,504			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	5.00%	4.08%			Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,525	2,279			Moving Target	+	

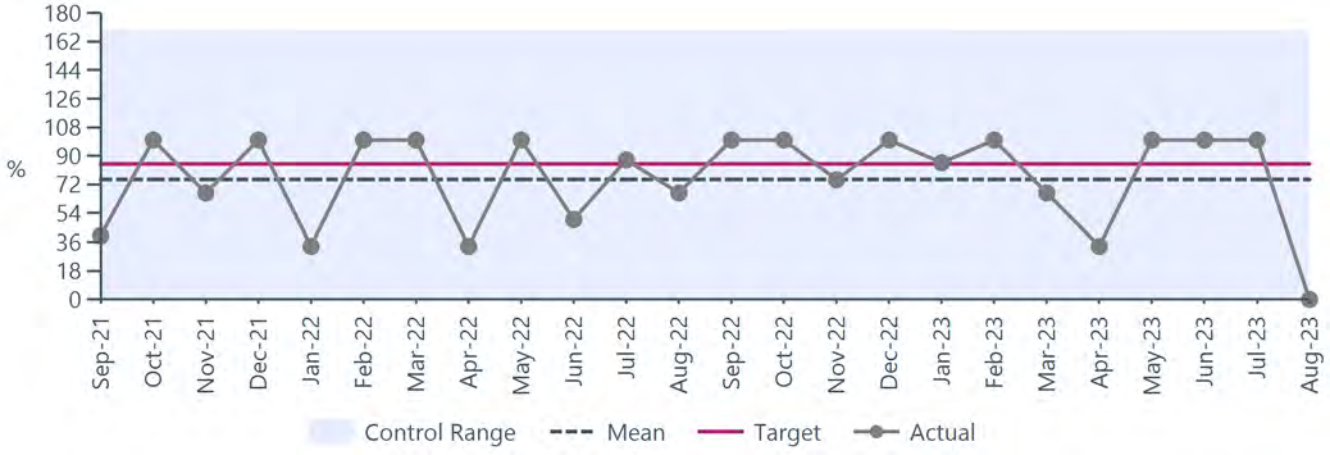
Cancer Plan 62 Days Standard (Tumour)*

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85%	0%		

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 Standard was not met in August; this measure is reported in arrears. The August performance is reported at 0% against the 85% target. The data reported relates to one patient where the pathway was a breach due to administrative reasons.

Please note, the data previously reported for June has also been updated this month. It had been reported at 33.33% due to data that was allocated to RJAH by another Trust in error. This has now been rectified and the correct position of 100% is now recognised.

Actions

The Assistant Service Manager will be copied into all referrals going out to other hospitals from the Tumour unit.

The Assistant Service Manager will follow up on the referral at Day 3 and Day 7 after their transfer.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
100.00%	100.00%	75.00%	100.00%	85.71%	100.00%	66.67%	33.33%	100.00%	100.00%	100.00%	0.00%	

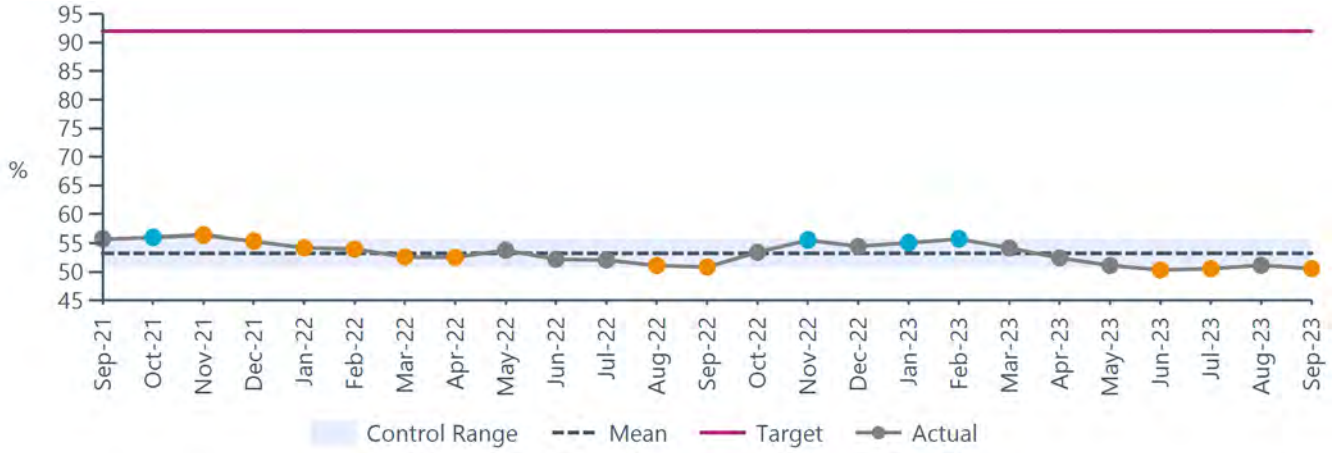
18 Weeks RTT Open Pathways

% 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%	50.57%	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 September performance was 50.57% 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 – 8156 patients waiting of which 2582 are breaches
* MS2 - 1364 patients waiting of which 907 are breaches
* MS3 - 5496 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

The Trust has been focusing on treatment of its longest waits. Agreements made for mutual aid support, for English patients, with both ROH and Walton. Patients being contacted and transferred where appropriate for our most challenged sub-specialty.

The Trust has a continuous validation programme in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. Validating patients down to 12 weeks is in progress.

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.

Current recruitment to increase capacity; Interviews planned in September for additional Upper Limb Consultant and Spinal Disorders advert currently open.

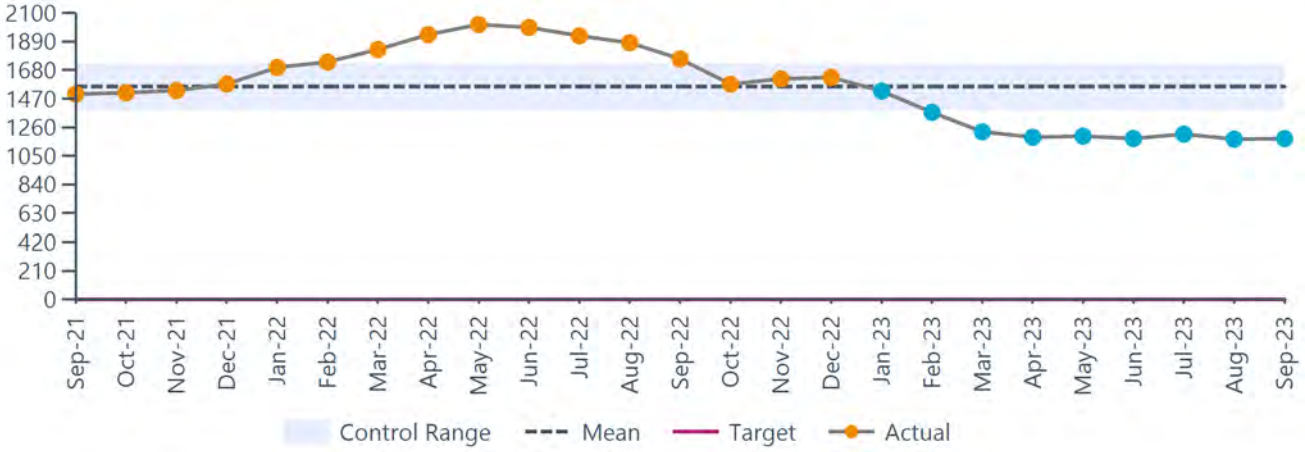
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
50.84%	53.43%	55.53%	54.47%	55.09%	55.74%	54.18%	52.44%	51.12%	50.33%	50.55%	51.15%	50.57%

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	1,177	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 September there were 1177 English patients waiting over 52 weeks; below our trajectory figure of 1265 by 88. The patients are under the care of these sub-specialities; Arthroplasty (491), Upper Limb (175), Knee & Sports Injuries (168), Foot & Ankle (147), Spinal Disorders (155), Paediatric Orthopaedics (10), SOOS GPSI (9), Metabolic Medicine (6), Tumour (5), ORLAU (4), Spinal Injuries (2), Physiotherapy (2), Orthotics (1), Neurology (1) and SOOS Physiotherapy (1). Patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 1165 patients
* >78 to <=95 weeks - 11 patients
* >95 to <=104 weeks - 0 patients
* >104 weeks - 1 patient

Actions

The national planning requirements issued in December 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 eliminate waits of over 65 weeks by March-2024, the Trust is focusing on all patients that will be greater than 52 weeks by the end of December to ensure they have a first appointment by the end of October-23. The Trust has submitted a plan to NHSE that forecasts zero 65+ weeks waits by March-24. Industrial Action impacts are being reviewed recognising the impact of reduced activity levels which are required to meet this standard.

The Trust has a continuous validation programme in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. Validating patients down to 12 weeks is in progress with discussions with external providers to support this. The Trust is exploring digital solutions with external suppliers to further support validation processes. Actions are also progressing to enable patient initiated mutual aid.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods. Internal insourcing options are being explored to further increase capacity.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
1763	1577	1616	1627	1526	1370	1227	1187	1195	1178	1210	1173	1177

Patients Waiting Over 52 Weeks - Welsh (Total)

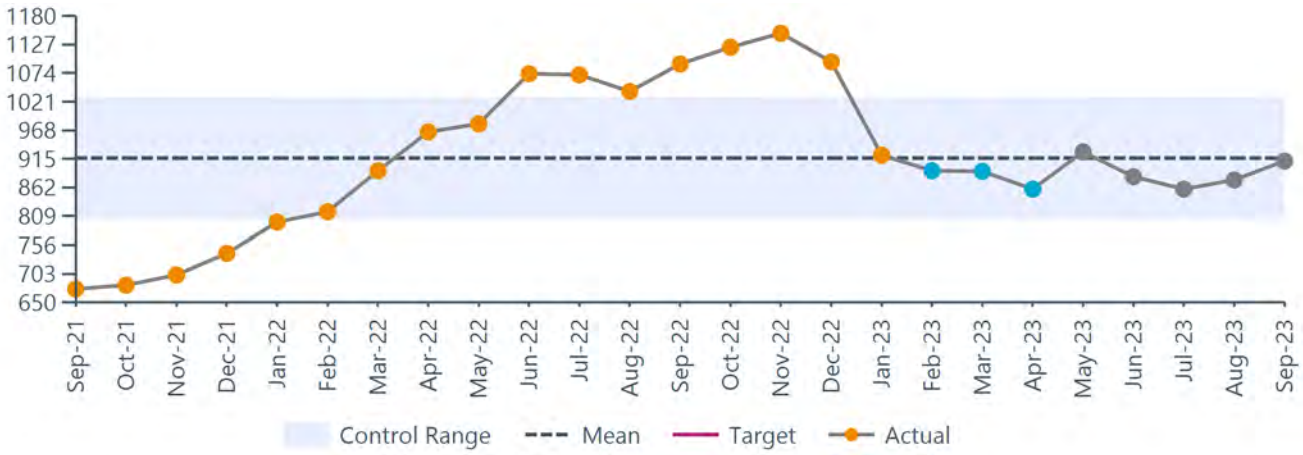
Patients Waiting Over 52 Weeks - Welsh (Total) - Welsh and Welsh (BCU Transfers) combined 217788

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	911		No Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of September there were 911 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (337), Arthroplasty (191), Knee & Sports Injuries (148), Upper Limb (101), Foot & Ankle (74), Veterans (33), Paediatric Orthopaedics (19), Tumour (4), Metabolic Medicine (1), Rheumatology (1), Orthotics (1) and Metabolic Medicine (1).

Patients are under the care of the following commissioners: BCU (481), Powys (408), Hywel Dda (20), Anurin Bevan (1) and Cardiff & Vale (1). The number of patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 688 patients
* >78 to <=95 weeks - 133 patients
* >95 to <=104 weeks - 37 patients
* >104 weeks - 53 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.

The Trust has a continuous validation programme in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy.

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

Internal insourcing options are being explored to further increase capacity.

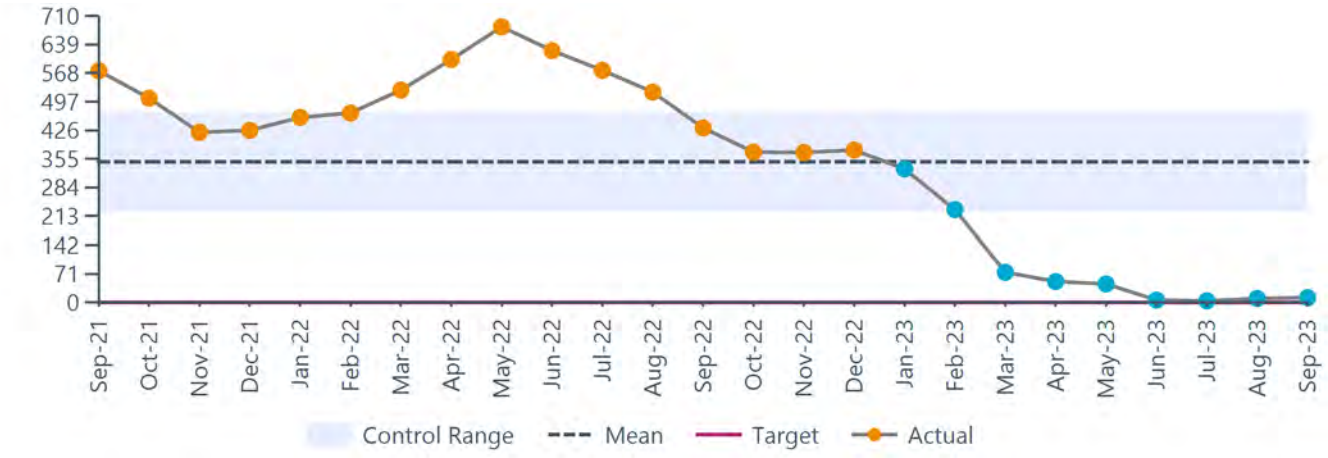
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
1091	1122	1148	1095	922	893	892	859	928	882	859	876	911

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	12	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 September there were 12 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; Knee & Sports Injuries (4), Arthroplasty (4), Upper Limb (2), Foot & Ankle (1) and Spinal Disorders (1).

0 (zero) 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.

The Trust has sought mutual aid to support its most challenged specialty. Agreements made with both ROH and Walton for support with this being reviewed with those providers. Patients being contacted and transferred where appropriate and agreed with the patient and relevant provider. Agreement in place to participate in the Digital Mutual Aid system that is being led by NHS England. A mutual aid co-ordinator and validation resource are in place and this resource has been extended into 23/24 to support actions being taken. Chief Operating Officer discussions also take place between providers to monitor progress. The Trust is exploring digital solutions with external suppliers to further support validation processes. Actions are also progressing to enable patient initiated mutual aid.

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

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
432	372	371	377	330	229	75	52	46	6	4	10	12

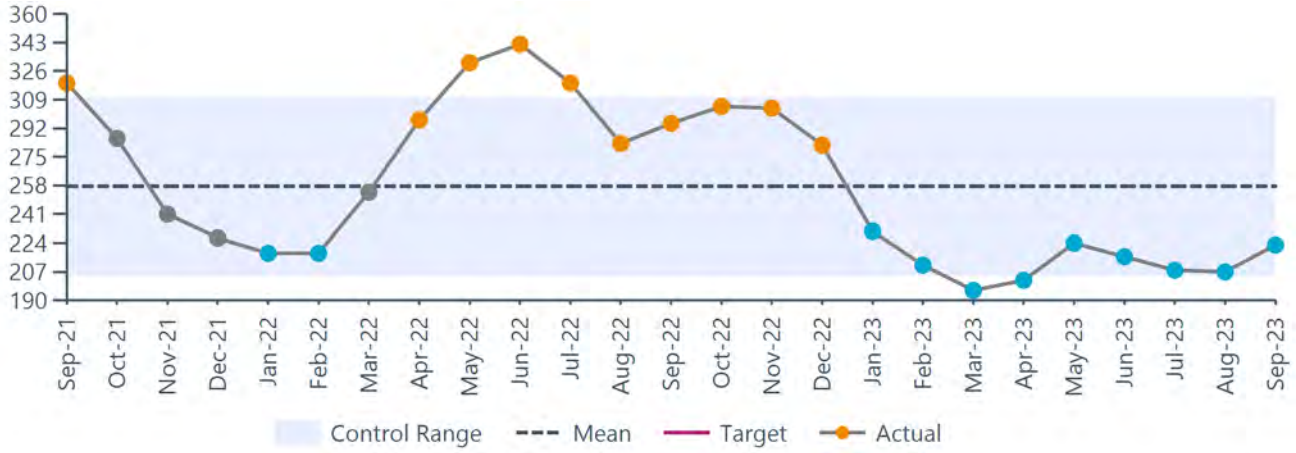
Patients Waiting Over 78 Weeks - Welsh (Total)

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
-	223	L	No Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of September there were 223 Welsh patients waiting over 78 weeks.

The patients are under the following sub-specialties; Spinal Disorders (125), Knee & Sports Injuries (44), Upper Limb (19), Foot & Ankle (17), Arthroplasty (14), Veterans (2) and Paediatric Orthopaedics (2).

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.

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.

Internal insourcing options are being explored to further increase capacity.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
295	305	304	282	231	211	196	202	224	216	208	207	223

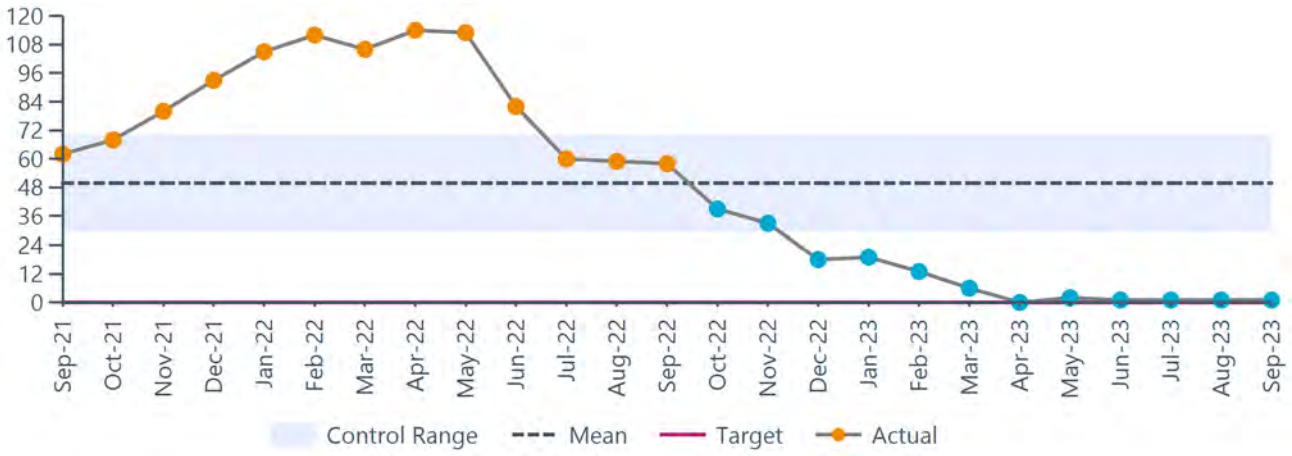
Patients Waiting Over 104 Weeks - English

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	1	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 September there was 1 English patient waiting over 104 weeks with details as follows:
* Knee & Sports Injuries (1): Complex case requiring a bespoke piece of kit sourced from abroad (ongoing supply issues) which has been raised with NHSE

The Trust is forecasting this one breach will remain for the end of October.

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward. The one breach is a known breach, as reported in previous months due to continued kit delays for a complex patient. The patient continues to be reviewed by the Consultant whilst awaiting treatment.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
58	39	33	18	19	13	6	0	2	1	1	1	1

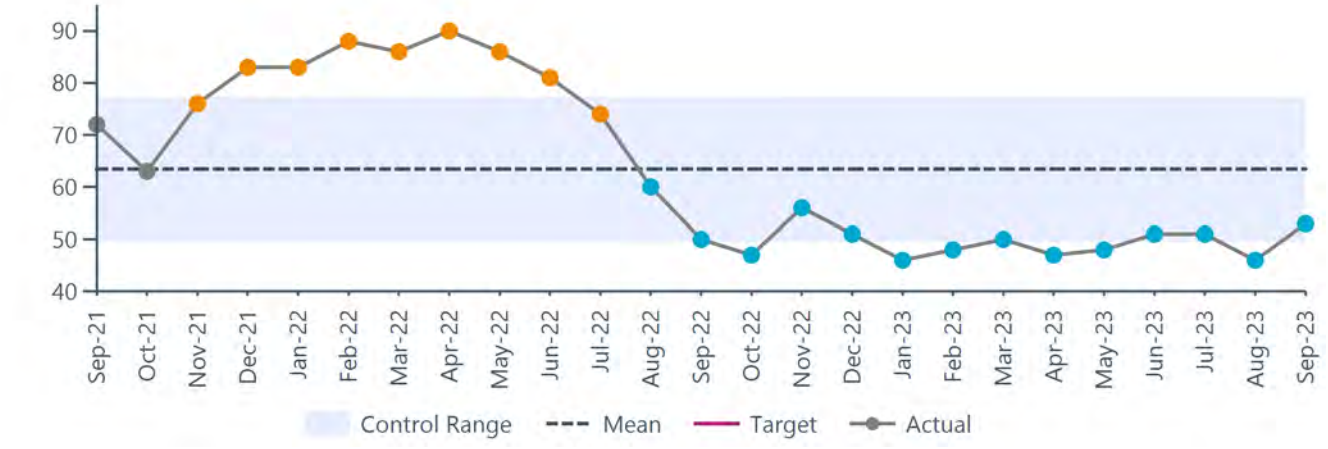
Patients Waiting Over 104 Weeks - Welsh (Total)

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
-	53	L	No Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of September there were 53 Welsh patients waiting over 104 weeks.

The patients are under the care of the following subspecialties:
* Spinal Disorders (51)
* Knee & Sports Injuries (1)
* Upper Limb (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.

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

Overdue Follow Up Backlog

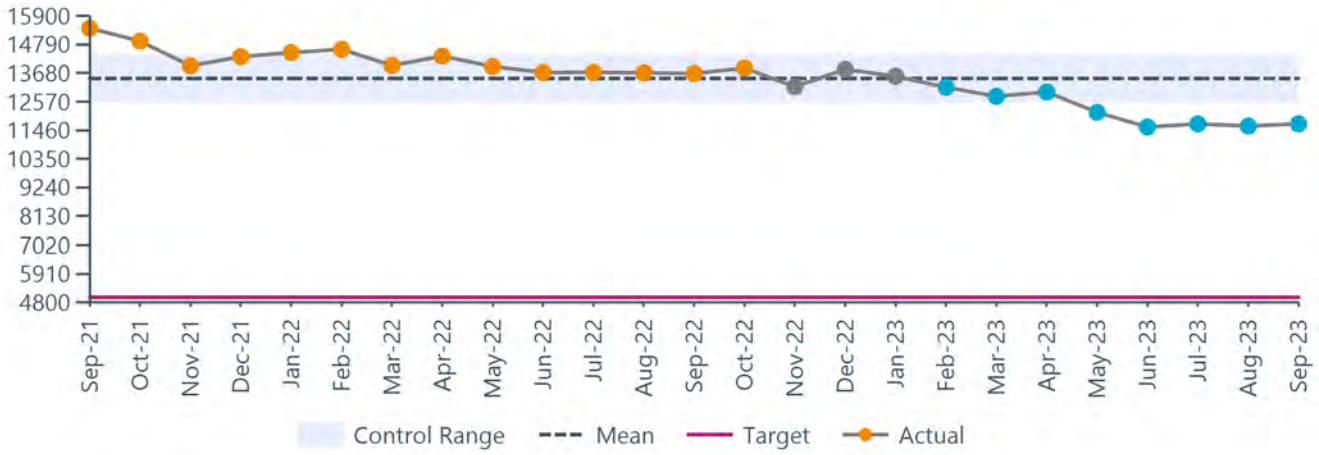
All dated and undated patients that are overdue their follow up appointment 217364

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	11,710	L	F

Trajectory

Actual
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 September, there were 11710 patients overdue their follow up appointment. This is broken down by:
- Priority 1 - 7136 with 1193 dated (17%) (priority 1 is our more overdue follow-up cohort)
- Priority 2 - 4574 with 1308 dated (29%);

* The backlog increased by 80 from last month, however the priority 1 backlog reduced by 136.
* Of the 11710 patients overdue, 34% are diagnostic follow ups.
* Of all the patients on a non diagnostic follow up, 20% are overdue.
* Of all the patients on a diagnostic follow up, 56% are overdue.
* The sub-specialities with the highest proportion of overdue follow ups are: Spinal Injuries - 55%; Neurology - 49%; 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

The overdue follow up working group is on hold to allow the dedicated focus needed on the NHSE long wait RTT targets but this is still monitored through the Outpatient Improvement Group. The plan is to re-instate this group in the coming months, recognising its importance but balancing resource against the RTT long waits national ask.
* The Validation team have a long term follow up database and follow ups are validated regularly.
* Further validation of diagnostic follow ups is required.
* Clinical discussions are taking place with regards to validation of overdue follow ups.
* Main focus is to be on the sub-specialties with the greatest opportunity of reduction.
* 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.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
13665	13878	13151	13828	13554	13132	12777	12949	12158	11589	11707	11630	11710

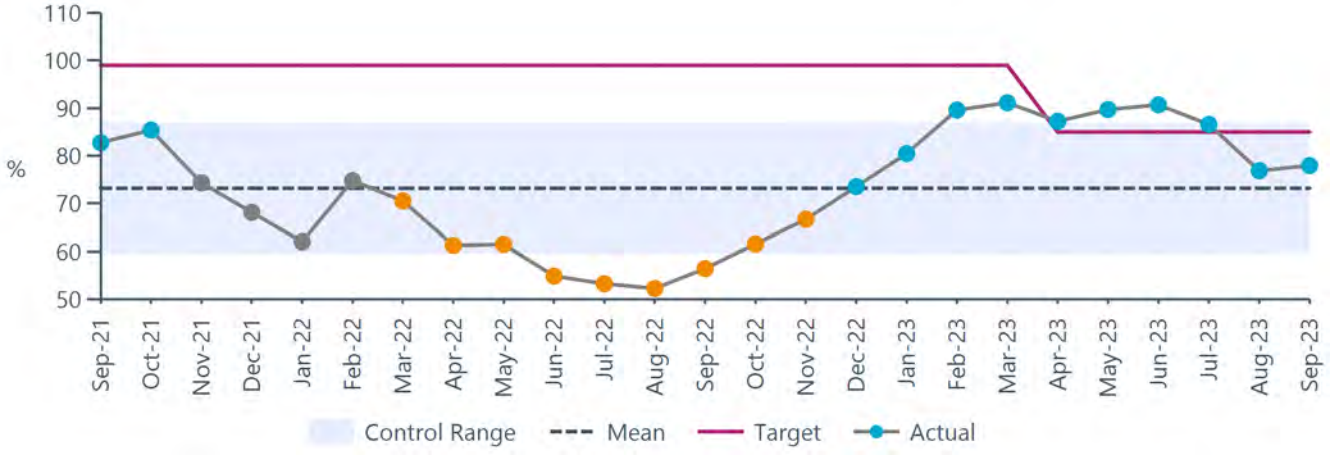
6 Week Wait for Diagnostics - English Patients

% 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%	77.97%	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 September position is reported at 77.97%; below the 85% target. Reported performance equates to 224 patients who waited beyond 6 weeks. Of the 6-week breaches; 53 are over 13 weeks (1 MRI and 52 Ultrasound). Breakdown below outlines performance and breaches by modality:
* MRI - 97.81% - D2 (Urgent - 0-2 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 6 dated
* CT - 97.64% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 2 dated
* Ultrasound - 58.32% - D2 (Urgent - 0-2 weeks) - 6 dated, D3 (Routine - 4-6 weeks) - 1 undated, D4 (Routine - 6 -12 weeks) - 206 with 48 dated
* DEXA Scans - 100%

Reduced performance in September is attributable to the following:
* Increased demand in ultrasound with that modality accounting for 53 breaches over 13 weeks. National expectations was to have no 13 weeks by end of June 2023.
* Workforce flexibility to deliver ultrasound scans was reduced as a result of Industrial Action.

March 2024 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.

Actions

* Review of current validation practice with an increase in validation shifting from monthly to weekly - this is currently on hold due to sickness within the access team
* Review of workforce capacity has identified the need to expand Consultant Radiologists within all areas of imaging and a business case in in progress.
* For Ultrasound, available sessions within core week have been identified by Radiology Manager and a proposal has been made to Radiologists to support this. Lead time of approx. 2 weeks. These would need to be reviewed after every strike period as this has caused the most damage to our ultrasound breaches.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
56.47%	61.62%	66.73%	73.55%	80.51%	89.63%	91.15%	87.27%	89.74%	90.71%	86.61%	76.91%	77.97%

8 Week Wait for Diagnostics - Welsh Patients

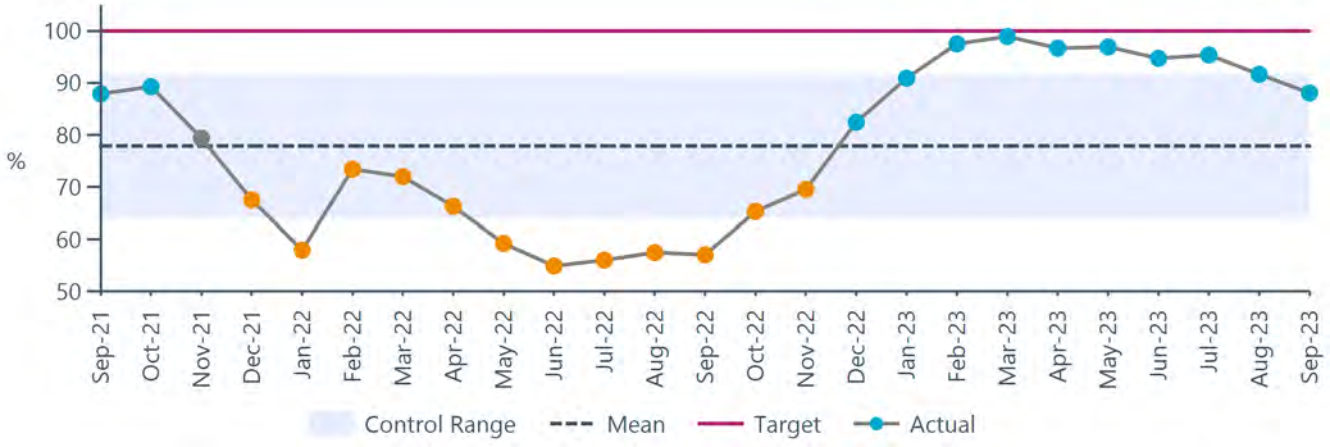
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	88.06%	H	F

Trajectory

Actual
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 88.06%.

Reported performance equates to 33 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
* MRI - 97.73% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 3 dated
* CT - 100%
* Ultrasound - 66.33% - D2 (Urgent - 0-2 weeks) - 1 dated, (D4 (Routine - 6-12 weeks) - 32 with 6 dated
* DEXA Scans - 100%

The trust continues to treat by clinical priority.

Actions

* Review of current validation practice with an increase in validation shifting from monthly to weekly - this is currently on hold due to sickness within the access team
* Review of workforce capacity has identified the need to expand Consultant Radiologists within all areas of imaging and a business case in in progress.
* For Ultrasound, available sessions within core week have been identified by Radiology Manager and a proposal has been made to Radiologists to support this. Lead time of approx. 2 weeks. These would need to be reviewed after every strike period as this has caused the most damage to our ultrasound breaches.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
57.05%	65.30%	69.52%	82.44%	90.92%	97.52%	98.94%	96.69%	96.92%	94.74%	95.38%	91.67%	88.06%

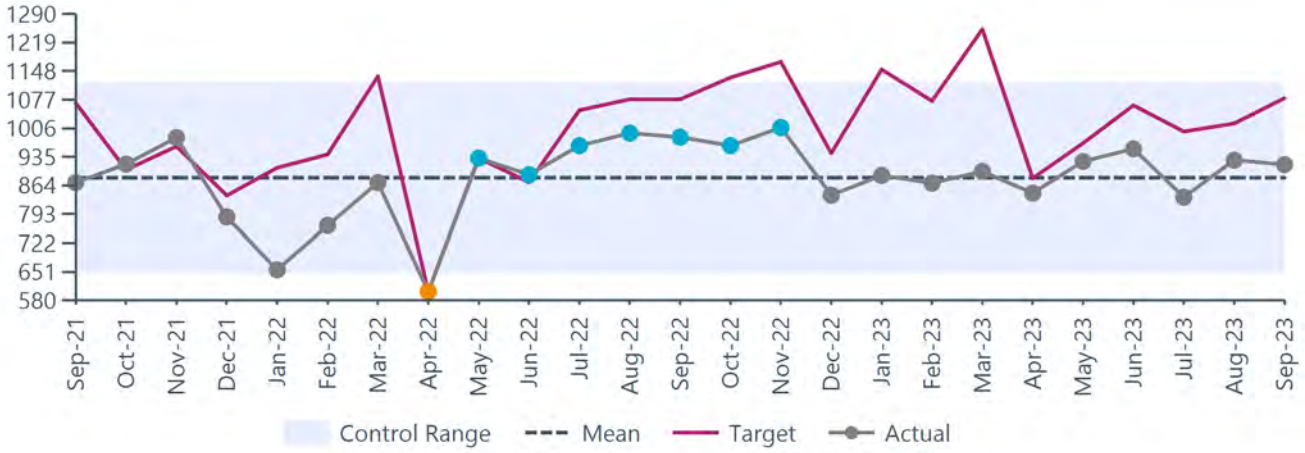
Elective Activity Against Plan (volumes)

Total elective activity rated against plan. 217796

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,081	916		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Total elective activity reported externally against 2023/24 plan of 1081 in September was 916, shortfall of 165 (84.74%).
Elective spell activity is broken down as follows:
- Elective patients discharged in reporting month following operation - plan was 914; 719 delivered (78.66%)
- Elective patients discharged in reporting month, no operation - plan was 167; 197 delivered (117.96%)
Non-theatre activity accounted for 21.51% of elective spells this month; plan was 15.45%

Actions

* Greater focus on Theatre Improvement programme of works, inclusive of early finishes, which is being reviewed by FPD subcommittee.
* The aim is to move to 12 theatres daily from October (currently averaging 11 in Sept) and utilisation of our theatres estate is reviewed as part of the 6-4-2 process.
* Underutilisation of Spines emergency lists for P2 patients is being addressed by improved alignment of list scheduling with consultant availability.
* 18 Week Insourcing undertaken in September, which has supported collaborative working.
* The commencement of 5 joint lists in month (staffing alignment); 6-4-2 meetings are addressing consultant concerns about known staffing and is running well; additional activity is being taken at this meeting.
* Headley Court Day Case Facility lists are being staffed and discussions are ongoing with OPD manager, requests are going out to relevant consultants to offer more for the procedure room. Use of the space for 18 Week Insourcing is being explored.
* Clear, staggered workforce pipeline for new starters; delivery of local training via simulation lab and an element of double scrubbing. It is recognised that the previous experience varies from new starter to new starter, and this is being taken into account with personalised training plans.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
984	963	1008	840	889	870	899	845	924	955	835	927	916

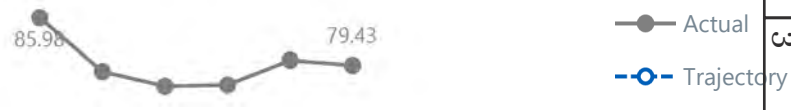
Overall BADS %

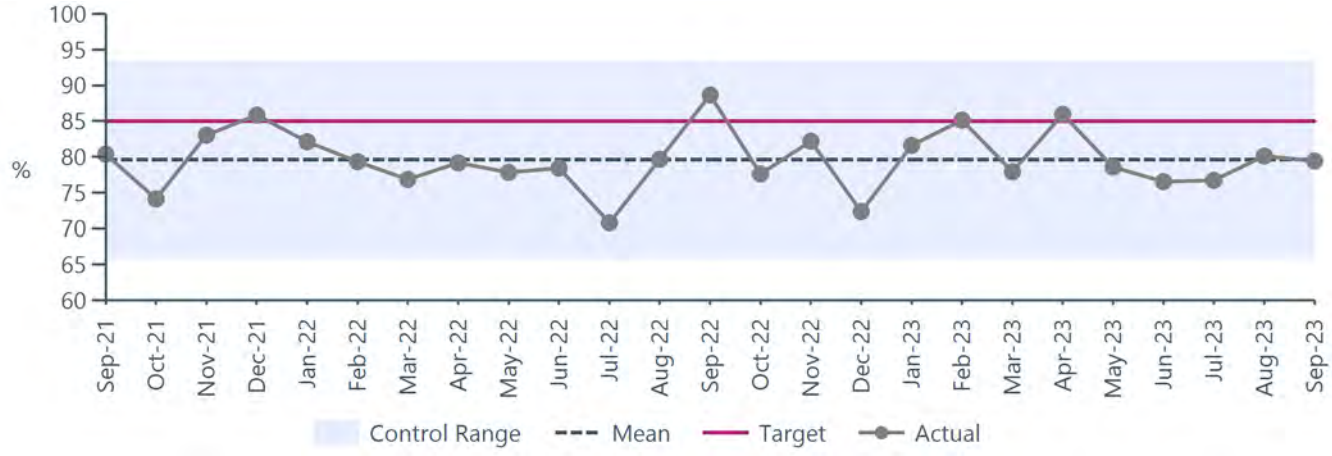
% of BADS procedures performed as a day case 217813

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	79.43%		

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) 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 September the Trust is reporting 80.37% BADS day cases against a target of 85%.

Actions

Day Case Clinical Lead is undertaking a deep dive to understand main reasons for declining performance.
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 meet 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.

A period of intensive support is underway in the Access team, led by Specialist Unit Managing Director, with a focus on improving accuracy of bookings which will include day case procedures.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
88.67%	77.61%	82.20%	72.34%	81.61%	85.14%	77.92%	85.98%	78.57%	76.54%	76.72%	80.12%	79.43%

Total Outpatient Activity against Plan (volumes)

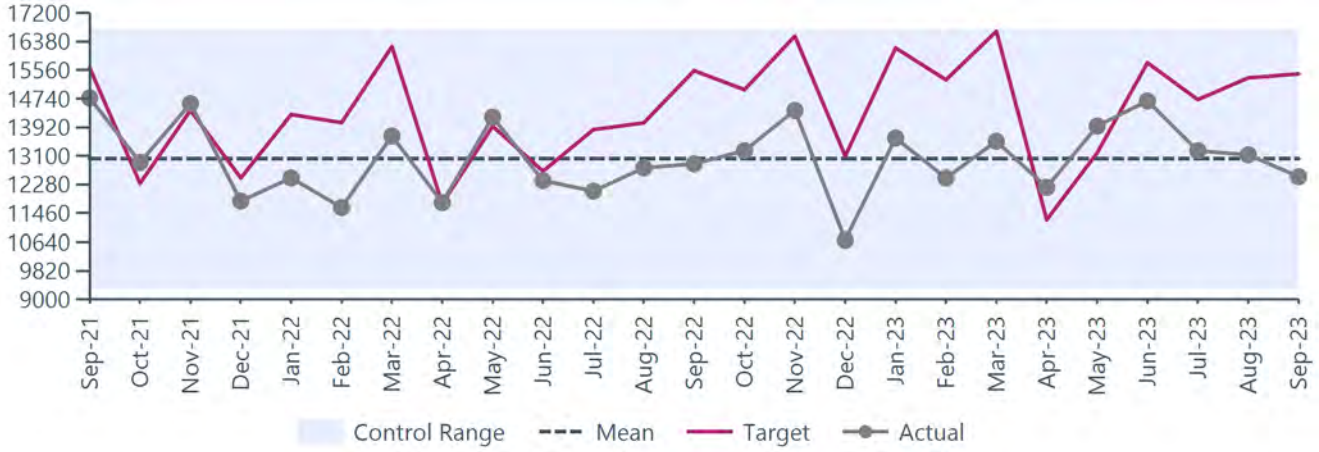
Total outpatient activity (consultant led and non-consultant led) against plan. 217795

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
15,453	12,504		Moving Target

Trajectory

Actual
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 September was 12504 against the 2023/24 plan of 15453; a shortfall of 2949 that equates to 80.92% of plan. This is broken down as; New Appointments – 3483 against 4698 - equating to 74.14% and Follow Up Appointments - 9021 against 10755 - equating to 83.88%
Factors affecting delivery:
- Reduction in SOOS activity on our PAS system as a result of the growth of the MUSST service (SOOS was 968 behind plan). This has also impacted the level of Therapies activity with 792 behind in September.
- Reduction in activity during period of consultant industrial action 19th to 20th September and Junior Doctors industrial action 20th to 22nd September.
- Step change in OJP plan not being met
The following sub-specialities then reported the highest variance to plan:
* Arthroplasty – 1269 against 1871 - 602 behind plan; 93.93% of IJP plan met, 33.33% of OJP plan met
* Upper Limb – 808 against 1230 - 422 behind plan; 80.94% of IJP plan met, 44.66% of OJP plan met
Year to date performance is under plan by 6019 cases (92.98% 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.
* Intensive support in Access Team to begin in October, led by Managing Director of Specialist Unit.
* Plans being reviewed for 23/24 and 24/25.
* The impact of MUSST service is under assessment.

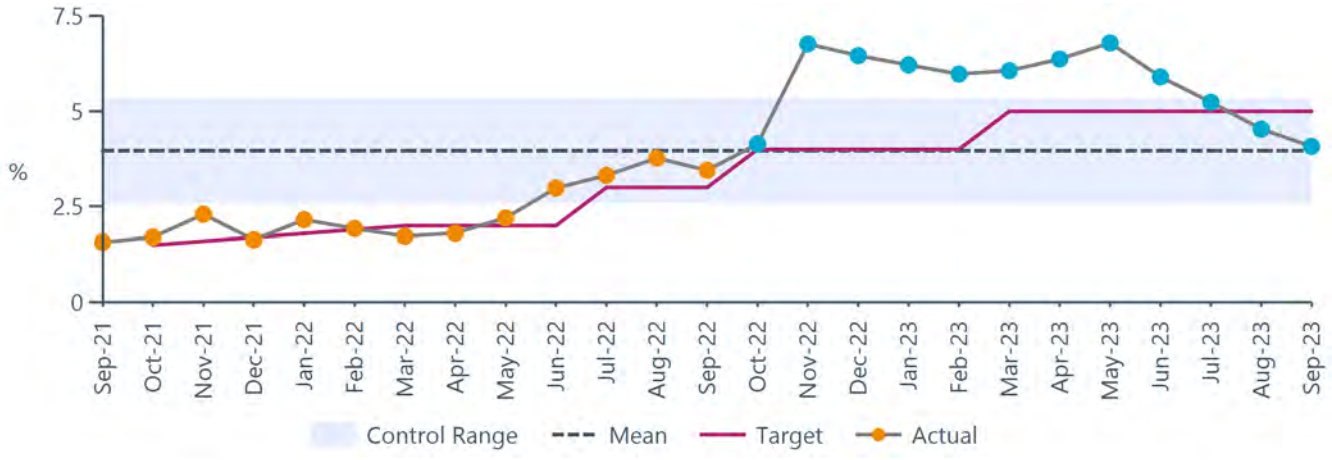
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
12871	13250	14407	10696	13613	12466	13521	12197	13956	14676	13244	13132	12504

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%	4.08%	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 September the target was not met with 4.08% 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 September our performance stands at 3.21%

We are monitoring our performance in this metric excluding SOOS numbers, being mindful of the transition to the new MSST service. SOOS team have a high PIFU rate of 30.49%.

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
* Focus on working practices and process being reviewed within Rheumatology by Operational Manager and Access

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
3.45%	4.14%	6.77%	6.46%	6.21%	5.98%	6.06%	6.37%	6.79%	5.90%	5.24%	4.53%	4.08%

Total Diagnostics Activity against Plan - Catchment Based

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
2,525	2,279		Moving Target

Trajectory

Actual
Trajectory

What these graphs are telling us

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

Narrative

The plan for September was not met as total diagnostic activity undertaken was 2279 against the 2023/24 plan of 2525; 246 cases below - equating to 90.26%.
This is broken down as:
- CT - 370 against plan of 428; equating to 86.45%
- MRI - 1175 against plan of 1299; equating to 90.45%
- U/S – 734 against 798; equating to 91.98%

Reduced performance in September is attributable to the following:
* The plan for MRI activity was initially based on the mobile scanner being on-site for 2 days each week but since plans have been submitted the schedule for the MRI scanner has changed. The mobile scanner was only on-site for 2 days in September due to how the schedule fell so activity was lost due to this.
* Workforce flexibility to deliver scans was reduced as a result of Industrial Action.

Actions

* Mobile scanner back on-site for 13 days from 30th September
* Review of workforce capacity has identified the need to expand Consultant Radiologists within all areas of imaging and a business case in in progress.
* Available sessions within core week have been identified by Radiology Manager and a proposal has been made to Radiologists to support this. Lead time of approx. 2 weeks. These would need to be reviewed after every strike period as this has caused the most damage to our US breaches.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
2491	2454	2871	2553	2838	2754	2977	2501	2360	2554	2603	2604	2279

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

RJAH Long Waiters - 2023/24

Trust Board

8th November 2023

Aspiring to deliver world class patient care

2023/24 September and October** Performance

		Plan	Actual	Difference
September	English 104+ Weeks	0	1	1
	Welsh 104+ Weeks	-	53	
	English 78+ Weeks	0	12	12
	Welsh 78+ Weeks	-	223	
	English 65+ Weeks	467	381	-86
	Welsh 65+ Weeks	-	456	

		Plan	Forecast*	Difference
October**	English 104+ Weeks	0	1	1
	Welsh 104+ Weeks	-	60	
	English 78+ Weeks	0	9	9
	Welsh 78+ Weeks	-	230	
	English 65+ Weeks	460	394	-66
	Welsh 65+ Weeks	-	485	

*** Unvalidated. 22nd October 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.

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

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
476	402	441	454	513	467	460	365	321	303	196	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Activity forecast
Theatre Activity and Outpatient Activity
October 2023

Mike Carr

Aspiring to deliver world class patient care

Theatre Activity Forecast Overview

September 2023 – 152 shortfall (171 shortfall against mitigations plan)

Key drivers:

- 81 Industrial action
- 67 Cases per session/productivity metrics
- (17) Workforce - additional 12th sessions not delivered, impacted by month end industrial action

October 2023 – 127 original plan, (230 shortfall against mitigations plan)

Key drivers for anticipated shortfalls:

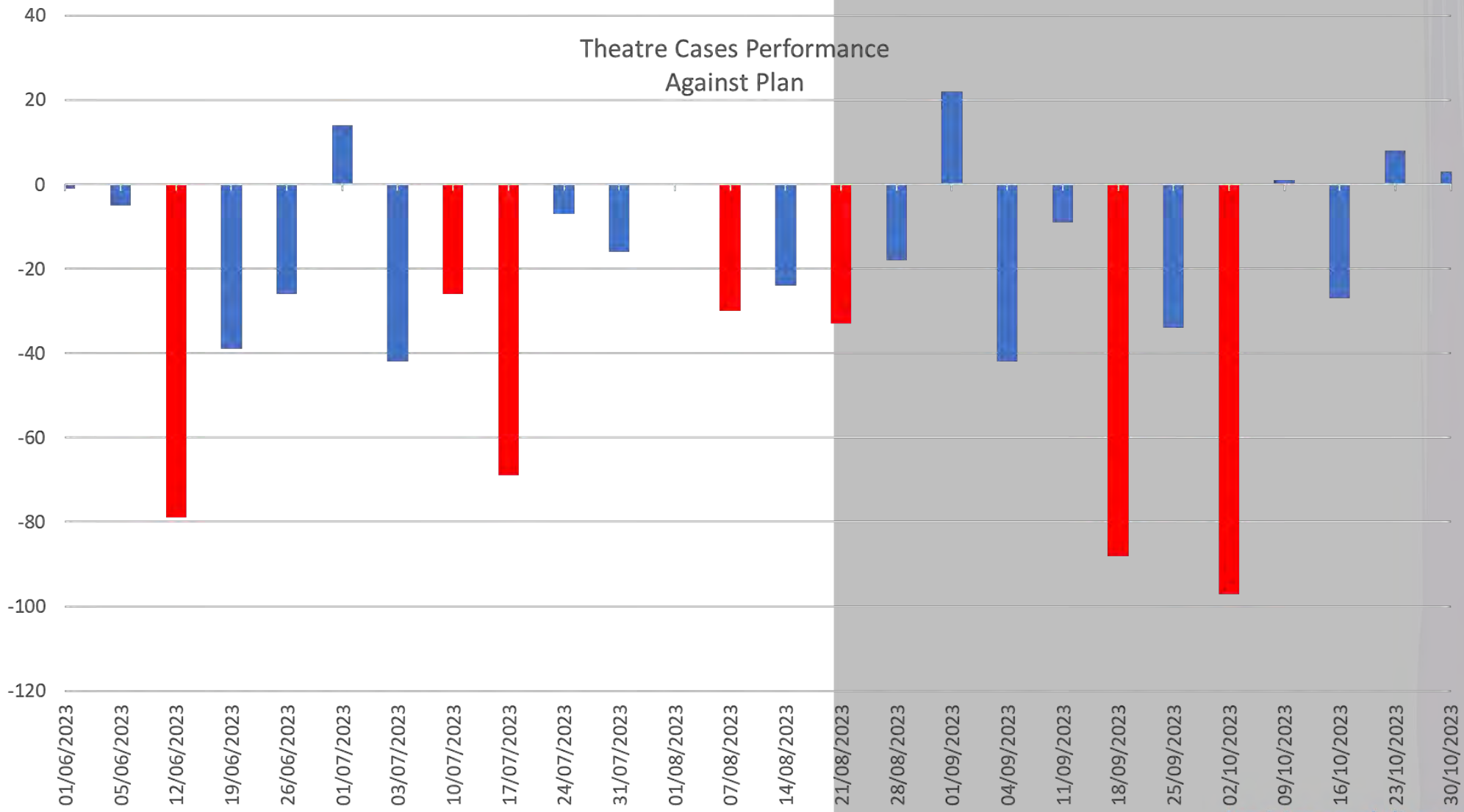
- 97 Industrial action
- 50 Cases per session
- (78) Workforce – additional 12th theatre sessions started to be delivered towards end of month, not at planned rate in recovery plan 16 cases delivered against plan of 94.

November 2023 – 110 shortfall to original plan (128 shortfall against mitigations plan)

Key drivers for anticipated shortfalls:

- 0 Industrial action – no dates confirmed
- 60 as risk workforce – plan session requirement for 12th theatre to be fully operational, additional session to be secured.
- 50 cases per session potential impact if recurrent

Theatre activity – weekly variance to plan



Aspiring to deliver world class patient care

Red = Industrial action took place during these weeks.

Outpatient Activity Industrial Action Impacts

Jun-23			Electives			
Area	Dates	Plan	IP Activity	DC Activity	Total Activity	Impacts (IP)
Junior Doctors	14th June	44	10	17	27	17
Junior Doctors	15th June	44	6	8	14	30
Junior Doctors	16th June	44	12	19	31	13
		132	28	44	72	60

Jul-23			Electives			
Area	Dates	Plan	IP Activity	DC Activity	Total Activity	Impacts (IP)
Junior Doctors	13th July	44	8	22	30	14
Junior Doctors	14th July	44	7	23	30	14
Junior Doctors	15th July	Weekend				
Junior Doctors	16th July					
Junior Doctors	17th July	44	17	12	29	15
Consultants	20th July	44	2	5	7	37
Consultants	21st July	44	3	0	3	41
		220	37	62	99	121

Aug-23			Electives			
Area	Dates	Plan	IP Activity	DC Activity	Total Activity	Impacts (IP)
Junior Doctors	11th August	44	14	13	27	17
Junior Doctors	12th August	Weekend				
Junior Doctors	13th August					
Junior Doctors	14th August	44	13	21	34	10
Consultants	24th August	44	8	4	12	32
Consultants	25th August	44	8	18	26	18
		176	43	56	99	77

Sep-23			Electives			
Area	Dates	Plan	IP Activity	DC Activity	Total Activity	Impacts (IP)
Consultant	19th September	44	6	12	18	26
Con & JD	20th September	44	1	1	2	42
Junior Doctors	21st September	44	13	6	19	25
Junior Doctors	22nd September	44	14	16	30	14
		132	28	23	51	81

Oct-23			Electives			
Area	Dates	Plan	IP Activity	DC Activity	Total Activity	Impacts (IP)
Con & JD	2nd October	44	0	8	8	36
Con & JD	3rd October	44	4	7	11	33
Con & JD	4th October	44	7	9	16	28
		132	11	24	35	97

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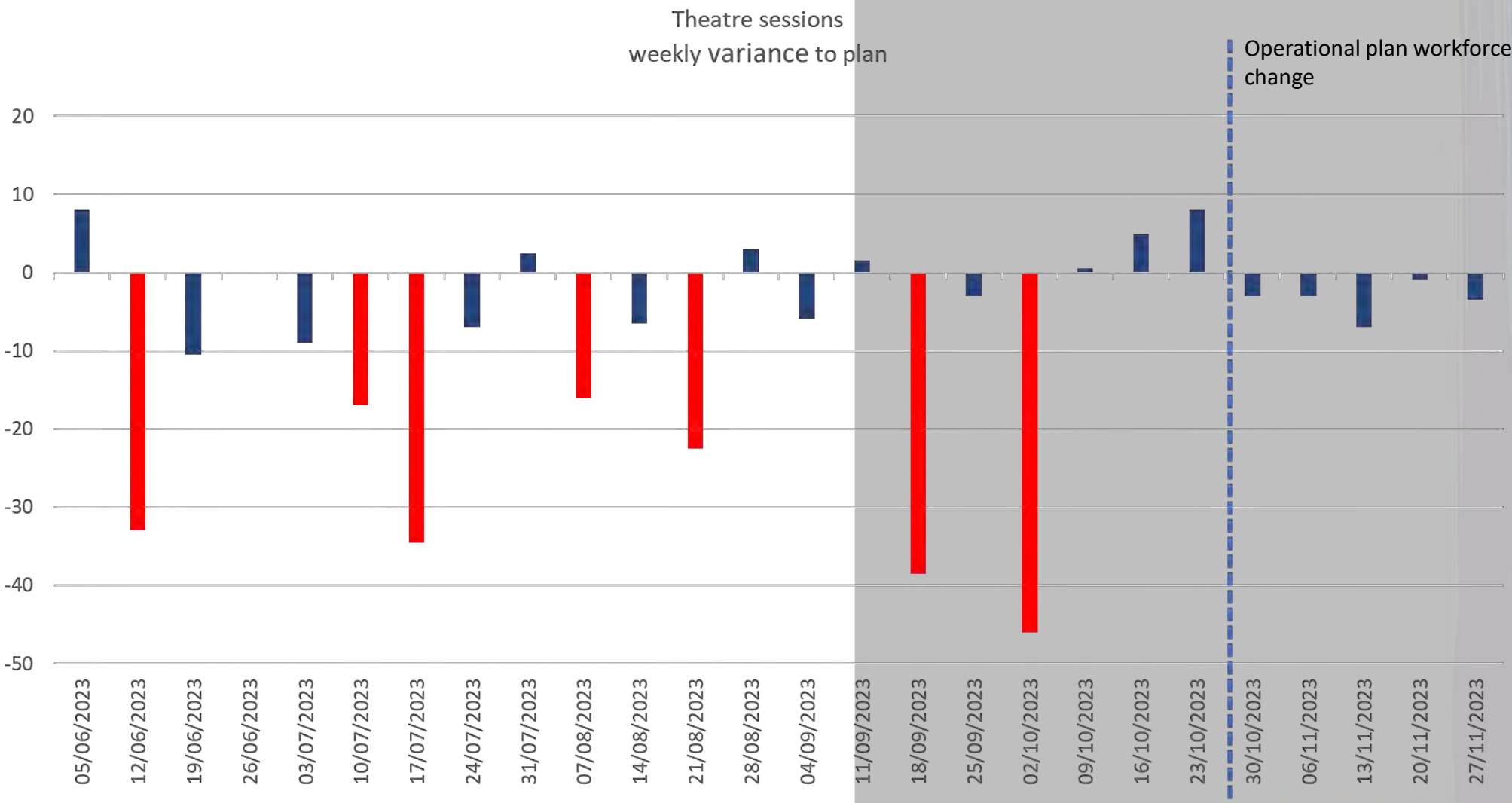
Theatre Sessions - Workforce



Red = Industrial action took place during these weeks.

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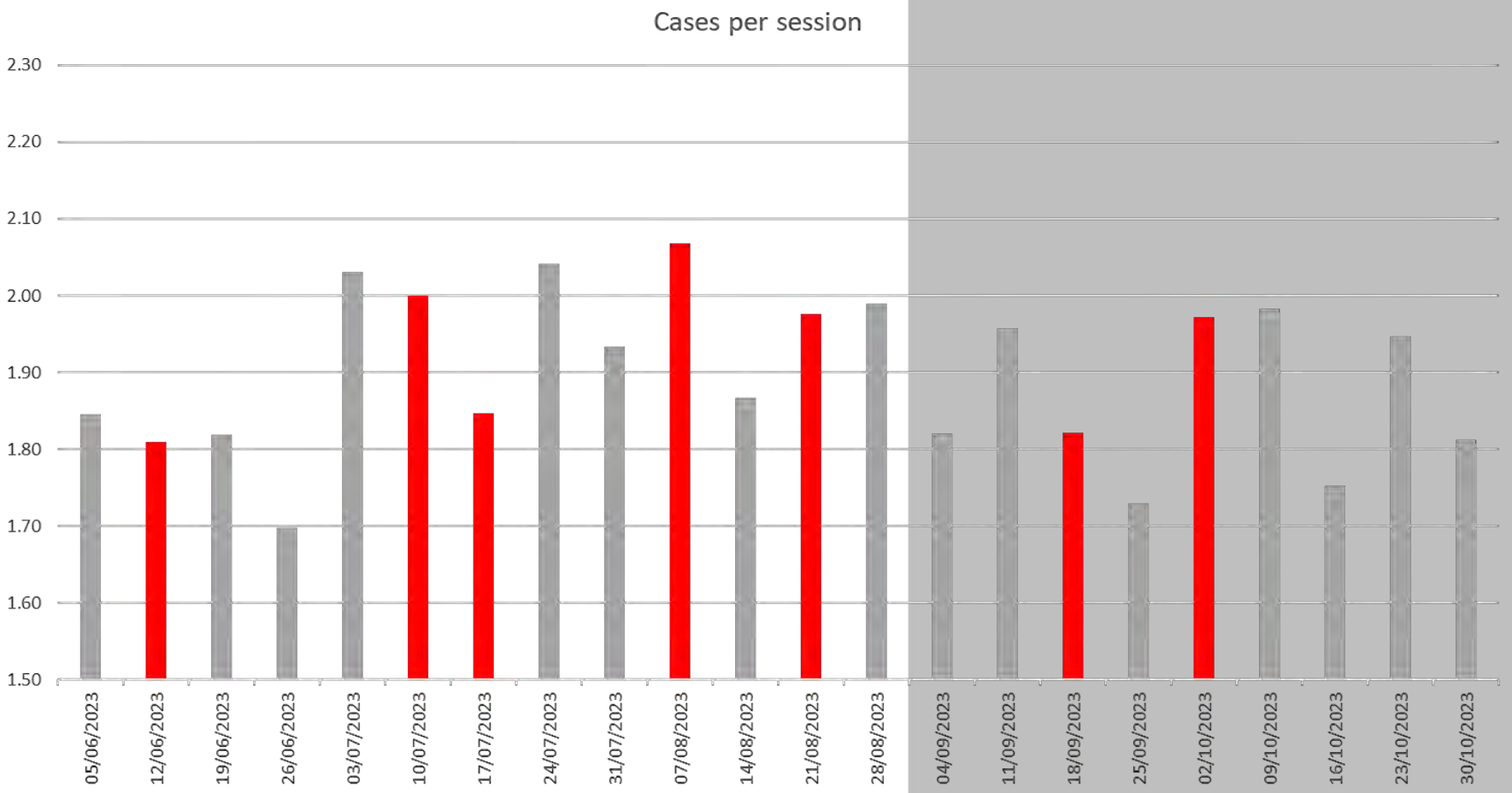
Theatre complexity and productivity – Cases per session



Red = Industrial action took place during these weeks.

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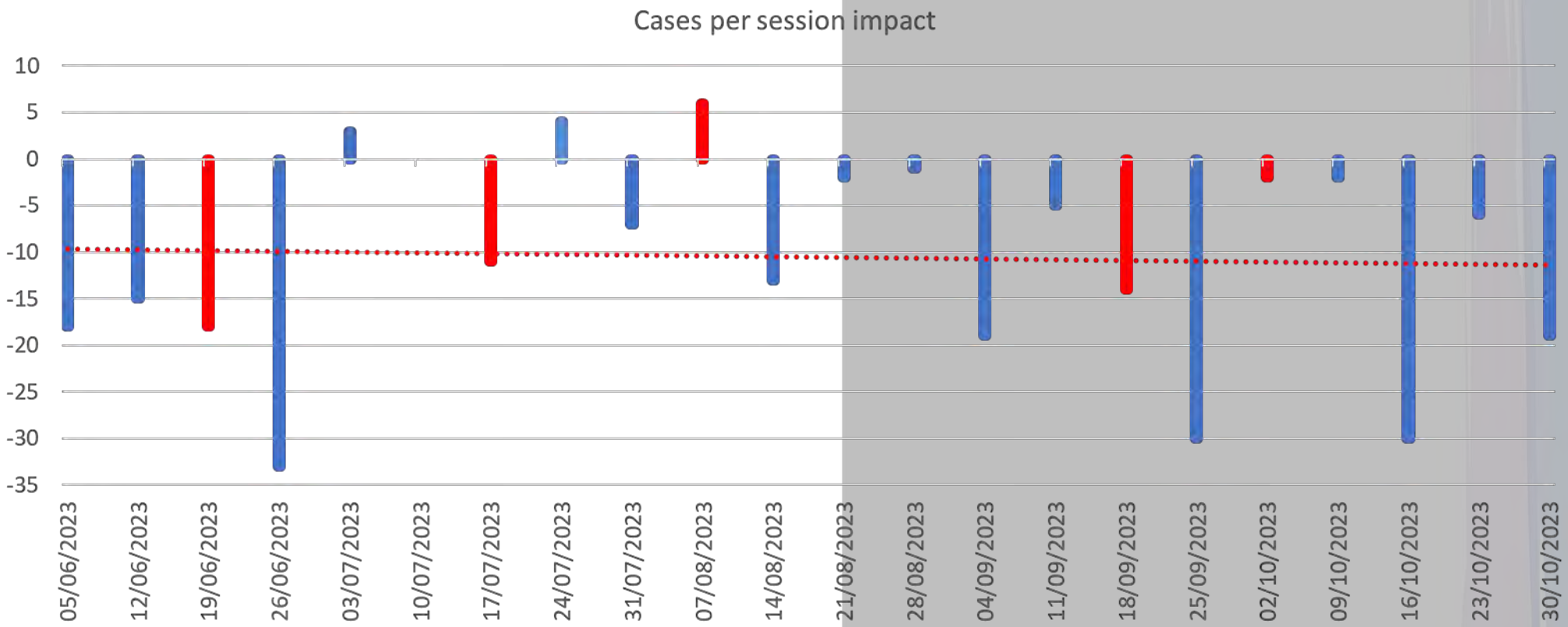
Theatre Activity – CPS cases shortfall per month



Red = Industrial action took place during these weeks.

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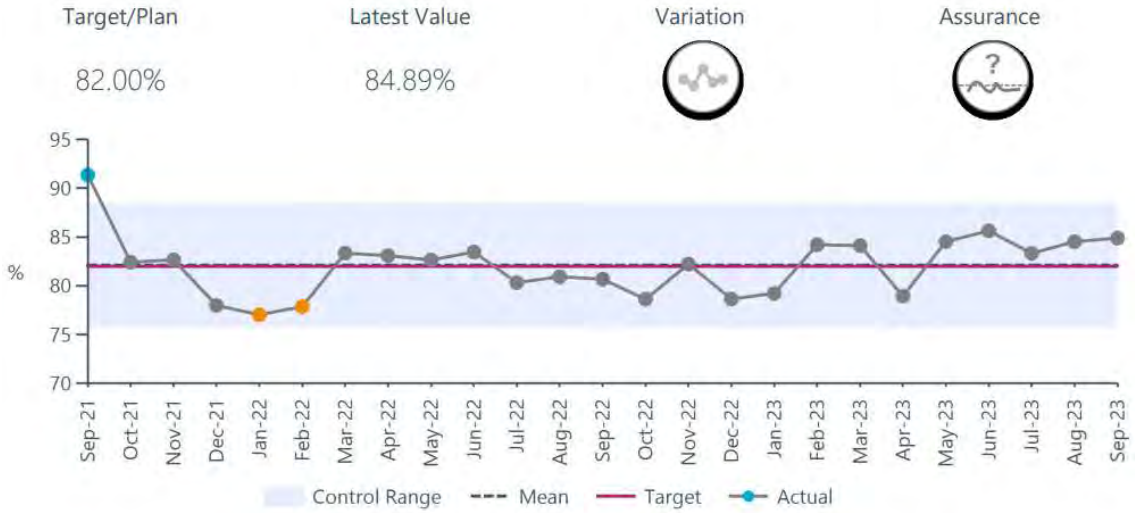
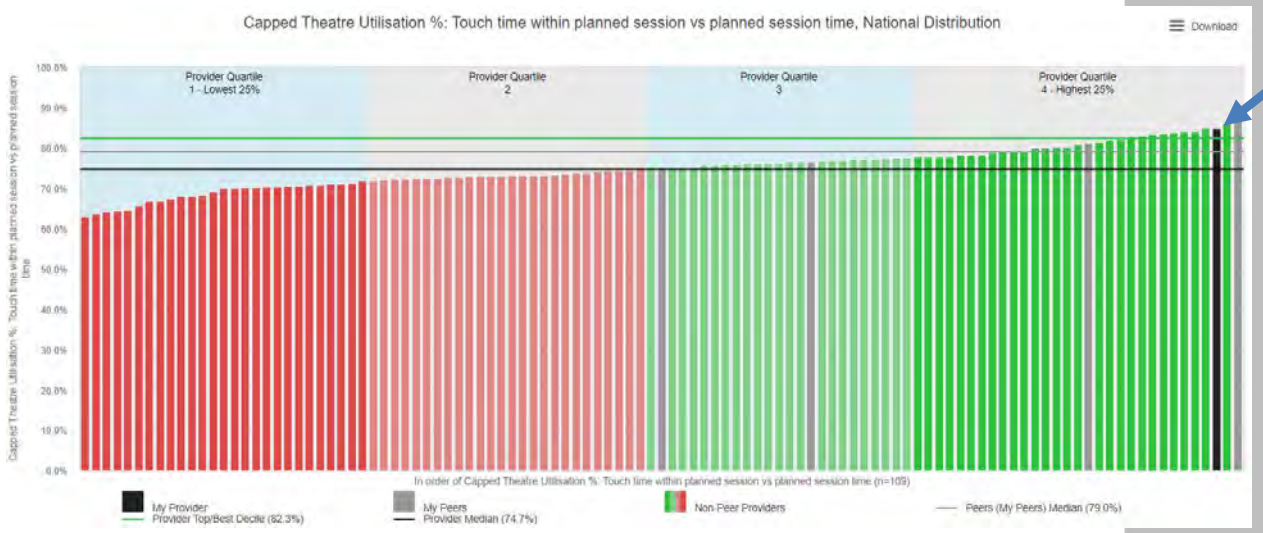
Theatre Productivity Checks:- Cases Per Session (1 of 2)

Cases per session: - Has our Touchtime utilisation seen a step change?



Trust Touchtime has not shown a decrease in overall performance.

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
80.68%	78.62%	82.23%	78.65%	79.22%	84.21%	84.12%	78.95%	84.53%	85.64%	83.33%	84.52%	84.89%



RJAH

Capped Touchtime continues to benchmark well (all specialties)

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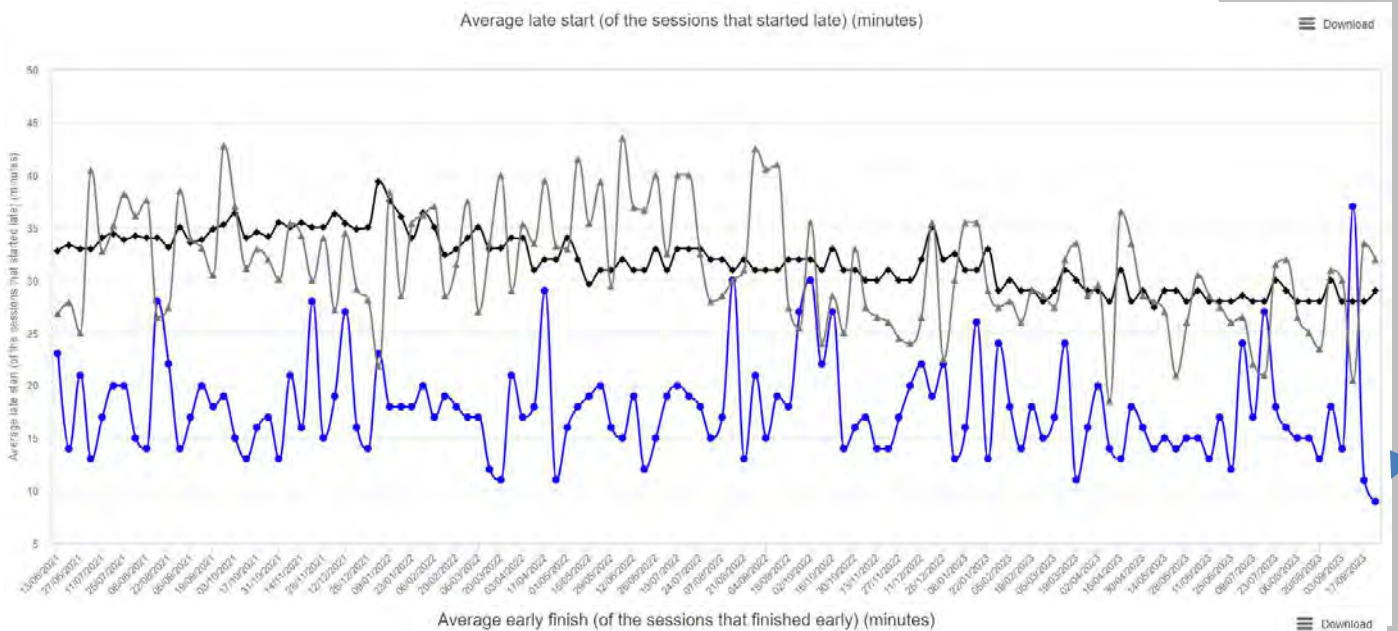
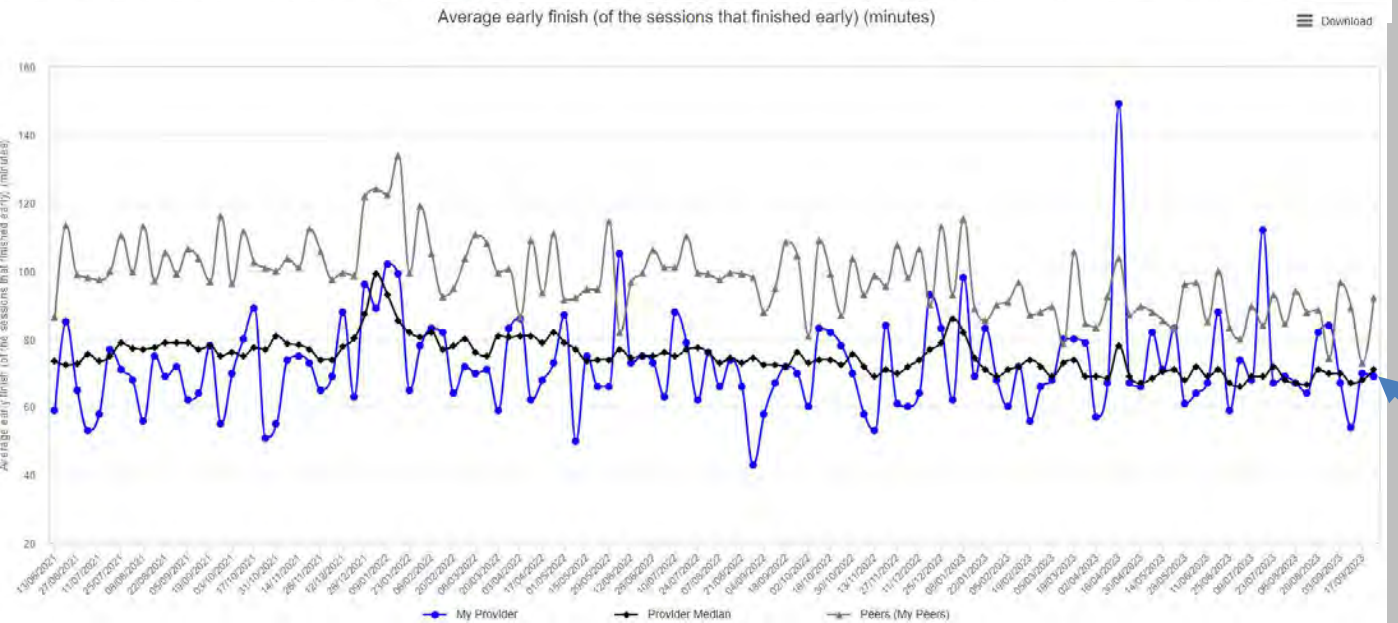
Theatre Productivity Checks:- Cases Per Session (2 of 2)

Cases per session: - Has our early finishes or late start seen a step change?





Average late start (minutes) benchmarks below peers and the national provider median too.

9 minutes

No significant changes in variation observed. This is aggregated performance. Internal reports being split by team for a deeper understanding. Forms part of peri-operative working group to further review.

Average early finish (minutes) benchmarks below peers but variable (above and below) when compared to the national provider median

69 minutes

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Outpatient Activity Forecast Overview

September 2023 – shortfall 2929
Key drivers:

- **833** Industrial action
- **947** SOOS - MSST activity reporting changes (still being delivered for the system, not RJAH activity)
- **749** Physio - MSST activity reporting changes also impacting on physio activity (approx 30% reduction in activity reported through RJAH system)
- **690** Additional outpatient facilities /OJP activity

October 2023 – shortfall 2500
Key drivers for anticipated shortfalls:

- **297** Industrial action
- **1031** SOOS & Physio - MSST activity reporting changes
- **668** Physio - MSST activity reporting changes also impacting on physio activity (still being delivered for the system, not RJAH activity)
- **486** Additional outpatient facilities /OJP activity

November 2023 – shortfall 2800
Key drivers for anticipated shortfalls:

- Industrial action – no dates confirmed however would need to keep as a risk at this point (risk 500 per month)
- **1462** SOOS/MSST activity reporting changes
- **668** Physio - MSST activity reporting changes also impacting on physio activity (still being delivered for the system, not RJAH activity)
- **648** Additional outpatient facilities /OJP activity

Outpatient activity Industrial Action Impacts New patients

Jun-23		Outpatients		
Area	Dates	New - Plan	New - Activity (Actual)	Impacts
Junior Doctors	14th June	143	141	2
Junior Doctors	15th June	143	172	-29
Junior Doctors	16th June	143	80	63
		429	393	36

Jul-23		Outpatients		
Area	Dates	New - Plan	New - Activity (Actual)	Impacts
Junior Doctors	13th July	139	115	24
Junior Doctors	14th July	139	64	75
Junior Doctors	15th July	Weekend		
Junior Doctors	16th July			
Junior Doctors	17th July	139	137	2
Consultants	20th July	139	97	42
Consultants	21st July	139	72	67
		695	485	210

Aug-23		Outpatients		
Area	Dates	New - Plan	New - Activity (Actual)	Impacts
Junior Doctors	11th August	137	39	98
Junior Doctors	12th August	Weekend		
Junior Doctors	13th August			
Junior Doctors	14th August	137	132	5
Consultants	24th August	137	55	82
Consultants	25th August	137	51	86
		548	277	271

Sep-23		Outpatients		
Area	Dates	New - Plan	New - Activity (Actual)	Impacts
Consultant	19th September	146	74	72
Con & JD	20th September	146	81	65
Junior Doctors	21st September	146	85	61
Junior Doctors	22nd September	146	53	93
		584	293	291

Oct-23		Outpatients		
Area	Dates	New - Plan	New - Activity (Actual)	Impacts
Con & JD	2nd October	148	134	14
Con & JD	3rd October	148	88	60
Con & JD	4th October	148	86	62
		444	308	136

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Outpatient activity Industrial Action Impacts Follow up

Jun-23		Outpatients		
Area	Dates	Follow Up - Plan	Follow Up - Activity (Actual)	Impacts
Junior Doctors	14th June	346	344	2
Junior Doctors	15th June	346	287	59
Junior Doctors	16th June	346	246	100
		1038	877	161

Jul-23		Outpatients		
Area	Dates	Follow Up - Plan	Follow Up - Activity (Actual)	Impacts
Junior Doctors	13th July	328	236	92
Junior Doctors	14th July	328	186	142
Junior Doctors	15th July	Weekend		
Junior Doctors	16th July			
Junior Doctors	17th July	328	304	24
Consultants	20th July	328	219	109
Consultants	21st July	328	222	106
		1640	1167	473

Aug-23		Outpatients		
Area	Dates	Follow Up - Plan	Follow Up - Activity (Actual)	Impacts
Junior Doctors	11th August	316	204	112
Junior Doctors	12th August	Weekend		
Junior Doctors	13th August			
Junior Doctors	14th August	316	328	-12
Consultants	24th August	316	200	116
Consultants	25th August	316	170	146
		1264	902	362

Sep-23		Outpatients		
Area	Dates	Follow Up - Plan	Follow Up - Activity (Actual)	Impacts
Consultant	19th September	340	185	155
Con & JD	20th September	340	185	155
Junior Doctors	21st September	340	302	38
Junior Doctors	22nd September	340	146	194
		1360	818	542

Oct-23		Outpatients		
Area	Dates	Follow Up - Plan	Follow Up - Activity (Actual)	Impacts
Con & JD	2nd October	346	346	0
Con & JD	3rd October	346	249	97
Con & JD	4th October	346	282	64
		1038	877	161

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Outpatient activity SOOS/MSST Activity reporting changes

RJAH -Estimated Impact of MSST on 23/24 Plans
16th Oct 23

		SOOS Total													Estimated reduction on curent year end plan (23/24)	Estimated Full year impact 24/25
		01/04/2023	01/05/2023	01/06/2023	01/07/2023	01/08/2023	01/09/2023	01/10/2023	01/11/2023	01/12/2023	01/01/2024	01/02/2024	01/03/2024	Grand Total		
New	Plan	505	594	718	768	806	779	835	855	648	833	792	707	8840		
	Actual	584	575	455	386	194	59	72	2	0	0	0	0	2327		
	Variance	79	-19	-263	-382	-612	-720	-763	-853	-648	-833	-792	-707	-6513		
		16%	-3%	-37%	-50%	-76%	-92%	-91%	-100%	-100%	-100%	-100%	-100%	-74%		
	Estimated MSST impact on plan	0	0	-263	-382	-612	-720	-763	-853	-648	-833	-792	-707		-6573	-8840
		0%	0%	-37%	-50%	-76%	-92%	-91%	-100%	-100%	-100%	-100%	-100%		-74%	-100%
Follow up	Plan	383	448	546	591	621	599	644	659	497	641	610	544	6783		
	Actual	559	609	621	472	454	372	376	50	0	0	0	0	3513		
	Variance	176	161	75	-119	-167	-227	-268	-609	-497	-641	-610	-544	-3270		
		46%	36%	14%	-20%	-27%	-38%	-42%	-92%	-100%	-100%	-100%	-100%	-48%		
	Estimated MSST impact on plan	0	0	75	-119	-167	-227	-268	-609	-497	-641	-610	-544		-3607	-6783
		0%	0%	14%	-20%	-27%	-38%	-42%	-92%	-100%	-100%	-100%	-100%		-53%	-100%
Total	Plan	888	1042	1264	1359	1427	1378	1479	1514	1145	1474	1402	1251	15623		
	Actual	1143	1184	1076	858	648	431	448	52	0	0	0	0	5840		
	Variance	255	142	-188	-501	-779	-947	-1031	-1462	-1145	-1474	-1402	-1251	-9783		
		29%	14%	-15%	-37%	-55%	-69%	-70%	-97%	-100%	-100%	-100%	-100%	-63%		
	Estimated MSST impact on plan	0	0	-188	-501	-779	-947	-1031	-1462	-1145	-1474	-1402	-1251		-10180	-15623
		0%	0%	-15%	-37%	-55%	-69%	-70%	-97%	-100%	-100%	-100%	-100%		-65%	-100%

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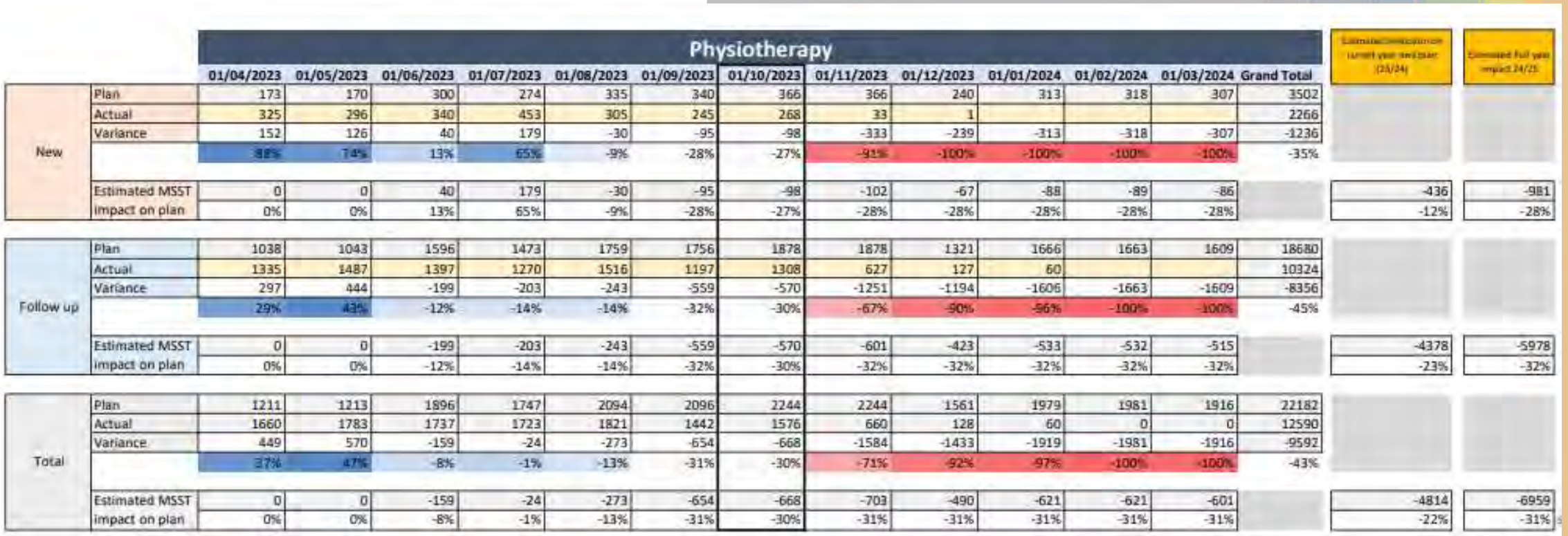
Outpatient activity Physio/MSST Activity reporting changes



Physiotherapy															
		01/04/2023	01/05/2023	01/06/2023	01/07/2023	01/08/2023	01/09/2023	01/10/2023	01/11/2023	01/12/2023	01/01/2024	01/02/2024	01/03/2024	Grand Total	[illegible] (23/24)	Estimated full year impact 24/25
New	Plan	173	170	300	274	335	340	366	366	240	313	318	307	3502		
	Actual	325	296	340	453	305	245	268	33	1				2266		
	Variance	152	126	40	179	-30	-95	-98	-333	-239	-313	-318	-307	-1236		
		88%	74%	13%	65%	-9%	-28%	-27%	-91%	-100%	-100%	-100%	-100%	-35%		
	Estimated MSST impact on plan	0	0	40	179	-30	-95	-98	-102	-67	-88	-89	-86		-436	-981
		0%	0%	13%	65%	-9%	-28%	-27%	-28%	-28%	-28%	-28%	-28%		-12%	-28%
Follow up	Plan	1038	1043	1596	1473	1759	1756	1878	1878	1321	1666	1663	1609	18680		
	Actual	1335	1487	1397	1270	1516	1197	1308	627	127	60			10324		
	Variance	297	444	-199	-203	-243	-559	-570	-1251	-1194	-1606	-1663	-1609	-8356		
		29%	43%	-12%	-14%	-14%	-32%	-30%	-67%	-90%	-96%	-100%	-100%	-45%		
	Estimated MSST impact on plan	0	0	-199	-203	-243	-559	-570	-601	-423	-533	-532	-515		-4378	-5978
		0%	0%	-12%	-14%	-14%	-32%	-30%	-32%	-32%	-32%	-32%	-32%		-23%	-32%
Total	Plan	1211	1213	1896	1747	2094	2096	2244	2244	1561	1979	1981	1916	22182		
	Actual	1660	1783	1737	1723	1821	1442	1576	660	128	60	0	0	12590		
	Variance	449	570	-159	-24	-273	-654	-668	-1584	-1433	-1919	-1981	-1916	-9592		
		37%	47%	-8%	-1%	-13%	-31%	-30%	-71%	-92%	-97%	-100%	-100%	-43%		
	Estimated MSST impact on plan	0	0	-159	-24	-273	-654	-668	-703	-490	-621	-621	-601		-4814	-6959
		0%	0%	-8%	-1%	-13%	-31%	-30%	-31%	-31%	-31%	-31%	-31%		-22%	-31%

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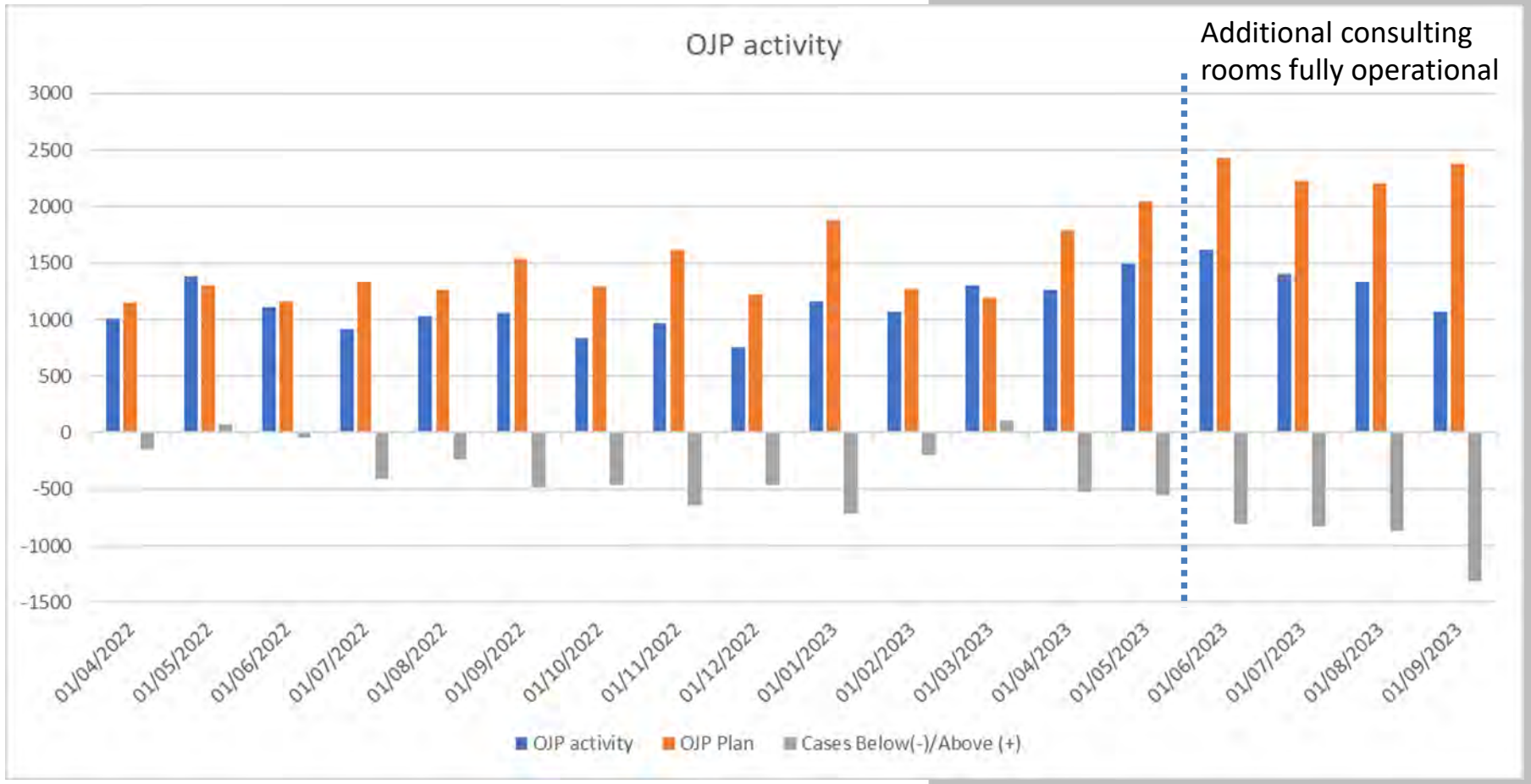
Outpatient Activity - OJP activity



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

M06 Agency update

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Agency Controls

- The Trust is set an agency cap, against which the regulator monitors actual agency expenditure throughout the year. The total cap against which the Trust is set at 3.7%of the total pay plan

- The regulator expects Trusts to limit use of off framework agency to be on exceptional patient safety grounds only.

- The process of requesting agency staff engagement is set out in the Trust's Agency and Temporary Staffing Policy. The priority order of sourcing agency is:
  - Framework suppliers within price cap if no take up of the shift through the bank;
  - Framework suppliers escalated rates for short notice bookings (24-72 hours before shift);
  - Off framework suppliers only within 48 hours of shift

- Following updated national guidance, new enhanced sign off arrangements have been introduced - Once a suitable agency worker has been sourced, approval must be sought as follows:
  - If shift is above £100 hour (to be signed off by CEO)
  - If framework shifts exceeds price cap by more than 50% (to be signed off by relevant Exec Director)
  - If off framework shift (to be signed off by CEO)

Agency Expenditure

Type	M6 £'000			YTD £'000			Forecast £'000		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Core	258	250	8	1,551	1,678	-127	3,102	2,955	147
Insourcing	0	195	-195	0	1,275	-1,275	0	3,500	-3,500
Total	258	445	-187	1,551	2,953	-1,402	3,102	6,455	-3,353

Core Agency	M6 £'000					
	M1	M2	M3	M4	M5	M6
Off framework	59%	49%	42%	19%	28%	26%

- Month 6 core agency expenditure £250k, which is £8k favourable to cap in month and £23k favourable to forecast
- Off framework usage 26% in month, an improvement on the prior month and an area of ongoing focus as still flagging as a national outlier with NHSE
- In line with national guidance agency reporting now includes costs of Insourcing arrangement. We are required to report our costs of activity commissioned from Oswestry Orthopaedics LLP, 18 Week Support Ltd & Dr Thomas Staunton (Neurology). There is no separate allowance for these costs, and discussions are ongoing with NHSE regarding the benefits of the LLP arrangement.

Average Cost per Shift* (12 hours)	Nurses	HCA
Internal Enhanced Rate	£297	£189
On Framework	£594	£268
Off Framework	£707	£349

- This table shows the average cost of shifts under different rates.
- Off framework agency commands a premium of c25% above on framework rates

* Blended 23/24 YTD average rate for day/night shifts.

Agency Expenditure, 3 month run rate

		£'s																
		M4			M5			M6			M6 Year to Date		
Unit	Ward / Department	On Framework	Off Framework	Total	On Framework	Off Framework	Total	On Framework	Off Framework	Total	On Framework	Off Framework	Total
MSK	Clwyd Ward	8,189	374	8,563	7,712	-115	7,597	2,259	0	2,259	30,582	19,211	49,793
	Kenyon Ward	5,947	-316	5,631	3,173	0	3,173	3,470	0	3,470	37,635	14,862	52,497
	Ludlow Ward	1,531	0	1,531	3,609	0	3,609	-305	660	355	8,104	8,913	17,017
	Powys Ward	13,216	746	13,962	4,576	0	4,576	10,116	0	10,116	69,873	30,185	100,058
	Theatres - Scrub	22,234	0	22,234	18,721	0	18,721	16,960	0	16,960	119,162	0	119,162
	Theatres - ODP	5,163	15,419	20,582	15,601	11,277	26,878	6,817	12,002	18,819	66,505	81,718	148,222
	Anaesthetics	-906	0	-906	0	0	0	0	0	0	17,361	0	17,361
	HDU	3,144	1,602	4,746	1,736	0	1,736	336	0	336	1,855	27,775	29,629
	X Ray	4,123	0	4,123	12,769	0	12,769	12,606	0	12,606	56,046	0	56,046
	Therapies	14,625	-2,925	11,700	205	11,245	11,450	15,440	8,694	24,133	35,118	50,874	85,991
	Orthopaedics	6,750	0	6,750	9,544	0	9,544	1,500	0	1,500	29,044	0	29,044
Total MSK		**84,014**	**14,901**	**98,915**	**77,645**	**22,407**	**100,052**	**69,198**	**21,356**	**90,554**	**471,283**	**233,537**	**704,820**
SPEC	Oswald Ward	69	0	69	528	649	1,176	1,473	0	1,473	5,132	1,559	6,690
	Gladstone Ward	43,411	15,219	58,630	40,142	9,136	49,278	56,644	9,699	66,343	226,846	154,144	380,990
	Wrekin Ward	44,165	13,649	57,814	36,685	25,336	62,020	35,068	23,058	58,126	220,031	217,940	437,970
	Sheldon Ward	17,832	826	18,658	13,137	-209	12,928	16,228	818	17,046	81,319	21,058	102,378
	MCSI Medical Staff	0	0	0	0	0	0	8,532	0	8,532	8,532	0	8,532
	Rheumatology Consultant	2,282	0	2,282	6,962	0	6,962	-1,774	0	-1,774	22,116	0	22,116
	Orthotics	0	5,126	5,126	0	9,781	9,781	0	9,347	9,347	0	35,004	35,004
	OPD	0	0	0	0	0	0	0	0	0	2,469	0	2,469
Total SPEC		**107,759**	**34,820**	**142,580**	**97,453**	**44,692**	**142,145**	**116,171**	**42,921**	**159,092**	**566,445**	**429,704**	**996,149**
Corporate	E-Rostering	0	0	0	0	0	0	0	0	0	226	0	226
	Education & Learning	2,869	0	2,869	627	0	627	0	0	0	3,969	0	3,969
	Corporate Accruals	-9,750	-5,310	-15,060	-9,599	-3,044	-12,643	0	0	0	-19,349	-8,354	-27,703
Total Corporate		**-6,881**	**-5,310**	**-12,191**	**-8,972**	**-3,044**	**-12,015**	**0**	**0**	**0**	**-15,154**	**-8,354**	**-23,508**
Total Agency Spend		**184,893**	**44,411**	**229,304**	**166,127**	**64,055**	**230,182**	**185,369**	**64,277**	**249,646**	**1,022,574**	**654,887**	**1,677,461**
Agency Cap		**258,000**	**0**	**258,000**	**258,000**	**0**	**258,000**	**258,000**	**0**	**258,000**	**1,548,000**	**0**	**1,548,000**
Variance		**73,107**	**-44,411**	**28,696**	**91,873**	**-64,055**	**27,818**	**72,631**	**-64,277**	**8,354**	**525,426**	**-654,887**	**-129,461**
% Framework / Off Framework		**81%**	**19%**	**100%**	**72%**	**28%**	**100%**	**74%**	**26%**	**100%**	**61%**	**39%**	**100%**

September 2023, Key Highlights:

- Increase in Nursing agency spend (+£12k) compared to the previous month –
  - SPEC +£18k
  - MSK -£6k
- Reduction in Medical agency spend -£8k partially offset by an increase in AHP spend +£4k
- Highest users of agency are Gladstone and Wrekin Wards making up 50% of total agency spend during the month.

Unit	£'000 Vacancies	£'000 Agency	£'000 Bank/OT	£'000 Total Premium spend	£'000 Vacancies less Premium spend
MSK	245	91	189	280	-35
Spec	168	159	125	284	-116
Total	**413**	**250**	**314**	**564**	**-151**

Across the two units, £413k of funded posts were vacant during the month. Total premium costs incurred to provide a safe level of staffing to patients, totalled £564k, so a net cost pressure of £151k.

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Agency Expenditure Forecast

Agency	Actual £'000s						Forecast £'000s						Total
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	
Core	346	249	375	229	228	252	196	234	239	217	216	175	2,955
Cap	259	259	259	259	259	259	258	258	258	258	258	258	3,096
Variance	-88	10	-116	29	31	7	61	24	19	40	42	82	141

- Forecast agency spend for the year is £2,955k, £141k favourable to cap
- Run Rate reduction is expected during the second half of the year linked to the recruitment pipeline

Agency	Actual £'000s						Forecast £'000s						Total
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	
Nursing and Midwifery Registered	272	203	272	183	155	184	133	169	175	163	173	132	2,214
Scientific and Technic	33	42	77	38	61	59	51	47	46	36	25	25	541
Support Services	26	-5	0	-3	1	-1	0	0	0	0	0	0	18
NHS Infrastructure	5	0	1	3	0	0	0	0	0	0	0	0	9
Medical and Dental	10	9	25	8	11	8	12	18	18	18	18	18	173
Total Core	346	249	375	229	228	252	196	234	239	217	216	175	2,955
Cap	259	259	259	259	259	259	258	258	258	258	258	258	3,096
Variance	-88	10	-116	29	31	7	61	24	19	40	42	82	141

Agency Expenditure – Financial Controls

M6 Core Agency - Top 10 Highest Paid Agency Workers							
Worker	Post / Grade	Hourly Rate	Unit	Department	Supplier	On Framework	Note*
1	Consultant Rheumatologist	£130	SPEC	Rheumatology	ID Medical	Yes	Note 1
2	B7 Orthotist	£87	MSK	Orthotics	Burton Waters Clinic	No	
3	RN B5	£80	SPEC	MCSI	Medlocums	Yes	
4	RN B5	£69	SPEC	MCSI	Legion Healthcare	No	
5	RN B5	£69	SPEC	MCSI	Medlocums	Yes	
6	RN B5	£69	SPEC	Sheldon	Medlocums	Yes	
7	RN B5	£69	SPEC	MCSI	Medlocums	Yes	
8	RN B5	£68	SPEC	MCSI	Elite Nursing	No	
9	RN B5	£68	SPEC	MCSI	Sanctuary Personnel	Yes	
10	B6 Occupational Therapist	£65	MSK	Therapies	Priority Nursing	No	

September 2023, Key Highlights:

- Following updated guidance, Trusts are now encouraged to report the top 10 most expensive agency shifts & the top 10 longest serving agency workers each month as part of improvement & oversight plans.

M6 Core Agency - Top 10 Longest Serving Agency Workers								
Worker	Post / Grade	Hourly Rate	Unit	Department	Supplier	On Framework	Length of Engagement	Note*
1	Consultant Rheumatologist	£130	SPEC	Rheumatology	ID Medical	Yes	45 months	Note 1
2	ODP B6	£42	MSK	Theatres	Focusmed24	Yes	23 months	
3	ODP B6	£43	MSK	Theatres	Blackrock Medical	Yes	23 months	
4	Scrub B6	£42	MSK	Theatres	Applocum	Yes	22 months	
5	Scrub B6	£42	MSK	Theatres	Applocum	Yes	21 months	
6	B6 Theatres ODP	£42	MSK	Theatres	Bluestones Medical	Yes	11 months	
7	B6 Radiographer	£41	MSK	Xray	Globe Locums	Yes	7 months	
8	B5 Theatres Scrub	£49	MSK	Theatres	Novello	No	6 months	
9	B7 Pharmacist	£36	SPEC	Pharmacy	Hunter Gatherer	Yes	5 months	
10	B6 Occupational Therapist	£65	MSK	Therapies	Priority Nursing	No	5 months	

*Note 1 - Spend recharged fully to SCHT as provider of the Rheumatology Service, shown for completeness but reported via SCHT agency returns

Ward Staffing Ratio – September – Nurses

	Registered Nurses	WTE Worked M06				% Split on Wards		
		Sub	Bank	Agency	Total	Sub	Bank	Agency
MSK	Clwyd Ward	12.20	1.59	0.44	14.23	86%	11%	3%
	Kenyon Ward	11.56	0.07	0.37	12.00	96%	1%	3%
	Powys Ward	12.03	1.38	1.21	14.62	82%	9%	9%
	Ludlow Ward	12.70	1.15	0.07	13.92	91%	8%	0%
	Baschurch	12.74	0.52	0.00	13.26	96%	4%	0%
	Total	61.23	4.71	2.09	68.03	90%	7%	3%
Spec	Oswald Ward	11.64	0.63	0.15	12.42	94%	5%	1%
	Gladstone Ward	13.69	1.87	7.70	23.26	59%	8%	54%
	Wrekin Ward	14.59	2.88	6.86	24.33	60%	12%	48%
	Alice Ward	13.16	1.29	0.00	14.45	91%	9%	0%
	Sheldon Ward	12.64	1.30	1.88	15.82	80%	8%	13%
	Total	65.72	7.97	16.59	90.28	73%	9%	18%
	Total	**126.95**	**12.68**	**18.68**	**158.31**	**80%**	**8%**	**12%**

Worked wte from monthly Provider workforce return
Sub* Substantive

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M6 Financial Position Update

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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	10,692	10,692	(859)	60,794	58,433	(2,361)
Private Patient income	6,354	518	602	84	3,066	3,563	497
Other income	7,302	608	595	(13)	3,646	3,645	(1)
Pay	(87,125)	(7,154)	(7,260)	(106)	(42,926)	(43,298)	(372)
Non-pay	(48,801)	(3,803)	(3,977)	(174)	(22,857)	(23,184)	(327)
EBITDA	6,696	861	(207)	(1,068)	1,723	(841)	(2,564)
Finance Costs	(7,341)	(612)	(515)	97	(3,623)	(3,146)	477
Capital Donations	150	25	0	(25)	100	67	(33)
Operational Surplus	(495)	274	(722)	(996)	(1,800)	(3,920)	(2,120)
Remove Capital Donations	(150)	(25)	0	25	(100)	(67)	33
Add Back Donated Dep'n	836	70	66	(4)	418	395	(23)
Control Total	191	320	(656)	(975)	(1,482)	(3,592)	(2,109)

Overall £656k deficit in month, £975k adverse to plan.

YTD £3,592k deficit, £2,109k adverse to plan.

Clinical Income £859k adverse:
- Industrial action impact £449k (largely theatre activity 81 cases)
- Productivity / capacity impact £411k adverse (largely theatre activity 71 cases)
- LVA activity in excess of block £50k

Partially offset by:
- MCSI activity £109k

- Private Patients £84k favourable driven by volume

- Pay £106k adverse:
  - MCSI £129k adverse – largely offset by income in month
  - Theatres supernumerary staff in training (18.5wte) £63k
  - Anaesthetist OJP above vacancies £38k adverse

- Non Pay £174k adverse:
  - Estates & Facilities £98k adverse (2/3rds energy driven)
  - Orthotics £53k adverse (partially activity driven)
  - OJP £51k adverse (Anaesthetics & Surgeon)
  - Note: £186k underlying casemix pressure due to treatment of long waiters offset by marginal cost savings from volume shortfalls

- Finance costs £97k favourable driven by interest receivable

Agency £250k spend in month, £8k below agency cap

Off framework usage £64k (26%) no increase in spend and 2% reduction from month 5

I&E YTD Drivers

Control	Financial Position Drivers	YTD				Month 6			
		Activity	Income £'000	Cost £'000	Net £'000	Activity	Income £'000	Cost £'000	Net £'000
External	Industrial action theatres	-434	-2,170	434	-1,736	-81	-405	81	-324
	Industrial action new outpatients	-997	-150	0	-150	-291	-44	0	-44
	Elective baseline adjustment mitigation		874	0	874		0	0	0
	Sub Total Industrial Action Impact	**-1,431**	**-1,446**	**434**	**-1,012**	**-372**	**-449**	**81**	**-368**
Internal	Theatre Capacity	-286	-1,430	286	-1,144	-71	-355	71	-284
	New Outpatients Capacity		-203	0	-203		-56	0	-56
	Private patient mitigation	61	497	-125	372	20	84	-36	48
	Theatre Recovery (Additional Sessions)		0	0	0		0	0	0
	Sub Total Capacity Impact	**-225**	**-1,136**	**161**	**-975**	**-51**	**-327**	**35**	**-292**
Internal	Out of job plan (net of vacancies)		0	-333	-333		0	-75	-75
	Casemix (implants & consumables) complexity		250	-838	-588		122	-308	-186
	Supernumary staffing		0	-313	-313		0	-63	-63
	MCSI premium staffing		532	-779	-247		109	-129	-20
	Estates & facilities (energy, materials, maintenance)		0	-437	-437		0	-107	-107
	Efficiency programme slippage		0	-5	-5		0	49	49
	Sub Total Internal Pressures	**0**	**782**	**-2,705**	**-1,923**	**0**	**231**	**-633**	**-402**
External	Low Value Agreement (LVA) block impact		-200	0	-200		-49	0	-49
	Injury Cost Recovery (ICR/RTA) Income Shortfalls		-70	0	-70		-70	0	-70
	Excess inflationary impact		-193	0	-193		-32	0	-32
	Sub Total External Pressures	**0**	**-463**	**0**	**-463**	**0**	**-151**	**0**	**-151**
Internal	Interest recievable mitigation		0	373	373		0	77	77
	Vacancies		0	892	892		0	56	56
	Balance sheet mitigation		0	1,001	1,001		0	107	107
	Enhanced financial controls		0	0	0		0	0	0
	Sub Total Mitigations	**0**	**0**	**2,266**	**2,266**	**0**	**0**	**240**	**240**
	Grand Total Variance to Plan M6	**-1,656**	**-2,263**	**156**	**-2,107**	**-423**	**-696**	**-277**	**-973**

External pressures outside of the Trusts control total £1.5m YTD :

- £1.0m unmitigated industrial action (of which £0.6m is Wales)
- £0.3m technical income (ICR/RTA and LVA)
- £0.2m inflation above funded levels

Internal pressures total £2.9m YTD offset by £2.3m mitigations leaving a net impact of £0.6m :

- Cost pressures total £1.9m but are offset by mitigations largely in the form of vacancies, interest receivable and balance sheet support.
- Capacity/productivity challenges total £1.0m and are partially mitigated by private patient income and remaining non-recurrent balance sheet support.

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RJAH Financial Forecast Scenario's

Most Likely Scenario		Income £m	Cost £m	Total £m	Recurrent / Non Recurrent
	Planned I&E Surplus			0.2	
Pressures:					
External Drivers	Unmitigated industrial action - England	-2.7	0.5	-2.2	NR
	Unmitigated industrial action - Wales	-1.6	0.4	-1.2	NR
	Other income technical shortfalls (RTA H1 & LVA)	-0.8	0.0	-0.8	NR
	Excess inflation	0.0	-0.4	-0.4	R
	External Sub Total	-5.1	0.5	-4.6	
Internal Drivers	Workforce capacity (impact on activity/income)	-2.3	0.4	-1.9	NR
	Cost pressures (agency, casemix, energy)	1.6	-3.4	-1.8	NR
	TIF2 theatre delay	-1.4	0.7	-0.7	R
	Efficiency slippage (stretch target)	0.0	-0.2	-0.2	R
	Internal Sub Total	-2.1	-2.5	-4.6	
Forecast Deficit before mitigations		-7.2	-2.0	-9.0	
	Variance to plan			-9.2	
Mitigations:					
Internal Drivers	Non recurrent savings & balance sheet support	0.0	2.0	2.0	NR
	Interest recievable	0.0	0.8	0.8	NR
	Private patient income	0.7	-0.2	0.5	NR
	Theatre activity recovery	0.4	-0.3	0.1	NR
	Enhanced financial controls	0.0	0.1	0.1	NR
Forecast Deficit after mitigations		-6.1	0.4	-5.5	
	Variance to plan			-5.7	
Best Case Scenario					
English industrial action support		2.2	0	2.2	NR
Delivery effiiency plan in full no slippage		0	0.2	0.2	R
Forecast Deficit		2.2	0.2	-3.2	
	Variance to plan			-3.4	
Worst Case Scenario					
Workforce capacity further shortfall		-1.0	0.2	-0.8	NR
RTA income shortfall continues H2		-0.4	0.0	-0.4	NR
Further efficiency slippage (10%)		0.0	-0.2	-0.2	R
Forecast Deficit		-1.4	0.0	-6.9	
	Variance to plan			-7.1	

All scenario's assume industrial action continues to March 24 with the exemption of November. This impacts on elective activity / clinical income, this is the largest single variable for RJAH.

The Most Likely scenario has been updated to reflect latest activity projections for October and November. Plan is assumed to be achieved from December onwards.

- Most likely scenario £5.5m deficit, £5.7m adverse to plan.
  - External drivers £4.6m :
    - £2.2m industrial action English impact
    - £1.2m industrial action Welsh impact
    - £0.8m Road Traffic Accident (RTA) H1 & Low Value Agreement (LVA) income impact
    - £0.4m excess inflation pressures
  - Internal drivers £4.6m :
    - £1.9m workforce capacity H1 (impacting income)
    - £1.8m case complexity of clearing long waiters
    - £0.7m TIF2 delay by one quarter
  - Mitigations identified £3.5m

- Best case scenario £3.2m deficit, £3.4m adverse to plan.
  - Assumes that the £2.2m English industrial action impact is mitigated through national guidance

- Worst case scenario £6.9m deficit, £7.1m adverse to plan.
  - Assumes workforce capacity constraints continue Dec-March

Elective Activity Monitoring

Elective activity recovery is monitored through a 'Weighted Activity Unit' currency for 23/24 against the revised 101% elective baseline (relative to 19/20).

Elective activity includes: Elective inpatients and day cases, first attendance outpatients & Outpatient procedures (with a published tariff price).

Performance is monitored against baseline throughout the year from national NHS England returns which utilise formal activity submissions through SUS.

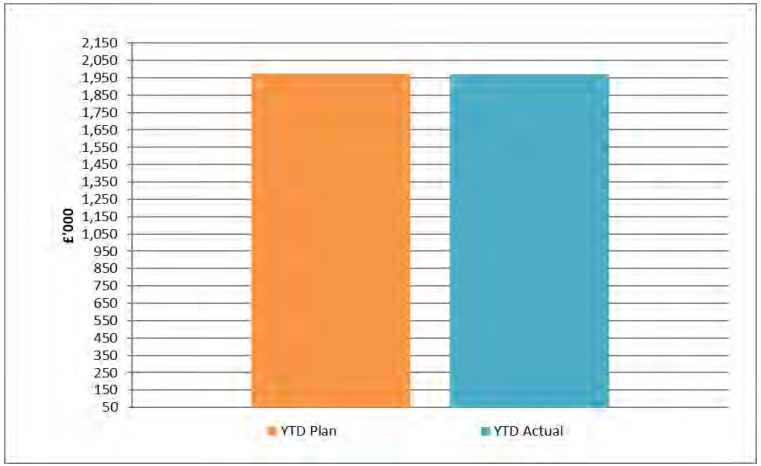
The Trust carries out an internal calculation of elective activity to monitor our performance before the national data release to give a forward look of performance included in the IPR.
Note: this currently excludes NHSE specialised commissioning due to expecting revised baselines in month 7.

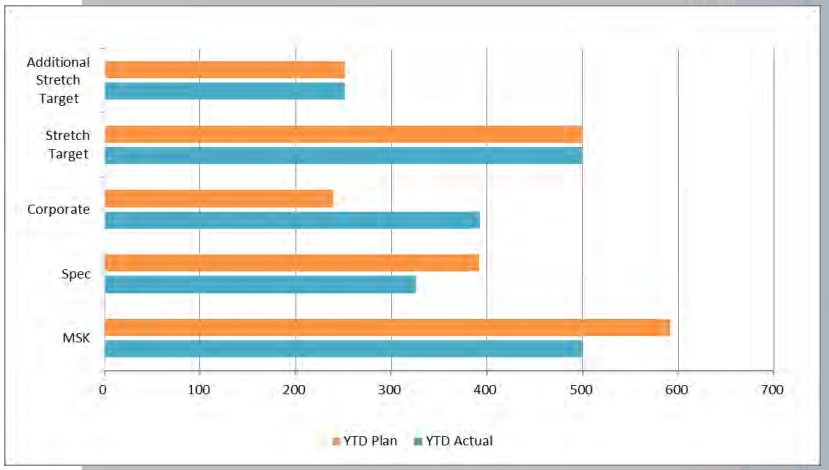
Current position to date is 87% against a plan of 94%.

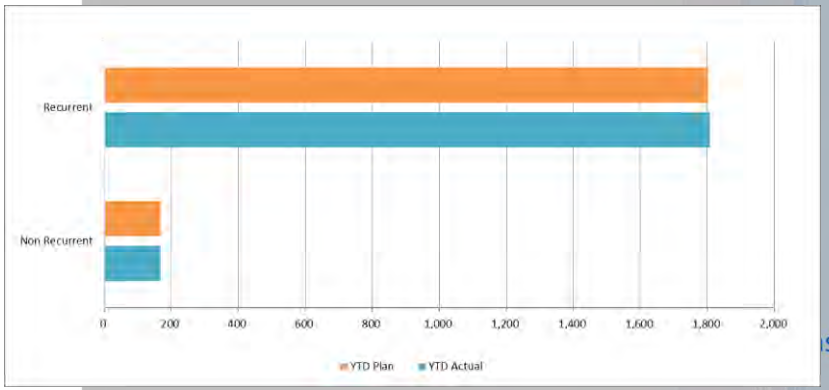
All English ICBs (Excluding NHS England)				
Month	% Planned of ERF Baseline	% Achieved of ERF Baseline	% Difference	Source
April 2023	91.8%	89.2%	-2.6%	External
May 2023	90.8%	94.5%	3.7%	External
June 2023	94.4%	83.9%	-10.5%	External
July 2023	100.0%	89.5%	-10.5%	Internal
August 2023	97.7%	86.1%	-11.6%	Internal
September 2023	89.1%	82.6%	-6.5%	Internal
Month 6 Year to Date	93.8%	87.0%	-6.8%	Internal

patient care

Efficiencies





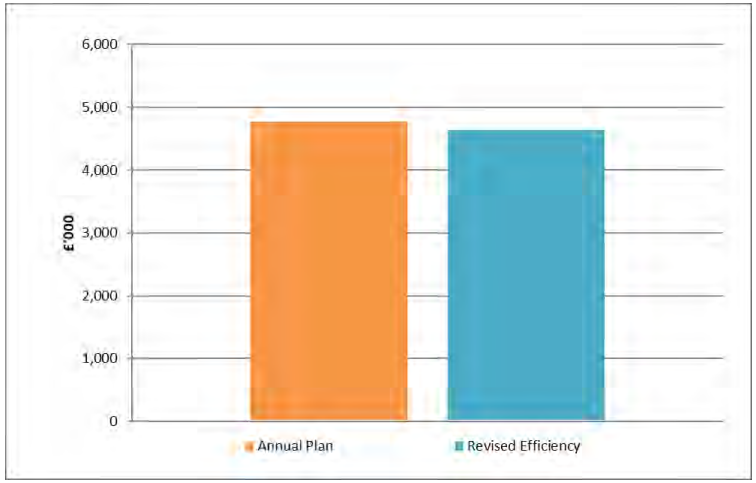


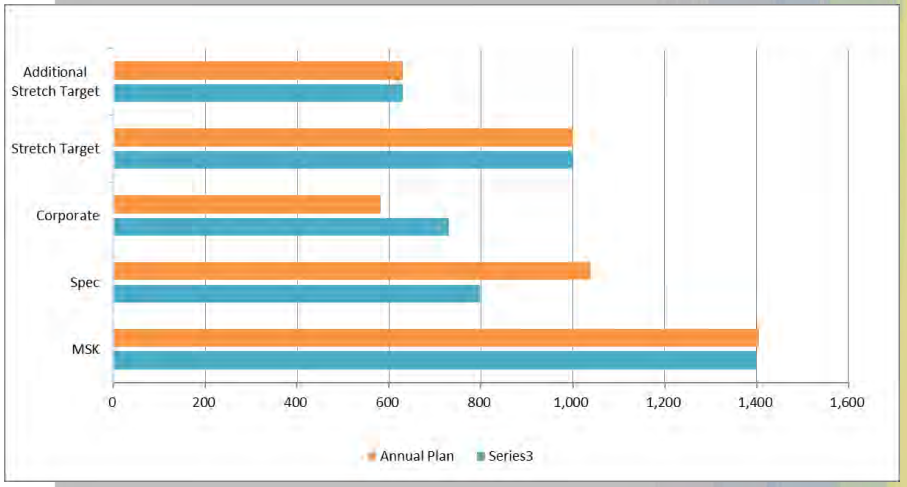
Efficiency performance is £5k adverse to plan year to date.

- MSK unit £92k adverse to plan ytd
- Specialist unit £66k adverse to plan ytd
- Corporate £153k favourable to plan ytd

Extra stretch target achieved in month through 1/3rd recurrent schemes identified and 2/3rds non recurrent interest receivable mitigations.

Efficiencies Forecast





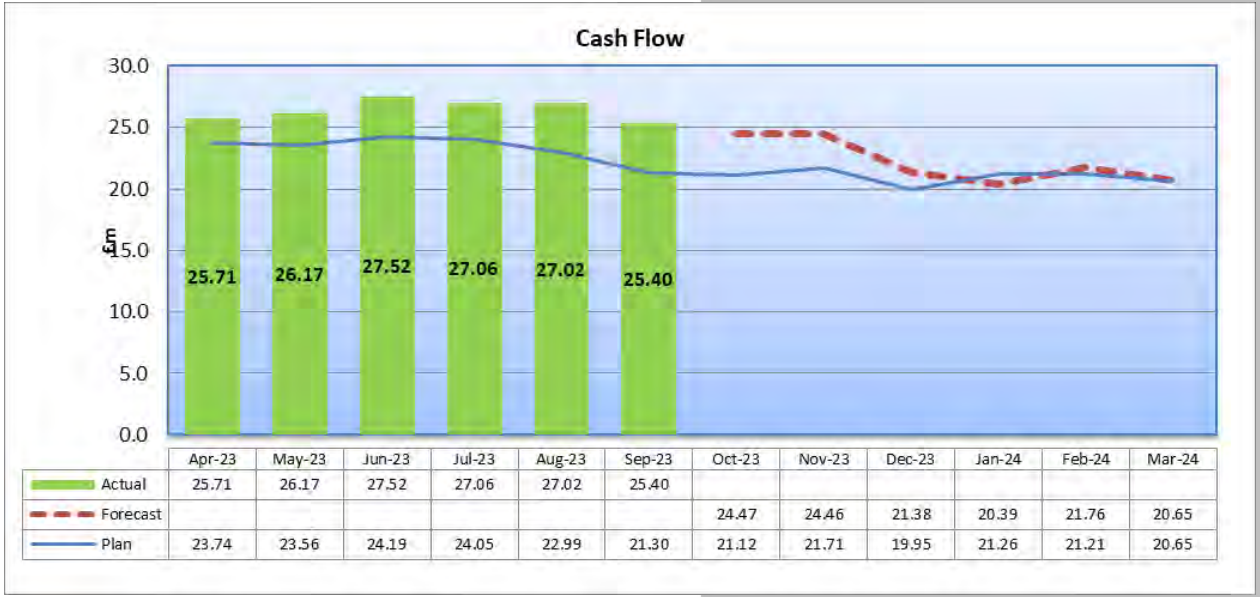
Annual plan requirement of £4.7m (3.7%) including initial stretch of £1m and extra stetch of £0.6m.

Forecast is £4.6m of which £0.2m is red rated and £0.4m is non recurrent.

Unit	Annual Plan	£'000s		
		Recurrent	Non Recurrent	Forecast
CORPORATE	2,329	2,025	420	2,445
SPEC	1,039	798	0	798
MSK	1,405	1,399	0	1,399
Total	4,773	4,223	420	4,643

RAG	Forecast
g	4,030
a	443
r	171
Total	4,643

Cash Position



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Actual	25.71	26.17	27.52	27.06	27.02	25.40						
Forecast							24.47	24.46	21.38	20.39	21.76	20.65
Plan	23.74	23.56	24.19	24.05	22.99	21.30	21.12	21.71	19.95	21.26	21.21	20.65

The cash balance dropped to £25.4m mainly due to the September PDC payment, however cash remains £4m above plan. This is due to profiling of the 2 major capital schemes (Theatre replacement and Apollo EPR implementation).

It is planned to drop to £20.7m during the year, largely due to the investment in the capital programme.

Capital

Position as at	2324-06		Capital Programme 2023-24						
Project	Submitted Annual Plan £000s	Revised Annual Plan £000s	In Month Plan £000s	In Month Complete d £000s	In Month Variance £000s	YTD Plan £000s	YTD Complete d £000s	YTD Variance £000s	Forecast Outturn £000s
Backlog maintenance	430	430	50	20	30	235	310	-75	430
I/T investment & replacement	600	600	0	5	-5	0	19	-19	600
Capital project management	130	130	11	11	-0	64	69	-5	130
Equipment replacement	750	750	100	162	-62	300	191	109	750
Diagnostic equipment replacement	500	300	50	13	37	50	13	37	300
IPC & safety compliance	170	170	30	0	30	90	55	35	170
Estate reconfiguration	100	100	9	0	9	50	16	34	100
EPR planning & implementation	4,600	4,600	1,490	123	1,367	2,057	392	1,665	4,600
Invest to save	300	300	0	0	0	100	37	63	300
Theatre replacement strategy	4,380	4,380	836	20	816	2,537	82	2,455	4,380
Donated medical equipment	150	150	25	0	25	100	67	33	150
Leases (IFRS16)	120	120	0	0	0	45	66	-21	120
Contingency	0	200	100	0	100	100	0	100	200
Total Capital Funding	12,230	12,230	2,701	354	2,347	5,728	1,317	4,411	12,230
Donated medical equipment	-150	-150	-25	0	-25	-100	-67	-33	-150
NHS Capital Funding - Charge to CDEL	12,080	12,080	2,676	354	2,322	5,628	1,250	4,378	12,080
Less leases (IFRS16)	-120	-120	0	0	0	-45	-66	21	-120
Charge to CDEL excluding IFRS16	11,960	11,960	2,676	354	2,322	5,583	1,184	4,399	11,960

The total capital programme for the year is £12.2m with the Theatre replacement and Apollo EPR implementation being the most significant schemes.
The YTD underspend has increased to £4.4m in September, mainly due to the profiling of these 2 schemes.
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).

Trust Board - Finance
September 2023 – Month 6

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

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SPC Reading Guide

SPC Charts

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

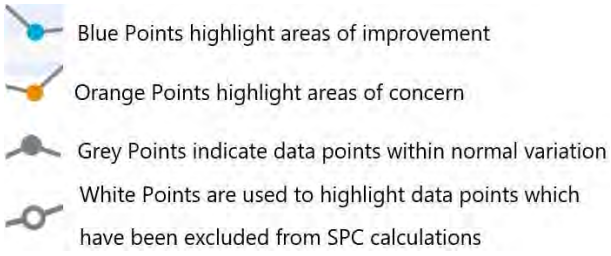
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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

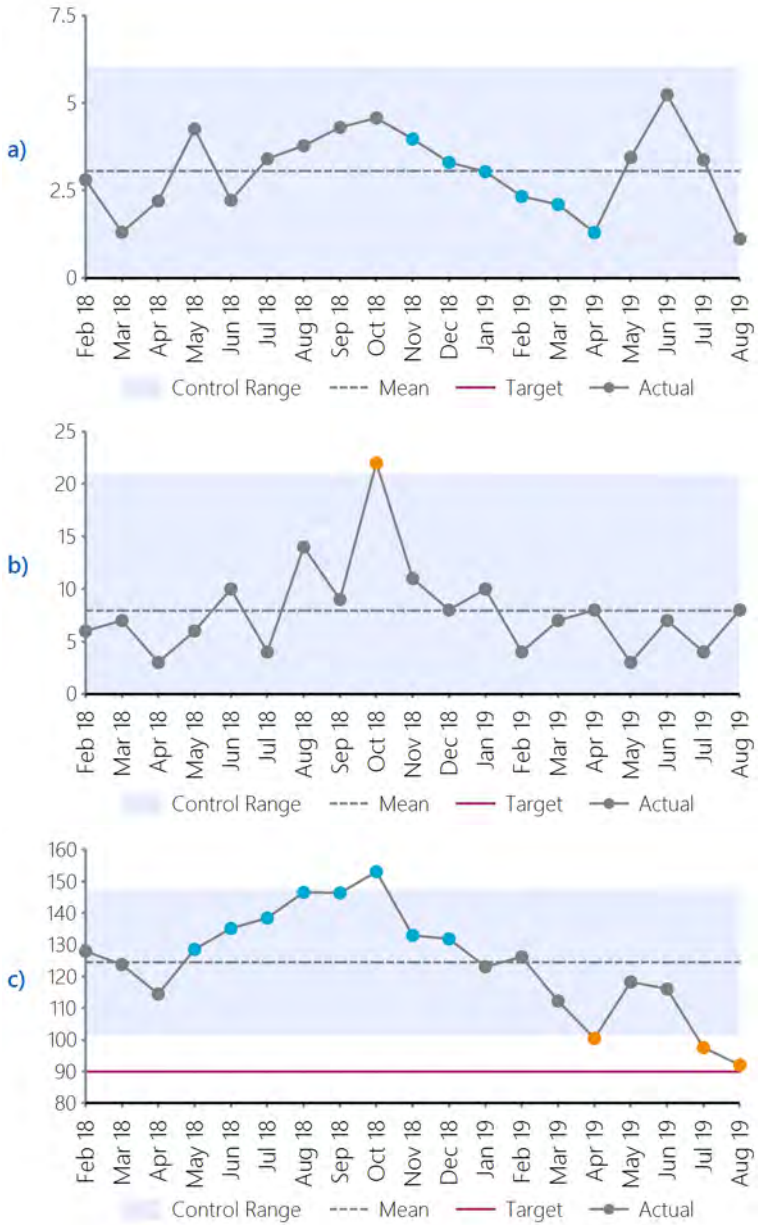


Some examples of these are shown in the images to the right:

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

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

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



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

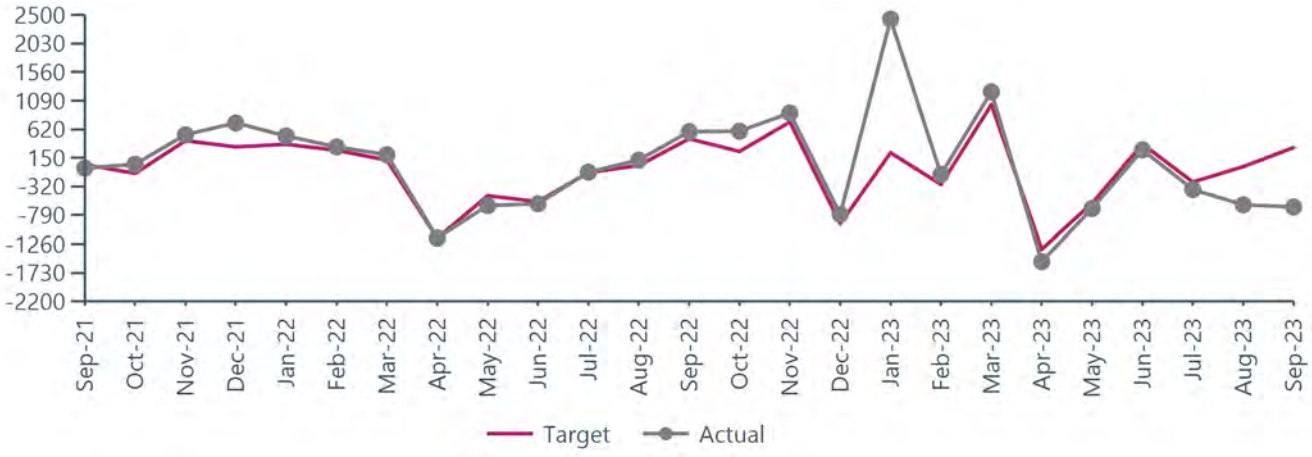
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	319	-656		N/A to SPC	Moving Target	+	
Income	11,818.52	11,657		N/A to SPC	Moving Target	+	
Expenditure	11,499.33	12,384		N/A to SPC	Moving Target	+	
Efficiency Delivered	431	480		N/A to SPC	Moving Target		
Cash Balance	21,304	25,397			Moving Target		
Capital Expenditure	2,701	354		N/A to SPC	Moving Target		
Value Weighted Assessment	86.26%	82.30%		N/A to SPC	Moving Target	+	

Financial Control Total

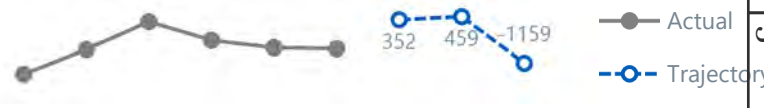
Surplus/deficit adjusted for donations 215290

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
319	-656	N/A to SPC	Moving Target



Trajectory



What these graphs are telling us

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

Narrative

Overall £656k deficit in month, £975k adverse to plan.

YTD £3,591k deficit, £2,109k adverse to plan.

Actions

- Recover activity shortfall which has impacted clinical income
- Guidance required on financial treatment of industrial action impact
- NHSE standard financial controls implemented including controls on pay and non pay
- Agency reduction action plan, linked to recruitment pipeline to reduce reliance on premium pay cost

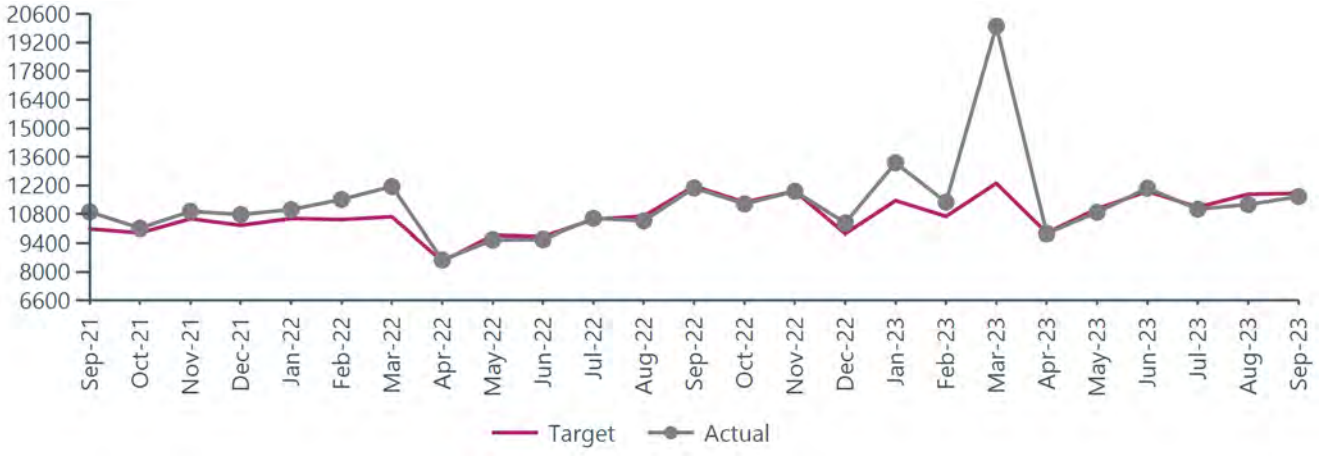
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
581	590	888	-780	2431	-122	1236	-1545	-682	283	-370	-621	-656

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
11,818.52	11,657.00	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Income adverse to plan £788k excluding pass through in month driven by :

Industrial action Impact theatres and outpatients- £449k adverse
Theatre and outpatient capacity impact - £411k adverse
Partially offset by MCSI Income £66k and private patient favourable performance

Actions

Await further guidance from NHSE in respect of further support for Industrial Action impact
Activity recovery plans inpatients and outpatients

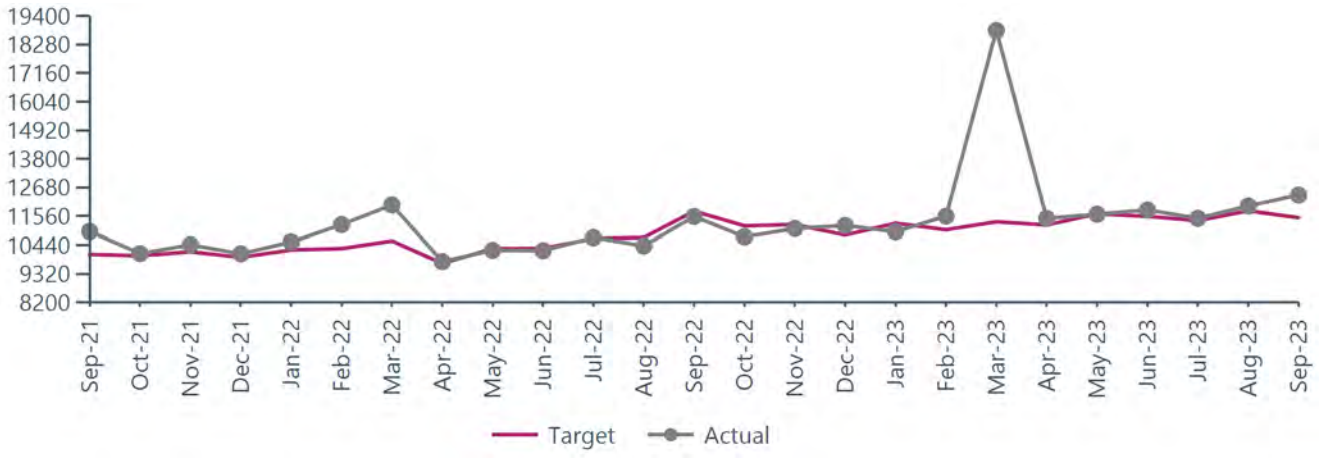
Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
12079	11299	11918	10368	13312	11383	20006	9859	10886	12069	11039	11266	11657

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
11,499.33	12,384.00	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Expenditure adverse to plan £186k excluding pass through in month driven by :

Material pressures in month:
£247k net pressure
MCSI pay £129k , partially offset by clinical Income. YTD
Anaesthetic OJP £71k
Estates & Facilities £98k (mainly driven by energy)
Theatres super nummary staff £63k

Mitigations partially offsetting pressures:

Interest Receivable £100k favourable

Actions

Performance board to gain assurance on pressure areas

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
11548	10759	11080	11197	10960	11558	18833	11469	11635	11800	11472	11957	12384

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
86.26%	82.30%	N/A to SPC	Moving Target

Trajectory

What these graphs are telling us

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

Narrative

Adverse to plan ytd driven by theatre performance impact and outpatients

Actions

Recover activity shortfall

Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
							85.08%	88.08%	94.25%	81.49%	88.56%	82.30%

Chair's Assurance Report
Finance and Performance Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	08 November 2023
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	02 November 2023
Paper Reviewed by:	Sarfraz Nawaz, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors – Private	**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 23 October 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.

Treasury Management Policy

The Committee received the refreshed policy for consideration with a proposed increase in authorisation limits for investments placed with the National Loans Fund to £10m given higher cash balances than when last set. Following a discussion, the Committee agreed the limits should be increased further to £15m. Subject to this further change, The Committee recommended the Board of Directors approve the updated policy.

Chair's Assurance Report
Finance and Performance Committee

Board Assurance Framework
The Committee acknowledged the current position of the framework. It was noted that a revised version of the board assurance framework is required to align the document to the recently approved corporate objectives and the risk appetite.
Following consideration, the Committee had asked for the risks to be revised specifically relating to the Trusts' finances and activity. The Committee requested that the document is shared with the Committee ahead of the next quarterly report.

Corporate Risk Register
The committee agreed the corporate risk register and the improved risk management process which the Trust has embedded. Following a discussion, it was agreed that the register would be presented to the committee on a bi-monthly basis.

Performance Report
The Committee raised concerns with the current performance as follows:

- There is a sustained greater proportion of out of job plan activity to offset reduced in job plan sessions.
- Waiting lists continue to rise and this will remain the case until 12 theatres are regularly running.
- Theatre 13 will accelerate the opportunity to reduce the waiting list.

Following a discussion of the Committee asked for the impact of the increased theatre capacity to be built into future projections.

Financial Performance Report
The Committee noted a continued challenging financial position with a further £1m shortfall against plan in month bringing the cumulative distance from plan to £2.1m The key drivers of the position were noted as:

- Industrial action (still no further mitigation announced by NHSE)
- Shortfall in Theatre activity driven by a shortfall of both overall sessions planned and cases per session.
- A more complex case mix thought to be driven by long waiters driving up higher costs.
- Premium cost pay (OJP, bank and agency further inflated by super numerary posts)
- It was further noted that there had been no recovery of year-to-date activity losses previously assumed which would further deteriorate the forecast

The forecast presented showed a most likely adverse variance to plan of £5.1m and assumed ongoing industrial action unmitigated until the end of the financial year and activity recovery plan previously agreed would deliver in full. It was noted that this would require amendment given the activity outlook.
The Committee asked noted that most of the drivers of the position were income related and non-recurrent so asked for this to be presented in a way that better highlighted this particularly given the importance of understanding the Trust's underlying position.

Activity Mitigation and Forecast Assurance
It was noted that the activity recovery plan had not delivered for September with a shortfall of 171 theatre cases only half of which was because of industrial action. A forward look of October and November showed a similarly bleak outlook assuming cases per session continues at lower levels than previously modelled.
In order to gain further assurance and to offer support, the Committee agreed the next steps would include the following:

- Focus on consistent running of 12 theatres every day.
- Review further mitigation opportunities.
- Performance benchmarking data against ROH around complexity to be completed.
- Complete a deep dive into case-mix position.

The Committee were reassured that the Trust have increased focus on activity and finance by implementing a financial recovery group. The group will meet on weekly basis to discuss the key areas. It was welcomed that a monthly chairs' assurance report will be provided at future meetings.

With consideration given to the challenges the Trust is facing with the activity and financial performance, the members of the meeting agreed to meet outside of the scheduled meeting dates as required.

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:

Specialist Unit Efficient Delivery Report
The Committee received a further report from the Specialist Unit with an updated efficiency forecast. to be £103k adverse to plan. It was noted that further schemes are being developed to mitigate the gap, these include spinal emergency lists, veterans' day cases, review of medication costs, review of the outpatients' bookings. An update report will be presented in December.

Additional Financial Controls Self-Assessment
The Committee noted the progress made with the implementation of further financial controls and further work still in progress. The Committee asked for evidence that the additional controls are reducing costs or improving income alongside the RAG rating as part of the future updates. It was noted that this will be overseen by the Financial Recovery Group going forwards.

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.

Long Waiters Presentation
The Committee were assured with the ongoing work with relation to waiting lists and commended the comprehensive presentation. It was noted that there are still ongoing discussions with the Welsh commissioners to support Welsh patients.

Insourcing Action Plan
The Committee noted the action plan and requested Board engagement and decision making to be incorporated into the document.

Planning Timetable
The Committee noted the planning timetable which has been received from NHSE. The Trust is expecting the guidance to be received at the end of October 2023 with a submission date of February 2024. The Committee agreed for an Extra-Ordinary meeting to be scheduled to consider and approve the plan for 2024/25 in February.

Chairs Assurance Reports
The Committee noted the following chairs report with no concerns to highlight to the Board;

- Procurement Steering Group
- Sustainability Working Group
- Theatre Development Group
- Capital Management Group
- Trust Performance and Operational Improvement Group – the Committee suggested that this Chairs Report is circulated to all Committees to note.

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.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Title:	Treasury Management Policy		
Unique Identifier:	POL025	**Document Type:**	Policy
Version Number:	9.0	**Status:**	Draft
Responsible Director:	Craig Macbeth, Chief Finance and Planning Officer		
Author:	Diana Owen, Head of Financial Accounting		
Scope:	Finance Department / Finance & Performance Committee		
Replaces:	Version 8.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Standing Financial Instructions		
Keywords:	treasury, cashflow, investments, borrowing		

Considered By Executive Owner:	Craig Macbeth, Chief Finance Officer	**Date Considered:**	16/10/2023
Endorsed By:	Finance and Performance Committee	**Date Endorsed**	23/10/2023
Approved By:	Trust Board	**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Treasury Management Policy

1. Scope and Objectives

1.1. Scope

This policy sets out the arrangements the Trust will make for managing its treasury activities including cashflow management, investments and borrowings.

The investment of Charitable Funds is subject to a separate policy which is approved and monitored by the Charitable Funds Committee.

1.2. Objectives

The Trust's principal role is the provision of healthcare services. As such, the Board needs to ensure surplus operating cash is invested in accordance with its duty to safeguard and properly account for the use of public money.

The key objectives of the Treasury Management function are:

- To ensure sufficient cash is available to meet the day-to-day running costs of the Trust and maintain it as a going concern.
- To ensure any surplus cash balances are utilised in the most optimal way with regard to risk and return.
- To ensure competitively priced borrowings are available to be called upon if and when required.
- To maintain good working relations with the providers of the Trust's banking services.

2. Risks and Controls

2.1. Risks

The main risks relating to Treasury Management are set out below:

- Inaccurate cashflow forecasting leading to insufficient funds available to meet immediate operational requirements or lost investment return opportunity.
- Failure to optimise investment returns on surplus cash balances.
- Cash being tied up on long-term investment and not being available to meet unforeseen operational requirements.
- Cash placed on investment being lost due to the failure of the investing institution.
- Mis-appropriation of funds through undetected fraudulent activity.

2.2. Controls to Manage Risk

The following controls are in place to mitigate the risks identified:

- A cashbook is maintained daily, and a monthly cashflow forecast for the current year is maintained and reviewed by senior management before being reported to the Trust Board monthly. Additionally, variances from forecasts are investigated and explained as part of Board reporting. If forecast cash balances fall below £10m, a 12 month rolling cash forecast is produced.

- Clearly defined roles and responsibilities for the Trust Board, the Finance & Performance Committee, the Chief Finance Officer, the Head of Financial Accounting, and the Financial & Systems Accountant.
- Adherence to the agreed investment policy (covered at section 4.1).
- Separation of duties between those who invoice and receipt for cash and those who make payments.
- Controlled access to bank accounts in terms of mandates, signatories and sign-off limits.

3. Organisation and Responsibilities

3.1. Trust Board

- Approves the Treasury Management Policy.
- Approves all external borrowing facilities and long term borrowing to support investments.
- Authorises sign off arrangements for drawing down external borrowing.

3.2. Finance & Performance Committee

- Oversees the Investment Register (where active investment activity in commercial banking is taking place).
- Requests detailed reports on specific areas of performance/concern regarding the Trust's cashflow management

3.3. Chief Finance Officer

- Approves cashflow profiling plans and ensures an appropriately resourced team and systems are in place to maintain and report.
- Regularly reviews the Treasury activities of the Trust and uses judgement to consider any points that should be brought to the attention of the Finance & Performance Committee and/or Trust Board.

3.4. Head of Financial Accounting

- Has operational responsibility for ensuring appropriate accounting systems are maintained and that regular cashflow projections are undertaken with any material variances investigated and explained.
- Assesses the impact on the Trust's liquidity regarding proposed investments.
- Reviews the Investment Register and is the first point of consideration for investment requests.
- Assesses all planned term borrowings against the Trust's long term financial plans to ensure that liquidity requirements can be met.
- Provides updates on Treasury Management issues for the Chief Finance Officer, the Trust Board and the Finance & Performance Committee as required.

3.5. Financial & Systems Accountant

- Manages treasury activities on a day to day basis within the agreed policies and procedures.
- Manages day to day relationships with providers of banking services.

- Maintains cashflow forecasts based on operational plans.
- Identifies surplus cash for investment, and considers whether external investment is optimal by review of interest rates available.
- Undertakes a review of the credit ratings for commercial banks and compares these to the requirements under our Safe Harbour investment requirements.
- Maintains the Investment Register.
- Prepares updates to Senior Finance Management and highlights any material variances from planned cash balances.
- Identifies any short term borrowing requirements.

4. Investments

4.1. Investment Policy

The Trust maintains a risk averse stance to investing its surplus cash balances and therefore forbids speculative trading/investment. All investments placed must meet the following criteria:

- Be with an institution that meets the permitted rating requirement issued by a recognised rating agency (defined in Appendix 2 – Safe Harbour Investments).
- Have a defined maximum maturity date.
- Be denominated in sterling, with any payments and repayments for the investment payable in sterling.
- Pay interest as a fixed, floating or discount rate. The interest rate secured from investments in non-government backed institutions must exceed the Public Dividend Capital interest rate given that daily cash balances are used to offset the annual calculation of dividend payable, but investments outside of the public sector are excluded.

In order to minimise risk, there is a capped limit of no more than £2m for investments placed with each approved institution, apart from the National Loans Fund which is a Government Treasury backed account, for which a limit of £15m will be applied.

4.2. Identification of Surplus Cash Balances for Investment

The Trust will seek to maintain cash balances equivalent to coverage for 15 days operating expenditure. The 15 days corresponds to an acceptable level of liquidity. Should cash drop below these levels and forecasts indicate a recurrent deterioration, the Trust would be eligible to access emergency financing, so this level of minimum balances would give sufficient time to complete the necessary application to protect short term liquidity.

Surplus cash balances for potential investment will be identified from review of the following:

- Daily cash book.
- 12 month cashflow forecast.
- Longer term cashflows as reported in the Trust's most recent financial plan.

If a surplus of cash is identified, prior to recommending an investment, the Financial & Systems Accountant will check that:

- At least £500,000 will be remaining as a contingency in the cashbook over and above planned expenditure levels for the duration of the proposed investment.

- In addition to the £500,000 contingency prescribed above, at least a further £750,000 is available on 7 days notice without penalty.

- Sufficient cash will remain within the Trust's current accounts to meet all the Trust's projected financial commitments before the return of the investments (including payment of invoices in accordance with the Better Payments Practice Code).

4.3. Investment of Surplus Cash Balances

The Financial & Systems Accountant identifies the most appropriate way to invest the surplus funds with the permitted institutions.

The comparison quotes (including the do nothing option) and values are detailed onto an Investment Spreadsheet showing:

- Proposed amount of the investment.

- Proposed period of the investment.

- Rate of interest – if investing in a non-government backed institution (defined as all commercial banks) this must exceed the rate payable by the Trust in respect of its annual Public Dividend Capital (PDC) liability given that daily cash balances may be used to offset the asset value from which the dividend is calculated. The National Loans Fund is excluded from this requirement as it is included in the daily cash balance offset.

- The expected value of the return.

The required level of authorisation for investment is set out below:

Investment period	National Loans Fund (up to £15m)	Non-Government Backed Institutions (up to £2m)
1 month	Operational Director of Finance	Operational Director of Finance
1 – 3 months	Operational Director of Finance	Chief Finance Officer
3 – 6 months	Chief Finance Officer	Chief Finance Officer
Longer than 6 months	Chief Finance Officer with approval from F&PC	Chief Finance Officer with approval from F&PC

The Financial & Systems Accountant maintains records of all investment transactions in an Investments Register.

As an additional control, the Trust's standing instruction to its investment counterparties is to send transaction confirmations directly to the Head of Financial Accounting, **not** to the Financial & Systems Accountant. This allows for them to be independently checked and matched to the daily movement records and the Investment Register.

4.4. Borrowing Policy

The Trust maintains a risk averse stance to funding and thus:

- Requires approval from the Board of Directors before obtaining any proposed funding facilities.

- Forbids entrance into trading positions or purely speculative training.

- Recognises the ongoing need for committed funds to be accessible to provide coverage for cash flow fluctuations or to support capital investments.

- Forbids pre-financing in anticipation of need.

4.5. Key Controls for Borrowing Facilities

Loan applications to support short-term working capital reqirements or to support long-term capital investment will be made by the Chief Finance Officer subject to the Trust's policies and procedures which comply with the instructions issued by NHS England.

The Trust has in place a Business Case and Investment Policy which will ensure that any requirement for long term borrowing is subject to rigorous appraisal.

The Trust will adopt a risk averse attitude to funding, preferring where possible to use existing business cash-flow to provide the headroom required.

The Trust will not allow its authorised assets to be used to secure loans.

4.6. Borrowing Periods and Limits

There are no prescribed borrowing limits, but all borrowings should be kept to the minimum amount and period possible.

All short term borrowings are advised to the Board as part of the monthly Finance Board report, together with an explanation for the cause of the borrowing need.

All long term borrowings must be assessed against the Trust's long term financial plans to ensure that liquidity requirements can be met i.e. the ability to cover current liabilities and to meet borrowing repayments/interest.

5. Reporting

5.1. Monthly Reporting

Fortnightly, the Financial & Systems Accountant prepares a cash forecast for the Head of Financial Accounting, Head of Finance and the Operational Director of Finance showing the current cash balances together with a month end projection which is compared against plan. This allows senior management to intervene in instances of non-receipt of significant contract payments or issues with excessive creditor payments.

Each month the Financial & Systems Accountant updates the cash-flow forecast for inclusion in the Finance Board paper.

The Executive team receive an update on treasury matters from the Chief Finance Officer as part of a monthly dashboard of financial performance issues.

5.2. Quarterly Reporting

A quarterly report will be provided to the Finance & Performance Committee detailing investment activity (excluding the government backed National Loans Fund) and any short term borrowing requirements.

If no such activity has taken place then no report will be required.

5.3. Annual Reporting

The Trust's treasury management activities are reviewed and reported on annually by Internal Audit as part of their Key Financial Controls audit.

6. Policy Review

This policy requires approval by the Trust Board.

This policy will be reviewed every 3 years.

Policy updated: October 2023
Next review due by: October 2026

7. Record of Amendments

Date	Section number	Amendments
Nov 2017	Various	Minor amendments to terminology, job titles, etc.
	4.2 & 4.3	Removed requirement to have no investments with commercial banks at the year end due to effect on PDC dividend – calculation has now changed
	4.3	Added in authorisation levels for National Loans Fund investments
	4.4	Removed references to commercial overdraft facility as no longer held
Oct 2019	Various	Minor amendments to terminology including changing "Financial Planning & Investment Committee" to "Finance & Performance Committee"
Oct 2021	Various	Minor amendments to job titles, etc.
	4.2	Expanded paragraph relating to minimum cash balances
Oct 2023	4.3	Investment authorisation limits amended for National Loans Fund
	3.4 & 4.6	Removal of references to NHS England's Use of Resources Risk Rating, including the the Capital Service Cover, as they no longer exist, and replacement with references to the need for basic liquidity requirements
	2.2 & 5.1	Amendments to cash forecasting requirements

Appendix 1

Investment Vehicles Used by the Trust

- The Government Banking Service
- The National Loans Fund, (NLF) – this is an approved investment under the NHS & Community Care Act 1990).
- Commercial banks supported by low risk credit ratings.

Appendix 2

Investment Criteria for "Safe Harbour Investments" as described by Monitor in Managing Operating Cash in NHS Foundation Trusts

Criteria	Detailed Explanation
Recognised rating agency	Only the following are recognised rating agencies: • Standard & Poor's; • Moody's Investors Service Ltd; and • Fitch Ratings.
Permitted rating requirement	The short-term rating should be at least: • A-1 Standard & Poor's rating; or • P-1 Moody's rating; or • F1 Fitch Ratings. The long-term rating should be at least: • A1 (Moody's); or • A+ (Standard & Poor's/Fitch Ratings).
Permitted institutions	Permitted institutions include: • Institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority to do business with UK institutions provided it has an investment grade[2] credit rating of A1/A+ issued by a recognised rating agency; and • The UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility.
Permitted Investment Type	Only investments that offer a guaranteed fixed rate return are allowed. Investments in pools or speculative trading are not permitted.
Maximum Maturity Date	• The maximum maturity date for all investments should be 90 days. • The maturity date for any investment should be before or on the date when the invested funds will be needed.
Preferred concentration limit	• If an institution is either downgraded or put on credit watch by a recognised rating agency, the decision to invest with them should be reviewed. • Investments with permitted institutions should not exceed the set limit at any time.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Digital, Education, Research and Innovation Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	08 November 2023
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	**Paper written on:**	02 November 2023
Paper Reviewed by:	Penny Venables, 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 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 Digital, Education, Research and Innovation Committee on 30 September 2023. It highlights the key areas the 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.

There were no items to alert to the Board.

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:

Terms of Reference

The Committee held a positive first meeting. The terms of reference for the Committee were considered and reviewed. Consideration was given to the areas of focus for the Committee and the realignment of the supporting meetings in order to gain assurance on the relevant areas of oversight for the Committee.

It was agreed the terms of reference would be reviewed following the discussion held throughout the meeting to include a separate section on Innovation and there would also be a focus on commercialisation as well as innovation with a view to developing a Commercial Strategy.. A draft version will be shared with the Board for consideration and approval at the December meeting.

Committee Workplan
The Committee discussed the areas of focus, which included the following:

- Education and Training
- Digital
- Research
- Innovation
- Policies
- Strategies
- Performance Indicators
- Internal Audit Reports
- Supporting Governance Structures

A discussion was held regarding the cross over of other assurance Committees and the importance on ensuring the alignment of upward reporting is correct. It was agreed that the responsibility for Clinical Audit should remain with the Quality and Safety Committee, but should the committee review any Business Cases or papers that related to this area, the Chair of the Quality and Safety Committee would be invited to attend. It was also agreed that the Research Committee that currently feeds into Quality and Safety should now fed into DERIC.

Risk and Governance
The Committee considered and noted the Board Assurance Framework and Corporate Risk Register. It was agreed that risks relating to education, digital and research are to be realigned to the Committee for their consideration at future meetings.

Reflection
The members of the meeting expressed excitement of the newly established Committee which will support in enhancing innovation across the organisation.

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.
There were no items to assure the Board.

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
Audit and Risk Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	08 November 2023
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	25 October 2023
Paper Reviewed by:	Martin NEWSHOLME, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Private	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the Audit and Risk Committee to the Board of Directors. The Board is asked to consider the recommendations of the Audit and Risk Committee.

2. Context

2.1 Context

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

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 Audit and Risk 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 Audit and Risk Committee

This report provides a summary of the items considered at the Audit and Risk Committee on 10 October 2023. It highlights the key areas the Audit and Risk 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 Audit and Risk 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.

There were no items to alert to the Board.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Audit and Risk 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:

Theatre Waste Briefing
The Committee were not assured from the paper tabled as it did not show any comparison data, therefore the Committee asked for the briefing to be tabled for discussion at the Finance and Performance Committee to provide further assurance. The members of the meeting discussed the wastage on the wards. It was recognised that there is the opportunity to reduce wastage of ward consumables.

Code of Governance
The Committee asked for regular reports on the status to be presented at future meetings. The Trust are considering any actions which can be aligned to assurance committees' terms of reference to improve the Trust's position. The action plan will be shared with the Committee and Board of Directors in due course.

Managing Conflicts of Interest Policy
The Committee considered the policy and asked for further amendments to be incorporated into the document before approval. It was agreed that the policy will be reviewed outside the meeting and circulated to members for approval to expedite the approval process.

Internal Audit Progress Report
The Committee raised concerns regarding the number of outstanding recommendations following receipt of the internal audit follow-up paper. The Trust offered re-assurance on the internal processes which are embedded. These included that Trust having their own internal audit tracker and regular meeting are in scheduled with the Executive Team to discuss the progress of each recommendation. It was confirmed that the internal audits are aligned and overseen at the relevant assurance Committee. The Committee asked for the paper to be discussed at the next Executive Team Meeting.

Risk Management Report
There continues to be good progress made by the Trust to embed and sustain risk management. The Committee asked the Trust to consider ways which the improvement can be reported and learning shared. It was noted that further support is required for the Corporate Services, which is currently being addressed. The next focus piece for the risk management group is age profiles of risk.

External Audit Lead Individual
Board are asked to note that the Deloitte audit partner will change this year as Mo Ramzan has reached the time limit for leading the audit. Deloitte will ensure continuity in the team.

3.3 Areas of assurance

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

Chair Report Information Governance Meeting
The Committee noted the report which had no issues to escalate. It was suggested that the report should be strengthened particularly within the advice and alert sections of the report.

Finance Governance Pack
The Committee were assured with the process and reporting in place for the finance governance paper. Further information is expected at a future meeting in relation to the theatre wastage.

Declaration of Interest and Hospitality Register
The completion figure is currently at 96%. It was acknowledged that it is difficult to obtain 100% due to reasons such as long-term sickness. Internal Audit are completing a review on the Declaration of Interest and Hospitality Register which will provide further assurance once complete.

GGI Action Plan
The Committee were assured with the action plan which reports one action outstanding.
Policy Tracker

The Committee were assured with the policy tracker in place which is aligned to all assurance Committees. Further work is to be completed to ensure the tracker is pro-active and a forward look of 12months is to be presented going forwards.

Counter Fraud Progress Report
The Committee were assured with the progress report provided by Counter Fraud. The Committee were informed that there are no issues raised in relation to the delivery of the programme of work. There has been one referral since the last committee meeting – this has been investigated and closed.

External Audit Progress Report
Deloitte are currently completing an audit of the Trust's charity which is due to be completed and presented for approval at the charitable Funds Committee in December.

Board Assurance Framework and Risk Appetite
Work is underway to review the Board Assurance Framework, align with the recently approved corporate objectives and consideration is being given to the risk appetite following the Board session with the Good Governance Institute. The Committee were assured with the processes in place.

4.0 Conclusion / Recommendation

The Council of Governors is asked to:

1. NOTE the content of section 3.1.
2. NOTE the content of section 3.2, (none to note)
3. NOTE the content of section 3.3. (note to note)