The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 06.03.2024

MEETING

6 March 2024 12:15 GMT

PUBLISHED

4 March 2024

Agenda

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Meeting Room 1, Main Entrance	6 Mar 2024	12:15 GMT

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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	
			Financial Interests	In Form Solutions Management Consultancy	February 2024	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.	June 2020	Ongoing	
			Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	November 2023	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	No conflict with role at RJAH
			Financial Interests	Associate NED at Dudley Integrated Health & Care NHS Trust	01/02/2024	31/03/2024	No conflict with role at RJAH
			Financial Interests	NED at Dudley Integrated Health & Care NHS Trust	01/04/2024	31/08/2024	No conflict with role at RJAH
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	
			Financial Interests	Digital Advisor and Webmaster to Pharmacy Care Matters LTD	2011	Ongoing	
			Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	2011	Ongoing	
			Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	2011	Ongoing	
			Financial Interests	Self-employed webhosting provider	2011	Ongoing	
			Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	2017	Ongoing	
Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	November 2019	Ongoing	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Craig	Macbeth	Chief Finance and Planning Officer	No interest to declare	N/A	N/A	N/A	
Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust May 2022 - May 2023	May 2022	Ongoing	
Denise	Harnin	Chief People and Culture Officer	No interest to declare	N/A	N/A	N/A	
Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
10 JANUARY 2024 AT 9.30AM IN MEETING ROOM 1, MAIN ENTRANCE AT RJAH
MINUTES OF MEETING

Voting Members in Attendance

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

Others in Attendance

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

Ref.	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting.
1.1	**Apologies**
	There were no formal apologies received. 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. The following was shared with the Board for transparency: • HT informed the Board that he is the lead of the Shropshire provider collaboration meeting. • PV informed the Board that she is has been elected as the substantive Chair.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 08 November 2023 were approved as an accurate record.
1.4	**Matters Arising and Action Log**
	There were no further matters to raise.
	There were no outstanding actions from the previous meeting.
2.0	**Chair and CEO Update**

Ref.	Discussion and Action Points
	Chair Update HT informed the Board the Trust continues to work with partners in Shropshire to arrange and embed the collaborative working between all organisations. **CEO Update** The Board received the CEO update report, SK highlighted the following key points with the member of the meeting: Industrial Action – the most recent phrase of action has ended. It was noted to be the longest scheduled action within NHS history (6 days) On behalf of the Board, SK thanked the teams who support the patients, staff and services, highlighted a lot of preparation work is embedded prior to a strike in order to keep the Trust safe. System – the Trust continued to support the system with winter planning by releasing 16 beds for other providers to utilise. The ward was closed as part of the planning and has since reverted back to the usual elective orthopaedic ward. Elective orthopaedics – the Trust are supporting with patients from Telford and the held their first list at the hospital yesterday. Operation Lazurite – the Trust are supporting the health needs for the Afghanistan families as part of operation lazurite. The organisation are supporting with health checks and vaccinations of patients in the short-term. Getting it right first time (GIRFT) – the Trust were successful in achieving the GIRFT accreditation following an application. As part of the accreditation the Trust is now an elective surgery hub as well as paediatrics hub. A lot of work was undertaken in order to support and prepare for the assessment which the Board acknowledged. As part of the assessment, recommendations were noted which the teams have started to address. A review will be completed in 3-year time. NHS sexual safety charter – the Trust have formally launched the sexual safety charter. There are 10 commitments which the Trust sign up to and a working group has been established to support the implementation of the recommendations. RJAH star award – • November's winner was Julie Rae, one of our Medical Secretaries. Julie, who is Medical Secretary to Consultant Surgeon Mr Simon Hill, was nominated by patient David Davies. David said: "Julie goes above and beyond her role as secretary to Mr Hill. If I need to know something she will help and she will respond with 'if you need any help, you know where we are and don't hesitate in calling'. Behind every brilliant Consultant is an even more brilliant Secretary. • December's winner was Jessica Hatton, one of our Theatre Scrub Practitioners, after being described as compassionate and demonstrating professionalism and composure. The nomination came from Dr James Pattison, Consultant Anaesthetist, after an especially difficult emergency case in the Theatre Department. Dr Pattison said that in his 20 plus years of anaesthesia, her professionalism and composure stood out as some of the best he had ever seen. She was flexible, proactive, and her communication with the team exemplary. After the patient was stabilised for transfer, she expressed such compassion for the patient and family. The Board thanked SK for the update and raised the subsequent comments: • Recognised the commitment with the collaborative working with the implementation of the Committee in Common. • Thanked the Trust for supporting the System with the winter planning pressures. • Consideration to be given on how the GIRFT accreditation can link into the Trusts strategy.
2.1	**Trust Strategy**
	The Trusts revised Strategy was shared with the public board for oversight. The document outlines the Trust plan for the next 5 years including the aims and objectives. SK informed the Board: • The Trust has held 2 briefing sessions with staff to support the launch of the strategy.

Ref.	Discussion and Action Points
	• The sessions were used as a platform to engage with staff in relation to the Trusts new mission and values. • A further discussion has been held at the Trust Management Group meeting where attendance is noted from the clinical staff. • The document will be circulated with the System for information and is live on the Trust's website. • The Strategy was approved by the Board at the Decembers private Board meeting. SK welcomed comments from the members of the meeting: • The Board asked for consideration on how to feedback to the patients and wider community who supported with shaping the new strategy. The Trust confirmed the document will be shared with the patient panel and there are other opportunities for wider circulation. • The Board asked how the Trust can communicate the progress and measures of success. The Trust confirmed this will be aligned to the corporate objectives. These discussions were held at the staff engagement meeting and consideration on how to present the information is underway. • Suggested the strategy is shared with the Council of Governors and ask for supporting in sharing the document wider into their constituents. ACTION: to be added to the Council of Governors workplan. • Confirmed the Trust has shared the document with partner. A suggestion was noted that the strategy is to be shared with local universities to enhance relationships.
3.0	**Risk Management and Governance**
3.1	**Corporate Risk Register**
	The Board considered the corporate risk register, DM highlighted the following key points: • The report is a high-level summary of risks with a score of 15 or above. • The assurance committees discussed the risks aligned to their remit through the month of December. • The report highlights the movements of the 12 risks which are presented or consideration. • 4 risks are recommended to be reduced following a review. The Board noted the following: • A separate risks register will be compiled for the EPR Implementation Assurance meeting. • All committee chairs confirmed there were content with the report following discussion at the recent meetings. • Risk 3097 - Insourcing Arrangements - Regulatory Intervention is currently under development and queried what mitigations are in place to ensure no patient harm? MC confirmed the ICB are investing in the service however this is not within the orthotics team. The Trust acknowledges the pressure on the service and support with mitigating. The risk has been flagged as risk on the ICB Quality and Safety Committee and asked for assurance back from the system at the next meeting. The Board approved the Corporate Risk Register.
3.2	**Risk Appetite**
	The final risk appetite was circulated to the Board for consideration and approval. A review of the Trusts risk management process was completed by GGI throughout 2023. The outputs of the Trust recent workshop have been reflected within the appetite. DM reminded the Board that a draft risk appetite statement was shared with the Board at the private meeting in November however, for transparency, the document is to be presented and approved in a public forum. The next steps included, amending the Trusts Risk Management policy to reflect the approved appetite and communications to be cascaded. The Board suggested the following: • Further work to be completed to incorporate the appetite and use this as a framework to make changes throughout the committee meetings. • Keep as a live document. • Review periodically as part of the Board development day agendas. ACTION: add to the Board development workplan for biannually.

Ref.	Discussion and Action Points
	The Board thanks DM for his support in developing the appetite and approved the document.
4.0	**Quality and Safety**
4.1	**Chief Nurse and Patient Safety Officer update (verbal)**
	PKF provided the following verbal update to the Board: • Vaccination for both Covid and Flu are still to be available for staff. The Trust is reporting a 32% uptake for the Covid vaccination and 54% uptake for the Flu vaccination. There a further events scheduled for offer the vaccinations and the Trust continue to ask managers to support in cascading the information to teams. • The Trust is working with partners and League of Friends to secure the workforce of the future with introducing scholarships. • The Trust has signed up the Cavell Nurses Trust which will be launched later this month – it is a charity which support the nursing staff cohort who are experiencing personal or financial hardship. • The Quality Strategy was presented to the Quality and Safety Committee where it received constructed feedback. The document will be reviewed and presented to the public board meeting in March. • The Nursing and AHP strategy are currently being developed and will be presented to the relevant Committees in due course. • The Trust has completed the safe staffing establishment review. This has also been reviewed by internal audit and substantial has been received. • Work continues to embed the recommendations from the sexual safety charter. The Board thanked PKF for the verbal update – there were no questions raised.
4.2	**Chief Medical Officer update (verbal)**
	RL provided the following verbal update to the Board: • Industrial action lasted a period of 6 days. The Trust attempted to continue with as many services as possible including the theatres department. On behalf of the Board, RL thanked all staff for ensuring that there are safe services in plan in order to continue providing safe care to patients. • The Trust continue to support the Nesscliffe camp, and the Trust has a responsibility for meeting health and governance needs for the patients. The processes are reported to be effective and working well. The Board thanked RL for the verbal update – there were no questions raised.
4.3	**Performance Report – Quality and Safety Committee**
	The following points were highlighted from the Quality and Safety performance report: • 1 case of Klebsiella recorded. • SSI reported in recent months, which include 4 in November, 2 in October and 1 in September. A case review is being completed using the one together audit and will be presented to the MDT meeting for wider circulation and learning. • 1 death was reported within the month which was referred to medical examiner. A review will be completed with a learning report will be presented to the Quality and Safety Committee. The Board noted the performance report, and no concerns were raised.
4.4	**Chair's Assurance Report – Quality and Safety Committee**
	LW provided the following updates from the Quality and Safety Committee in December. • Clinical audit forward plan – assurance was requested on national and local 'must do' audits in the form of a robust plan. Clinical audit will be reported through the revised clinical effectiveness meeting before upward reporting via the meeting chair report. The reporting through the clinical effectiveness meeting has been strengthened. • CQC framework has been updated and the Committee were informed of the changes via a presentation. Following the report, the Board subsequent discussion was noted: • Health inequalities deep dive – this is to be presented to the Committee next month. There are a number of areas being considered including how the service are provided, how we can target specific area and the disparity between English and Welsh patients. The Trust will utilise the complaints which have been received as another source of information on

Ref.	Discussion and Action Points
	how patients can be supported further. The Trust confirmed that discussions have commenced at System level and there are further opportunities to be explored with regards to collaborative working. ACTION: health inequalities deep dive to be presented at a public board meeting in time. The Board noted the Chairs assurance report.
4.5	**Health and Safety Annual Report**
	The annual report is shared with the Board for oversight and good governance. The report was presented to the Quality and Safety Committee in December where members of the meeting reflected on the paper. It was noted that it was considered at the Health and Safety Meeting prior to presentation at the assurance committee. The report included an oversight over the health and safety incidents and risks. LW confirmed the Committee were assured by the report presented. The Board noted the health and safety annual report.
5.0	**People and Workforce**
5.1	**Workforce – Performance Report**
	DH highlighted the following areas from the workforce performance report: • Successful in exceeding workforce targets • Noted the reduction within in month leavers, vacancies, sickness and turnover. The Board commended the Trust for being able to sustain the performance against peers and national averages and queried how the Trust can develop further. There is consideration to be given to the working metrics in relation to employment experience and how can the Trust present the quality of the time. The Board noted the workforce performance report, and no concerns were raised.
5.2	**Chair's Assurance Report – People and Culture Committee**
	ME provided the following updates from the People and Culture Committee in December. • Confirmed the Committee agreed to reduced risks in relation to recruitment. • Staffing establishment report was received and noted that there were no fundamental changes and is shared with the Board today for information following a suggestion from MIAA, Internal Audit. • Concerns were raised in relation to the ICS workforce metrics report as the Trust have noticed discrepancies within the reporting which have been escalated. • Concerns raised previously in relation to the lack of leadership within the System for the Workforce agenda has been mitigated as recruitment has commenced for a Chief People Officer. • Positive reporting noted in relation to all key performance indicators. • Further work to be completed on the time to recruit and therefore the Committee has requested a deep dive to be presented in order to provide further assurance. • There have been data quality issue raised by the Committee in relation to the theatre workforce metrics, further work is ongoing and learning is to be shared at the next meeting for oversight and assurance. • Consistent assurance received on nursing staffing levels. • Received the freedom to speak up report Q2 report – assurance received. The Board noted the performance report, and no concerns were raised.
5.3	**Safe Staffing Review**
	PFK provided an overview of the safe staffing review report, highlighting the following: • A review is to be completed on a bi-annual basis. • The paper provides the assurance to the Board. • There are no fundamental changes required following the review. • Staff were encouraged to present their own staffing reviews and innovative conversations were held. ME confirmed the Committee were assured by the report presented. The Board noted the safe staffing review. ACTION: add safe staffing reviews to the Board workplan.
5.4	**Freedom to Speak Up Q2 Report**
	PFK provided an overview of the freedom to speak up report, highlighting the following:

Ref.	Discussion and Action Points
	• There has been a total of 13 concerns raised. • It is important to note that the concerns were over a variety of categories and therefore there have been no themes or trends highlighted. • The increase in concerns raised is noted to be in relation to work the Trust has completed to promote the service – actions include; new dedicated office for staff to visit the freedom to speak up guardian, launch of the freedom to speak up champions and circulating information via communications. • The guardian has been supporting staff by pointing them in the right direction for support as some concerns raised are related to policy and process. The Board held the subsequent discussion: • Confirmed there were no themes or trends in relation to the increased number of concerns raised. • Difficult to support staff which report anonymously. • A post box has been introduced however, further work is to be completed to encourage and remind staff the safe and robust processes in place. • A close working relationship between the people services department and the guardian is required. • No concerns to raise in relation to the reported sub score – this is used for the guardian office to support in the metrics. • The report is used to form part of the next round of communications which are shared with the staff. • Suggested that following the changes within the guardian and the champions, the board receive feedback on the role. PFK confirmed a self-assessment is being undertaken which can be shared with the People and Culture Committee if appropriate. The Board noted the freedom to speak up Q3 report.
6.0	**Operations and Finance**
6.1	**Chief Operating Officer Update**
	Following on from SK update in relation to the GIRFT Accreditation, MC confirmed the Trust have commenced discussion with the paediatric team on how this can be taken forward and the support which the service requires. There is capacity within the service and hope to bring further work to the Trust. Following a query raised in relation to the outputs of the accreditation and the impact on the Trust, MC agreed there is a degree of protection with being awarded the accreditation. The Trust are able to gain support when required and do not have to take work on from other providers which would negatively impact elective patients. On behalf of the Board, HT thanked all the teams involved in achieving the accreditation with a special thanks to Steph Wilson who led on the organisations. In relation to Industrial Action, MC highlighted the following: • Processes are well embedded. • Due to ballot junior doctors in the future. • The Trust has approx. 2-month notice. • Communication and engagement continue with staff. The thanked MC for the verbal update and no concerns were raised.
6.2	**Performance Report**
	MC highlight the following from the performance report: • Progress on overdue follow up patient which has reported a 668 reduction in month. • Diagnostics 6.8 week – ultrasound remains an area which require focus, work is being undertaken to increase the capacity which will support the overall capacity. • Elective activity – October and November reported the highest levels of activity which is a positive direction which is needs to continue to progress. • BADS performance – 85% of day case expectation, the Trust continue to improve. • Outpatient acuity – impact is from a shift in activity from the Trust to Shropshire Community following the transfer of SOOS to MSST and therefore there is an anticipated higher rise in OJP activity.

Ref.	Discussion and Action Points
	The Board discussed the following: • Outpatients – noted the variance in reporting which need to be adjusted to align to the target. A deep dive is scheduled to be presented the Finance and Performance Committee this is to include, first outpatient appointment, patient experience point of view, are we under achieving? • It was noted the Trust has high follow up ratio which is to be considered for the next financial year. • Welsh trajectories – noted the commissioner difference and highlighted the trajectories before querying are the right decision being made? The Trust confirmed they have contacted the commissioners in Wales to share concerns on the disparity – there should be a positive trajectory for mutual aid. It was noted that spinal waits are to be supported by the Walton Centre going forward and the team are asked to prioritise patients on clinical urgency and longest waiters appropriately. The Trust report the information regularly to the Finance and Performance Committee for oversight an remains an uncomfortable position for the Trust. The patient harms review continues to be completed and oversight is presented to the Quality and Safety Committee. • Health and inequalities – highlighted the importance to consider patients from the organisations and local perspective. The Board noted the current performance position.
6.3	**Finance Report**
	CM provided the following key highlighted from the Finance report: • Month 8 reported a £238k favourable position. • Underlying position is reported as £600k shortfall. • Reaching an agreement on the risk shared in relation to the high cost spends on controlled drug. • £600k shortfall drivers are noted as the same themes as previous reporting. • Cost pressures relate to staffing, bank which continue to add pressure to service budget. • Forecast was held steady and reporting to be on track to be £3.1m a drift in year. • Discussion continues with the ICB relating to the Industrial Action funding award. • The Trust continue to hold weekly financial recovery group meetings. • Planning season has commenced however, the Trust is awaiting the planning guidance. • The Trust has reviewed the recurrent baseline financial position for next year and pleased to agree as a system no longer apply an income costs for fixed payments. • Need to ensure the case mix is reviewed. • There is a potential £2m recurrent deficit position however it was noted this will increase if the activity deteriorates. The Board thanked CM for the update and noted the current financial position.
6.4	**Chairs' Assurance Report – Finance and Performance Committee**
	SN provided the following updates from the Finance and Performance Committee in December. • The finance and performance section of the committee has already been covered elsewhere within the meeting. • There is likely to be a delay in the activity relating to the theatre development - a report was received on the development which raised a number of issues. The construction is due to be completed by June and the Trust require an independent review following issues which have arisen in relation to costings. • Agreed there will be a greater scrutiny on the theatre improvement board going forwards. The Board noted the lack of assurance provided along with the challenges which the Trust continue to face.
6.5	**Extraordinary DERIC Committee**
	PV provided the following updates from the DERIC Committee which took place in December. • The meeting was scheduled to specifically consider the EPR implementation assurance meeting. • Recognition on the amount of work being completed. • Received the terms of reference for the NHSE review and assurance was received. • Assurance provided the improving working relation between the team and the Trust. • Deliverables report is expected to be delivered in February.

Ref.	Discussion and Action Points
	• Received and discussed the risk aligned to the system implementation. • Patient portal is likely to go live after the System has been implemented and were reassured this won't impact the EPR roll out. • The financial risk is to be presented and tracked via the Finance and Performance Committee and there have been an increased oversight on the wider risks aligned to the System. • A chairs assurance report from the digital transformation board will continue to be received. • NHE review will determine the go live process and discussed the potential independent review. • Greater scrutiny and assurance on the roll out of the EPR will be sought. The Board discussed the following: • Since the meeting PV has met with key members of the Trust and discuss the governance process in establishing a sub meeting. • The sub meeting will report to the DERIC committee and oversee the EPR elements in order to have a focused meeting. • Assurance will be provided to the Board via the DERIC chair assurance report. • PV will observe an digital operational board meeting for oversight. • Consideration is to be given to the output of the NHSE review. • Processes mapping is being completed in relation to the original business case. The Board thanked PV for the update and welcomed the increased oversight on the EPR implementation.
7.0	**Any Other Business**
7.1	**Questions and Committee from the Public**
	The Board welcomed comments and questions from governors in attendance at the meeting: • Good to hear the challenges back on how the Trust are supporting Welsh patients and noted assurance that the Trust is doing all they can to support the discrepancy. • Positive to hear that the HCA has been recognised as this is a vital role within a clinical team. • Challenged the Trust on how we can empower staff within theatres. The Board noted a pre-determined question was submitted prior to the meeting in relation to the recruitment and retention agenda as the People Plan states: "Recruit, retain and transform our workforce to provide an exemplar experience for our staff and patients". The Chair of the People and Culture Committee led the discussion and highlighted the following key initiatives which the Trust have implemented in order to support staff: • Noted the main challenge is retaining staff especially those on lower bands. • Acknowledged a lot of work have been implemented and the Trust continue to prioritise as part of the Committee discussions. • The NHS are guided by the agenda for change however the Trust continue to support with the cost-of-living initiative which the Trust should be extremely proud of. • The NHS as a whole offer packages for example, pensions, annual leave, sick leave which support staff at a moment in time. • Further consideration and support are being given to pensions, quality of life and career progression. • A common factor in all pressures across the NHS is linked to workforce and the Trust welcomed any suggestions on how staff could be supported further. The Board thanked ME on the comprehensive response, which shared the benefits of NHS employment. The Board were assured recruitment and retention remain a focus topic for the People and Culture Committee and thanked the individual governor for raising the comment on behalf of staff.
7.0	**Any Other Business**
	There were no further items of business discussed by the Board.
8.0	**Date and time of next meeting**
	Public Board of Directors Meeting | 01 May 2024 | RJAH Conference Suite, Main Entrance

Board of Directors

Updated: 01 March 2024

Action Log No.	Original Meeting Date	Public or. Private	Minute reference	Action	By Whom	By When	Comments/Updates Outside of the Meetings	Status
13	11-Jan-2024	Public	2.1 Trust Strategy	to be added to the Council of Governors workplan	DM (MB)	06-Mar-2024	Complete - on the agenda for the next meeting	COMPLETED
14	11-Jan-2024	Public	3.2 Risk Appetite	add to the Board development workplan	DM (MB)	06-Mar-2024	Complete - added to the workplan	COMPLETED
15	11-Jan-2024	Public	4.4 Quality and Safety Chair Report	Health inequalities deep dive to be presented to the Board	MC	06-Mar-2024	Complete - added to the Board workplan	COMPLETED
16	11-Jan-2024	Public	5.3 Safe Staffing Reviews	Add to the bard workplan	PFK (MB)	06-Mar-2024	Complete - added to the Board workplan	COMPLETED

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director – Public Meeting, 6 March 2024

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
HSJ	Health Service Journal
BMA	British Medical Association
WDES	Workforce Disability Equality Standard
ABI	Ankle-Brachial Index
HCSW	Health Care Support Worker
NVQ	National Vocational Qualification
BCRT	Bone Cancer Research Trust

1. Trust response to media issue

Some may be aware of an article published in the Health Service Journal (HSJ) last month regarding an independent investigation carried out into the behaviour of a former member of staff. We take our obligations to protect personal data and privacy very seriously and as a result we have no comment to make about individuals. As a Trust we are committed to supporting all individuals who speak up about sexual safety and improper conduct. The Board have recently strengthened our own internal procedures as a result of the revised Fit and Proper Persons Test Framework and also the Sexual Safety Charter, supporting the implementation of this NHS England Charter in the Trust. We have been offering and providing support to all staff.

2. Industrial Action

Last week saw the conclusion of the latest round of industrial action by junior doctors as part of the dispute over pay between the BMA and the government. These strike periods are disruptive by design. I do want to thank all staff for their hard work to mitigate the impact on our patients. I know everything was done to ensure as much activity as possible could proceed safely. Sadly, there currently appears to be no end in sight for this dispute so we do anticipate further strike action in the weeks and months ahead. Like other NHS leaders, I would urge unions and government to start talking and find some common ground so that we can move on from this period.

3. Inclusion Strategy - This Is Me

Last year, we submitted an application to NHS England in relation to our Workforce Disability Equality Standard (WDES) agenda and, following this application, were successful in securing funding for a special event. That event – which we called 'This Is Me' – took place last week and was a huge success. It included stalls from different charities and organisations, speakers and interactive activities. Speakers included Melissa Johns, an actress and disability activist; Anna Turley, a Paralympic skier; and Shaun Flores, a mental health advocate. I am grateful to Caroline Nokes-Lawrence and the Organisational Development Team for pulling it all together.

4. Green agenda – phasing out single-use plastics

It was great to see our new reuseable scheme starting in our Denbigh's Restaurant last month with a soft launch. The scheme is part of our journey in removing single-use items across the Denbigh's Restaurant service. Initially on a voluntary basis, we actually moved to exclusive use of reuseable containers from yesterday (Tuesday 5 March). Staff pay a £5 deposit for one of the reuseable takeaway containers. After eating their meal, they can either return the container and swap it for a token, or just take it back and swap when you pick up their next meal. To sweeten the deal, participants even get their first meal free when opting into the scheme. Take up so far has been very positive and I am proud of our Estates and Facilities team for really driving this work forward and being a leader within the NHS.

5. League of Friends fund advanced machine to support patient safety

I want to thank our League of Friends for their fantastic support once again, in funding an advanced diagnostic tool to be used in the Pre-Operative Department. The Dopplex Ankle-Brachial Index (ABI) machine is designed to assess blood flow in the leg and detect any abnormalities in the circulatory system. The £4,000 device, which is non-invasive, will help give staff insight into the health of the blood circulatory system, enabling them to diagnose and manage conditions at an early stage.

6. Remark-cow-able murals installed with a little help from our Friends

Our 271-metre long corridor, which is somewhat famous to staff as well as regular patients and visitors, has been having a makeover – thanks to support from the League of Friends and Oswestry Show Committee. A project has been underway to update corridor seating, in a bid to offer comfort and support to patients, visitors and staff as they travel through the corridor. As well as updating seating options, the Friends decided to go one step further and include murals, each with a different theme voted for by staff members, alongside the different seating areas. The first seating area to be

updated is by Denbigh's Restaurant on the corridor, and the theme of Countryside Comfort was selected, and supported by Oswestry Show Committee. The next mural to be installed will be near Alice Ward, the dedicated children's ward, with a game of Where's Percy, the hospital's pet peacock who sadly passed away a number of years ago. Percy will be hidden in a forest illustration and people will have the opportunity to find him.

7. Healthcare Support Worker wins prestigious national award

Claire Partridge, who works within our Practice Development Team, has won the Chief Nursing Officer's Award for Healthcare Support Workers in the 'commitment to quality of care' category. In winning the honour, she becomes the first Healthcare Support Worker (HCSW) from Shropshire, Telford and Wrekin to be recognised for the prize. There are more than 153,000 HCSWs in England, with 287 of them having previously won the award – just one for every 550 in the profession – but she is the first of the 1,335 HCSWs across Shropshire and Telford and Wrekin to be selected. Claire was nominated for the award by Debi Clutton, Practice Development Nurse at RJAH, after her work to support new-to-care staff with the practical skills and awareness to help deliver and assist with the activities of daily living prior to going on the wards.

8. Cancer Team win Bone Idol Team of the Year Award

The Bone and Soft Tissue Tumour Service have won the Team of the Year Award at the Bone Cancer Research Trust's (BCRT) Bone Idols Awards. The team – who work on Montgomery Unit and Oswald Ward – were nominated by patients, who praised them for providing outstanding holistic care throughout the patient journey, from diagnosis, surgery, rehabilitation and then ongoing support and monitoring. The Bone Idols Awards were set up by the BCRT to celebrate those who show exceptional dedication to improving the lives of bone cancer patients. This award is a fantastic demonstration of how the team provide high quality, dedicated, personalised and holistic care to our patients on a day-to-day basis. The team expands much further than the Montgomery Unit and includes other areas that are involved in the pathway of bone sarcoma patients, including the Oswald Ward, Radiology, Pathology, Theatres, the High Dependency Unit, Pre-Operative Assessment and more.

9. National recognition for Deputy Housekeeping Manager

Congratulations to Abi Davies, Deputy Housekeeping Manager, who was shortlisted as a finalist in the MyCleaning Awards – which are a national celebration of all things healthcare cleaning and domestics, aiming to shine a light on the profile of healthcare cleaning and the knowledge and expertise required in these roles. Abi was shortlisted in the Newcomer of the Year category after being nominated by Sian Langford, our Facilities Compliance Manager, and Martine Williams, our Facilities Operational Manager. Abi has been a real success story for our Estates and Facilities Team. Originally joining us as administration apprentice, she worked through her NVQ before securing a substantive role, offering admin support to the Estates and Facilities Management team.

10. 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:

- Gemma Sweetman, Ward Sister, was a winner for her commitment to ensuring the Trust did their bit to support with system pressures throughout the busy festive period. We are so proud of the amazing leadership demonstrated by Gemma to ensure the best outcomes for every single patient across Sheldon and Kenyon Wards over the festive period. During Gemma's work with the Intergrated Discharge Team (IDT) Hub, her tenacity and energy were infectious, she really went the extra, extra, extra mile and worked over and above what was expected of her to ensure that RJAH delivered on its winter pressures commitment to the wider system and to ensure that Kenyon Ward were open for business-as-usual after that came to an end.

Chief Executive Officer Update

- I also presented a group RJAH Stars Award to various colleagues working in the Midland Centre for Spinal Injuries (MCSI) in recognition of their actions which saved a colleague's life. A staff nurse who works in the Outpatient Department on the unit fell dangerously ill and experienced a heart attack while on shift at the end of last year. Many staff were involved including – Dr Snezhana Kostova, Speciality Doctor; Kimberley Porter, Sister; and Fiona Parry, Healthcare Assistant; they quickly formed an immediate response team, who identified symptoms and, from their quick actions, saved the life of their colleague. All staff involved in this incident should feel incredibly proud of themselves and their actions – I know I'm extremely proud of them.

Congratulations to all our latest winners!

11. Conclusion

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Corporate Risk Summary

Committee / Group / Meeting, Date

Board of Directors, 6 March 2024

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

The Digital, Education, Research and Innovation Committee, via the Electronic Patient Record (EPR) Implementation Assurance Meeting, has also been keeping the risks related to the EPR under review. As such, these risks are receiving particular attention at Board sub-committee level but have not been incorporated into the Corporate Risk Register.

Corporate Risk Update

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

Ref	Title	Exec Owner	Oversight Committee/s	Score reported to Feb Ctte	Score reported to Dec Ctte	Comment
3027	Variable Income Performance linked to Elective Activity Performance *(see comment on change of risk descriptor)*	Mike Carr	F&P / P&C	**20**	**20**	Remains on CRR. The Committee noted that the variable income regime is an opportunity as well as a threat so the narrative did not pick up the true risk which is shortfalls on theatre activity reducing our clinical income. This has therefore been recast as: "Adverse Theatre Activity Performance leading to Income Shortfalls"
1511	Compromise to patient data due to cyber attack (Malware)	Simon Adams	DERIC	**16**	**16**	This risk reflects a corresponding BAF entry and remains high.
2934	Patient waiting times outside of national targets	Mike Carr	F&P	**16**	**16**	The current risk description reflects the previous focus on achieving the waiting list reduction targets for 104 weeks, 78 weeks etc. Performance against long waits has been regularly considered at the Committee and good progress has been made against target. Thought is now being given to recasting the risk to focus on the patient experience and the impact of long waits, rather than performance against national performance requirements (as they do not take account of the disparity between English and Welsh waiting targets).
3054	Financial Plan Delivery - Industrial Action	Craig Macbeth	F&P	**16**	**16**	Score remains at 16. Retained on CRR.
3135	Homecare Pharmacy Services	Dawn Forrest (Exec Owner tbc)	Q&S	**16**	**n/a**	Risk added following review of arrangements by Head of Pharmacy. Business case in development to strengthen the team to match increased demand.
3056	Non-compliance with Legislation/Guidance Relating to FFP3 Face Masks	Paul Kavanagh-Fields	Q&S	**15**	**15**	Score remains at 15. Considered and reported via IPC Working Group and captured on IPC BAF.

Corporate Risk Update

Ref	Title	Exec Owner	Oversight Committee/s	Score reported to Feb Ctte	Score reported to Dec Ctte	Comment
						Solution now agreed and orders placed but retained on CRR until now arrangements in place.
3078	There is a risk that the tumour service may not be able to maintain delivery	Ruth Longfellow	F&P	**16**	**16**	Score remains at 16. Retained on CRR. Locum appointed but did not take up the post. The post has been readvertised and the recruitment process in underway.
3096	PACS Procurement Timeline	Mike Carr	DERIC	**16**	**16**	Remains a live risk but score to be reviewed with a mind to reducing it. DERIC to review PACS development / implementation on a quarterly basis.
2996	Organisational capacity impacting on the effectiveness of Clinical Research	Ruth Longfellow	DERIC	**15**	**15**	This risk will be reviewed in line with a new research strategy which will provide a framework to assess activity, resourcing and associated risk.
3097	Insourcing Arrangements - Regulatory Intervention	Craig Macbeth	F&P	**15**	**15**	Score remains at 16. Retained on CRR. Working with the regulator to better understand classification of spend. Working with OOLLP and regulator to agree a compliant way forward on contract spend.
3131	Safe Storage of Medicines – Pharmacy *(see comment to confirm subsequent removal of risk from the register)*	Dawn Forrest (Exec Owner tbc)	Q&S	**~~16~~**	**n/a**	Risk added following review of arrangements by Head of Pharmacy. Storage of excess fluids and flammable products is in breach of best practice and of COSSH guidance. Reported to Committee at a 16. The problem had been addressed by the time the Committee met so the risk was removed from the CRR.
3007	Diabetic demand into the Orthotics service	Mike Carr	Q&S / P&C	**Tbc**	**16**	Risk currently under review and awaiting approval. Draft description is: *IF: We do not invest in increasing the capacity of the orthotics team to meet the increasing demand of diabetic patients.* *THEN: Patients will not be seen in the stipulated timeframes.*

Corporate Risk Update

Ref	Title	Exec Owner	Oversight Committee/s	Score reported to Feb Ctte	Score reported to Dec Ctte	Comment
						RESULTING IN: Potential patient harm and increased backlogs of patients awaiting treatment.
3132	*IF: the Trust is unable to secure long term accommodation for international recruits within the locality due to lack of availability and a competitive rental market.* *THEN: international recruits will not have a good experience, their wellbeing will be adversely affected, and RJAH will not be an employer of choice for new recruits.* *RESULTING IN: an inability to attract and retain staff which will affect quality and delivery of the Trust's activity plan (which will, in turn, have financial consequences for the Trust).*	tbc	P&C	**Tbc**	**Tbc**	The unmitigated risk is scored at 15. This risk is under development and will be reviewed via the regular risk review process to determine the current and target risk scores. As such, the risk description is subject to revision as it works through the review and approval process.

Corporate Risk Update

Strategic objectives and associated risks:

This work supports all of the Trust's objectives and feeds the Board Assurance Framework.

Recommendations:

That the Board NOTE the risks rated at 15 or above, and the movement in risks rated at 15 or above, as considered by the Board Committees during February 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 have been updated to reflect the revised risk appetite.

Trust Board - Quality & Safety

January 2024 – Month 10

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.

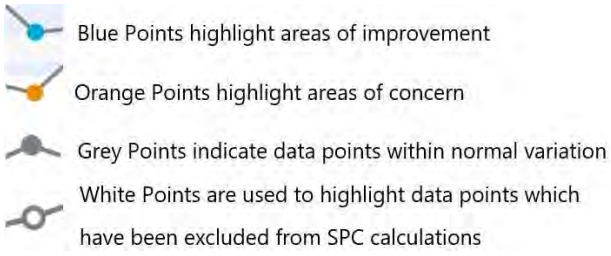
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

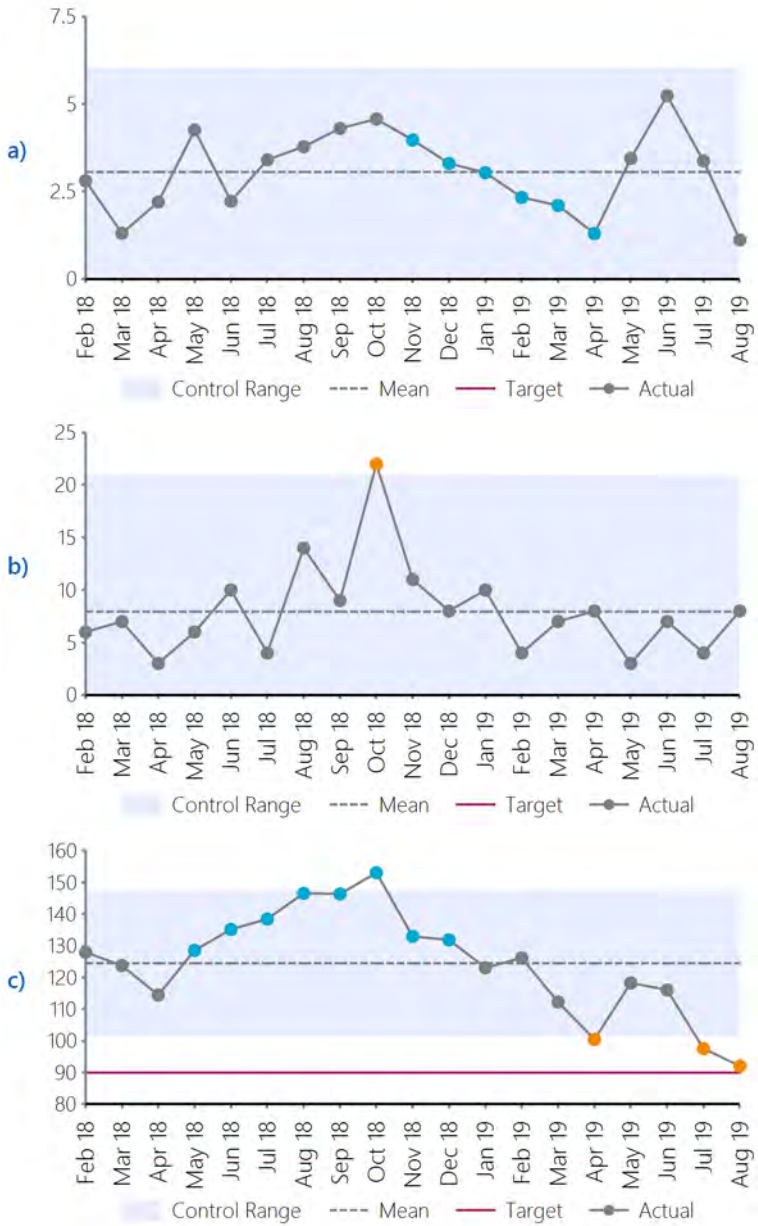


Some examples of these are shown in the images to the right:

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
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	12			?		11/05/18
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		
RJAH Acquired Klebsiella spp	0	1		N/A to SPC	?	+	
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?	+	
Outbreaks	0	0		N/A to SPC	P		

Summary - Caring for Patients

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

RJAH Acquired Klebsiella spp

RJAH Acquired Klebsiella spp 217635

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	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 RJAH Acquired Klebsiella spp infection reported in January.

Actions

The post infection review has been carried out where it has identified the cause as unavoidable urinary source. Relevant protocols were followed.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
1	0	0	0	0	0	0	0	0	1	1	0	1

Surgical Site Infections

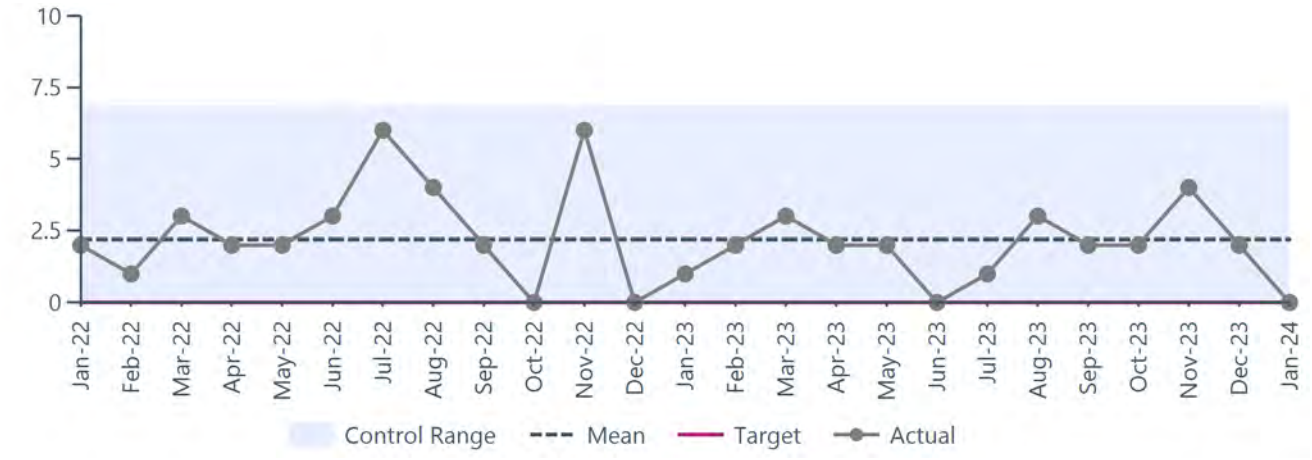
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

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.

There were two additional infections confirmed in January, these related to procedures that took place in November-23 (1) and December-23 (1). The IPC Team carry out case reviews within 30 days and are compliant with this process.

Actions

The IPC Team have completed case reviews for all SSIs which shows compliance against the OneTogether assessment. These are then explored further at MDT, in line with PSIRF, and all actions will be added to the IPC Quality Improvement plan and actioned by the SSIPWG. The One Together Audit is due to be repeated in February as part of a six-monthly cycle of assurance.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
1	2	3	2	2	0	1	3	2	2	4	2	0

Total Deaths

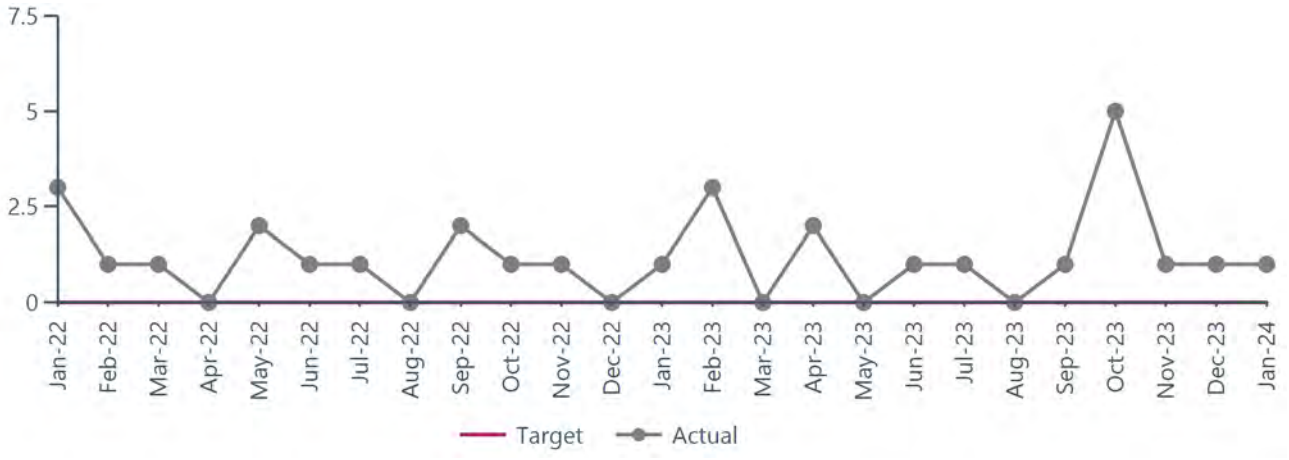
Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

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

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

There was one death within the Trust in January; this has been classified as an 'Expected Death'.

Actions

A Learning from Deaths Review will be completed.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
1	3	0	2	0	1	1	0	1	5	1	1	1

Chair's Assurance Report
Quality and Safety Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	06 March 2024
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	**Paper written on:**	01 March 2024
Paper Reviewed by:	Lindsey Webb, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

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

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

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

3. Assurance Report from Quality and Safety Committee

This report provides a summary of the items considered at the Quality and Safety Committee on 25 January 2024 and 22 February 2024. 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.

EPRR Annual Report

The Committee endorsed the EPRR annual report which was presented to the private Board Meeting in February for approval. The report is circulated within the papers for oversight.

Quality Strategy

The Committee endorsed the revised Quality Strategy and recommended the Board approves the document.

3.2 Areas of on-going monitoring with new developments

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

Chief Nurse and Patient Safety Officer and Chief Medical Officer Update

The Committee were informed of the following:

- Concern relating to blood provision due to the increased activity following the implementation of Sunday working. The Trust confirmed that mitigations have been embedded in relation to patient selection and a blood fridge has also been introduced. The Committee were reassured that other clinical support has been reviewed to support the process, including pharmacy provision and same day discharges.
- Concerns raised with Sunday working and the requirement to ensure all stakeholders are included within the process with ensure each service requirements are met.
- An open day for My Recovery was held in February and well received.
- Governance processes in relation to the 1 acquired pressure ulcer on Sheldon ward is being reviewed.

Board Assurance Framework (BAF)

The Committee held a discussion in relation to the current strategic risks which should be reflected within the revised BAF going forwards. The following was suggested:

- A holistic approach at capturing the organisational focus on patient safety and quality.
- Effectively bringing all strands of information together systematically to identify learning and continued improvement.

Corporate Risk Register

The Committee reviewed and endorsed the register. Concerns were raised with the lack of support from the System in relation to the FFP3 fit mask testing which was raised with the quality and safety ICB representative at the meeting.

Learning from Deaths Q3 Report and Policy

The Committee were assured with the processes in place in relation to reporting, reviewing and supporting deaths however requested further information to be incorporated into the report in relation to the lessons learnt following the completion of the reviews. The Committee endorsed the learning from deaths policy. The Q3 report is included within the Board papers for oversight.

IPC Q3 Report

There has been an increase in E-Coli and Klebsiella within the Trust and therefore the organisation has reported a breach of the national tolerance level. A deep dive into gram-negative bloodstream infections is being undertaken. The Trust have confirmed there is a link between the reported infections and urinary catheters. The MSCI were commended in recongnising the infections and supporting patients effectively.

The Committee also held a discussion in relation to the following issues which have arisen:

- Lack of engagement from the therapies team in relation to the action plan – this has since improved.
- The required for standardised hospital transfer documentation to support comprehensive transfers – this has been shared with the IPC system meeting.
- How to capture the SSI trends for previous years and complete a comparison review – this is to be considered by the Trust.

MSCI Gram Negative Bacteria Thematic Review

The Committee requested further assurance on how the continence lead gap is being addressed.

MSCI Peer Review

The review was completed in September however the Trust is awaiting the final report.

Health Inequalities Deep Dive

A deep dive has been completed with a focus to improve services alongside local authority colleagues. The data is currently being correlated and will be demonstrated via the performance report going forward. The Committee were informed of decisions that are ongoing regarding what support is required from the System.

Safeguarding Priorities
The dashboard is being developed and it was noted that the majority of actions are complete or on target for completion. Training compliance data is to be included within the chair report to the next meeting to provide further assurance.

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.

Paediatrics Governance Structure
The Committee were assured with the review which has been undertaken in relation to the paediatrics governance structure and the revised terms of reference. The Trust were asked to consider the reporting line for the paediatric meeting with a suggestion this should be reported through the Unit governance meeting in future.

Legal Claims Q3 Report
The Committee were assured following presentation of the paper – there were no concerns to raise in relation to the open claims.
The Committee were informed on the process of capturing and analysing learning from claims as well as any existing themes. The Trust is supplied with an annual review of trends which was noted to be reassuring.

Quality Accreditation
The Trust will commence their own quality accreditation and have implemented aspects of the international ward accreditation and pathway of excellence together which will support the CQC compliance toolkit. It was noted that the quality accreditation supported the Trusts Quality Strategy.

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

- 2 complaints have been reopened and under review.
- Harms reviews to be undertaken on delayed discharges.
- Improvements noted to the spinal patient waiting list.
- 3 incident relating to e-coli – a summary report has been requested.
- 3 SSIs in December and 2 in January reported.
- Improved positions in relation to medication incidents was noted.
- 1 expected death reporting – no concerns to raise.
- 1 case of Klebsiella which was unavoidable.
- 62-day cancer target has been breached however this is not due to the RJAH process.

The Committee discussed the following to sough further assurance:

- Theatre cancellations – mitigation opportunities are being considered and a review is being completed in Theatre.
- Complexity and co-morbidities of patients increased – comparison has been completed between RJAH and ROH.
- Reopening complaints – the Governance team continue to monitor the complaints and complete thematic review however this is difficult due to the nature of the complaint being reported.
- Overdue follow up – narrative to be amended to provide greater clarity on the actions being addressed.
- HCA positions – no external agency is currently covering the HCA shifts. The process of back filling roles is currently under review and there has been a noted decrease in the vacancy percentage since September.

- Medicine incidents – a report will be presented through the patient safety meeting.

PSRIF and Patient Safety Improvement Plan
The Committee were assured with the processes in place in relation to PSIRF and improvement plan. It was noted that there have been no PSIs in December or January and actions are being monitored. The Trust agreed to discuss the opportunity to include the reporting of patient safety incidents within the key performance indicators.

Metal on Metal Assurance Report
The Committee was assured on the appropriate and robust processes for the patients. The Trust is awaiting guidance following a national review.

Patient Harm Review Update
The Committee were assured with the process in place to review long waiting patient by priority. A total of 8 patients have been recorded as experience harm to date which related to a spinal surgery patient who has since been expedited following a deterioration of their clinical condition. The long waiters continue to be monitored via the Finance and Performance Committee

CIP Quality Impact Assessment Q3 Report
Overall, the Committee were assured with the paper which presented a £152k favourable position at year end and are due to be completed timely. Discussions were held relating to the rheumatology drugs changes and were assured with the safety measure in place to support patients.

CQUIN Q3 Report
The Committee considered and noted the report – no issues were to be escalated to the Committee.

IPC Quality Improvement Plan and HCSA/IPC Board Assurance Framework
The Committee received assurance on the good progress which continues to be made with no actions reported as behind plan. The remaining open actions predominantly in relation to digital and are due to be completed as part of the Apollo implementation.
The Committee gained reassured on the progress relation to the microbiology SLA where the Trust confirmed arrangements are in place with Sheffield in the interim.

IPC Visit Feedback Letter
It was noted that the majority of the recommendations within the letter have been addressed and a further visit is planned for May. The Committee discussed the current process of the IPC visits and suggested these should be scheduled for the following areas to provide assurance at the next meeting, Hydro pool, wheelchair store, ORLAU and Pharmacy. The Committee were content with the process in place to address issues and embed improvements.

Cleanliness and Estates IPC Q3 Report
The Committee were assured with the processes in place across the Trust to ensure high standards of cleanliness. An external audit has been completed where full assurance was reported. Following a query relating to legionella and water safety, the Committee were assured that the relevant plans are in place to review.

Barns Compliance Report
Assurance was provided to the Committee that there is an annual independent verification of safe ventilation system following the internal assessment. There are no foreseeable issues in terms of business continuity for theatres. The Trust will continue to monitor maintenance and there are no issues for the theatres to maintain the legacy standards.

Policy Tracker
In order to provide further assurance and oversight to the Committee, the members of the meeting requested for the tracker to be presented at each meeting which was presented at the February meeting. It was noted that concerns were raised in relation to some policies being overdue for a long period of time. The policies continue to be aligned to the workplan and monitored.

The Committee approved the following policies:

- Infection Control in the Built Environment Policy
- High Consequence Infectious Diseases (HCID) Policy
- Spinal Level Policy – subject to additional following an MDT discussion.
- Cancer Access and Escalation Policy

The Committee received the following **Chair Reports**:

- **Health Inequalities Meeting** – no concerns to escalate to the Committee.
- **Drugs and Therapeutics Meeting** – no concerns to escalate to the Committee. The meeting is undergoing a review following the appointment of the Chief Pharmacist and therefore an update will be reporting in due course.
- **Health and Safety Meeting** – no concerns to escalate to the Committee. It was noted the FFP3 face masks risk have been resolved with an external provider completing the testing.
- **Patient Experience Meeting** – no concerns to escalate to the Committee.
- **Patient Safety Meeting** – assurance was sought in relation to SWAN end of life pathway name. It was noted as a typing error on the report and is the SWAN end of life plan.
- **ICS Committee** – received a verbal update, there were no concerns to share with the Committee.
- **Clinical Effectiveness Meeting** - no concerns to escalate to the Committee.
- **IPC Meeting** – following the approval of the HCID policy, the Committee requested further information on the reporting links to public health.
- **Medical Device** – the Committee approved the recommendation for the group to e aligned to the patient safety meeting going forwards and will receive an update via the meeting chair report. The Committee asked for further assurance on the lack of awareness in relation to the yellow card reporting.

Internal Audit Assurance Report
1 recommendation is outstanding relating to the medical job planning policy – the Committee suggested the report is realigned to the People and Culture Committee going forwards.

Patient Safety Visits
The Committee welcomed the presentation which outlines the improvements embedded over 2023 and the plans for the visits through 2024.

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.

0. Reference Information

Author:	Dr James Neil	Paper date:	9-1-2024
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 Q3 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No trends identified.

Learning from deaths identified (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.
October 2023	5	4 (one inquest due April 24)	0 (inquest outcome awaited)	No concerns from two ME reviews.	One inquest (April 24). One form 100A.(No concerns with care). One fast track inquest (natural causes).
November 2023	1	1	0	I just wanted to pass on the following- we discussed how she found the care at RJAH- she told me that the care was wonderful. She also commented that Dr Ho was lovely- keeping the family informed as to what was happening. She was very impressed that he called on a Sunday!	No
December 2023	1	1	0	Suggested Coroner review.	Form 100A (No concerns with care).

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. Learning

Good MDT care approach to frail rehab patient. **Good documentation.** **Pragmatic plan for any deterioration discussed with patient and relatives.**
Good care at RJAH. **Good EOL care and liaison with family. Poor recognition of requirement for palliation from transferring trust prevented the possibility of death at home, which had been the wish of the patient and family.**
Very good evidence of shared decision-making discussions with family and patient which led to appropriate actions on deterioration.

Positive:
Very lengthy admission. Good evidence of communication with relatives and involvement of patient and family in plans and aims at all stages.

EOL care instituted once futility of continued treatment appreciated following honest discussions with next of kin and patient.

Negative:
Patients with severe respiratory illness may benefit from offsite review prior to transfer to fully appreciate complex care needs.

Positive:
Good liaison with family and communication of realistic goals.
Family very pleased with care received on ward.

Negative:
EOL care pathway started, then paused, then re-started.
Potential exists that this may have affected dispensation of anticipatory medications.

Positive:
Well documented pre-admission discussion of risk.
Escalated appropriately during deteriorations.
Good communication with patient and family.
Good recognition of futility and need for EOL care.

Negative:
Regular laxatives are part of our post-op protocol for joint replacements and were not prescribed here. Initial issues included post-op ileus that these may have been able to prevent.

All learning passed on to consultant teams.

All to be discussed at Mortality steering group and MDCAM in 2024.

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

Committee / Group / Meeting, Date

Board of Directors, 05 March 2024

Author:	**Contributors:**
Name: Kirsty Foskett Role/Title: Head of Clinical Governance, Quality and Patient Safety Specialist	Lisa Newton, Assistant Chief Nurse, Specialist

Report sign-off:

Paul Kavanagh Fields, Chief Nurse and Patient Safety Officer
Quality and Safety Committee, 21 December 2023
Quality and Safety Committee, 25 January 2024

Is the report suitable for publication:

YES

Key issues and considerations:

The RJAH Quality Strategy, relates to the Trust strategic objective to deliver high quality clinical services.

Drawing on the national patient safety strategy and the ICBs vision together with our local vision and strategies, and most importantly following feedback from our engagement events held with staff, we have devised six objectives that we believe will not only enable us to maintain our high standards of quality but continue to strive to improve quality standards across the organisation.

1. Ensure the trust takes a system-based approach to learning from patient safety events, promoting a just and learning culture.
2. Continue to improve on patient and carer experience through delivery of the patient experience strategy.
3. Implement a Quality Accreditation Programme that enables effective and sustainable change in the most important areas.
4. Work collaboratively with patients, system partners and third sector organisations to ensure our services meet the national priorities for tackling health inequalities.
5. Provide our workforce with the opportunities to ensure our services are clinically led and patients are at the heart of what we do (Nursing and AHP strategy)
6. Through delivery of our quality strategy, patient experience and Nursing AHP strategy, this will prepare RJAH for the pathway to excellence accreditation.

These six objectives embed the Trust's appetite for continuous improvement and change to ensure that we maintain our excellent standards.

Strategic objectives and associated risks:

This work supports the following Trust objective.

1. Deliver high quality clinical services.
    a. Ensure the highest standards pf care for our patients.
    b. Empower departments to develop services.
    c. Optimise productivity and efficiency within our services.
    d. Ensure a fair, equal and inclusive culture across the Trust.

Recommendations:

Following a recommendation from the Quality and Safety Committee, the Board is asked to endorse the RJAH Quality Strategy for 2024-2027.

Report development and engagement history:

The quality strategy has been developed in collaboration with key stake holders through focus group sessions, to develop the objectives outlined in the strategy.

Next steps:

Following approval, a detailed action plan will be developed to support delivery of the identified objectives.

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

Quality Strategy

Creating a culture of continuous improvement to increase and sustain the quality of our services for our patients, people and stakeholders

2024–27

www.rjah.nhs.uk

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Content

Foreword from Paul Kavanagh-Fields and Ruth Longfellow

It is a pleasure to welcome you to our Quality Strategy where we will share our aims and priorities for high quality care over the next three years.

Delivery of the 2017-2020 strategy was somewhat impeded by our response to the international COVID 19 pandemic, where we as a Trust responded to the challenges presented with innovation, standardisation, and a focus on improvement.

We continue to work in a challenging landscape and so will make the most of opportunities that are available, to deliver care in different ways. This means we can build our services back better with the learning and experience we have gained from our pandemic response, to ensure we continue to provide services that are clinically effective, safe, well-led, and responsive to patient's needs, offering a positive patient experience.

Furthermore, our Quality Strategy is intrinsically linked with the Trusts strategic objectives and supporting strategies, including the Nursing and AHP strategy which has been developed in collaboration with Nurses and AHPs across the Trust. The strategy is due to be launched in early 2024.

> *We continue to work in a challenging landscape and so will make the most of opportunities that are available, to deliver care in different ways*

– Ruth Longfellow
Chief Medical Officer

Introduction

Trust vision and strategic objectives

The Trust's vision of aspiring to deliver world class patient care is something we strive towards with the underpinning goals of;

- **Caring for Patients**
- **Caring for Staff**
- **Caring for Finances**

The Trust also prides itself on being a values driven organisation, with five core values;

- **Friendly**
- **Caring**
- **Excellence**
- **Professional**
- **Respect**

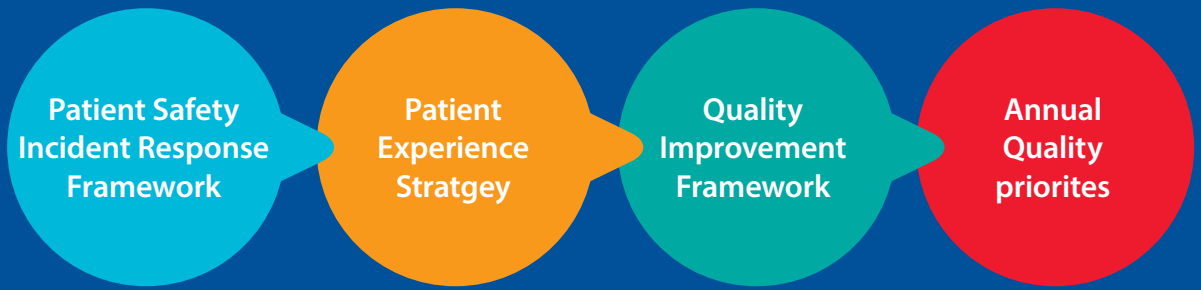
Our vision will be delivered through the achievement of the Trust's strategic objectives, which are:

1. Deliver High Quality Clinical Services
2. Develop our Armed Forces and Veteran service as a nationally recognised centre
3. Integrate MSK Pathways across Shropshire, Telford and Wrekin
4. Grow our services and workforce sustainably
5. Innovation and Research is at the heart of what we do

These objectives have quality embedded in them. This shows the commitment and reality that quality drives all that we do.

The diagram below shows this strategy supports delivery of our vision and objectives. It sets out several of the key enablers and examples of the projects required to improve performance and to illustrate the breadth of our work programme. We have the patient central to our improvement planning and our priorities are aligned to achieving our vision through annual goals and targets.

Enabling Strategies and Frameworks



Our trust

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust opened its doors in 1921. The founding members Sir Robert Jones and Dame Agnes Hunt established an organisation that prioritises quality and their vision continues to this day.

Overall patient experience:
RJAH rated No 1 in the country for the fourth year in a row

We are proud of the quality care we deliver and are thrilled that the results of the Care Quality Commission (CQC) National Inpatient survey 2022 reinforces this.

Overall, we have again been named by the CQC as one of the organisations placed in the top band of Trusts across England delivering results that are considered "much better than expected". The survey was carried out, whilst the Trust continues to recover from the impact of the COVID-19 pandemic however, our patients tell us that we continue to deliver excellent care. Indeed, we once again score No 1 in the country for the overall patient experience we offer, and this is just one of several significant highlights.

- Overall patient experience: RJAH rated No 1 in the country for the fourth year in a row
- Overall confidence in our doctors and nurses
- Hospital food: Our food has been rated No 1 in the country for the 17th time in the last 18 years.
- Cleanliness of wards and rooms: We rated No 1, for the third year running, for patients reported that their room or ward was clean.

None of this would have been achieved without the amazing, dedicated workforce that we employ at RJAH who continue to demonstrate compassion and resilience as we navigate our way through recovering from the impact of the pandemic.

Our focus now, is delivering our strategic operational plan headed by our Chief Operating Officer, to enable this organisation to not only meet the current operational pressures but to also be able to respond to wider pressures within the system such as winter pressures and workforce challenges. However, whilst we strive to increase our efficiency, we do so, by maintaining the high standards of quality care the Trust is renowned for.

RJAH also forms part of the Shropshire, Telford and Wrekin Integrated Care Board (ICB) and we will work collaboratively with system partners to ensure the patients and service users we serve, have a more personalised patient pathway that optimises health and reduces inequalities.

The Vision of the ICS:

Together as one, we want to transform the health and care across Shropshire, Telford & Wrekin by:

- Providing a greater emphasis on prevention and self-care
- Helping people to stay at home with the right support with fewer people needing to go into hospital
- Giving people better health information and making sure everyone gets the same high quality care
- Utilising developing technologies to fuel innovation, supporting people to stay independent and manage their conditions
- Attracting, developing and retaining world class staff
- Involving and engaging our staff, local partners, carers, the voluntary sector and residents in the planning and shaping of future services
- Developing an environmentally friendly health and care system

Together as one, we want to transform the health and care across Shropshire, Telford & Wrekin

– Integrated Care System (ICS)

Our Quality Strategy

Development of our strategy

Drawing on the national patient safety strategy and the ICBs vision together with our local vision and strategies, and most importantly following feedback from our engagement events held with staff, we have devised six objectives that we believe will not only enable us to maintain our high standards of quality but continue to strive to improve quality standards across the organisation.

These six objectives embed the Trust's appetite for continuous improvement and change to ensure that we maintain our excellent standards for quality

What are our priorities?

RJAH Quality Strategy is underpinned by the national NHS Patient Safety Strategy and its 3 strategic aims:

Insight
Improve our understanding of the quality and safety by drawing insight from multiple sources of patient safety and outcome information.

Involvement
People have the skills and opportunities to improve the quality of care provided throughout the services we offer.

Improvement
Improvement programmes enable effective and sustainable change in the most important areas.

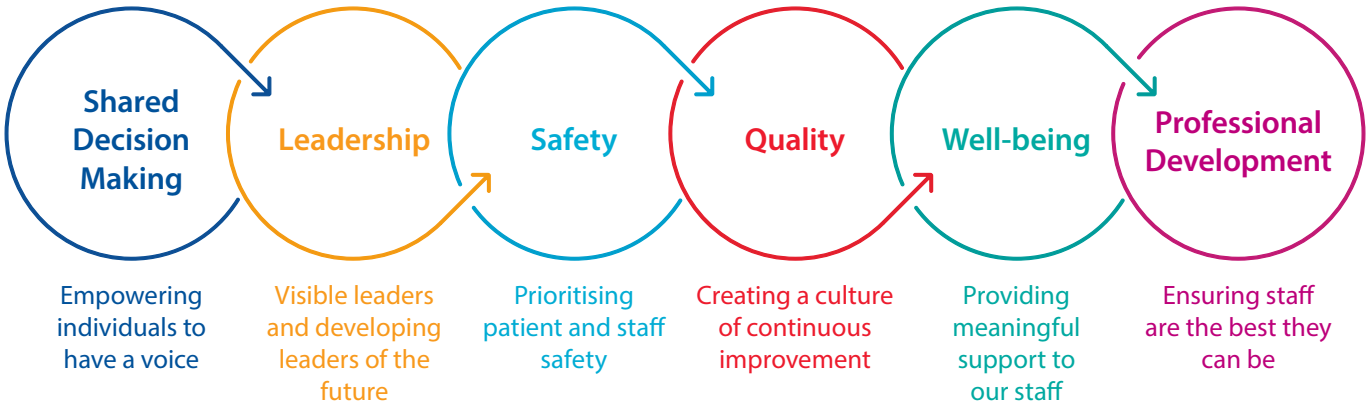
Pathway to Excellence

The Pathway to Excellence® programme is a framework for nursing and midwifery excellence, focussed on creating and sustaining a positive practice environment for our staff.

It is recognised globally as enabling excellence within our professions, instilling a strong sense of professional pride and offers proven strategies to help ensure that the care that we deliver to our patients and populations is of the highest calibre.

The Pathway to Excellence® framework aligns closely with the Chief Nursing Officer for England Ruth May's national vision to establish a country-wide collective leadership model, with a focus on transformational leadership, research and innovation.

There are six Pathways to Excellence Standards:



RJAH will work towards achieving accreditation in each of these standards over the forthcoming 2 years. The accreditation award will showcase that RJAH can demonstrate our commitment to patient and staff safety and our vision of delivering world class patient care.

Monitoring and Review

This strategy will be subject to review and evaluation on a yearly basis. The priority actions set out in this strategy will be prioritised in accordance with RJAH Corporate Objectives and BAF. The Quality and Safety Committee has ownership of and responsibility for the implementation of this strategy. The action plan will be monitored by the meeting members on a quarterly basis.

Clinical Effectiveness

We believe that that our patients' care and treatment should be based on the best available evidence drawn from sources such as the National Institute for Care and Health Excellence (NICE), National Confidential Enquiries and national audits, in addition to information gathered from our own internal audits and outcome data. We will ensure that we use robust data to demonstrate clinical effectiveness and support continuous quality improvement.

1. Building on our work so far

We have mechanisms in place to measure our performance and evidence improvement in the quality and clinical effectiveness of the care we provide to our patients. These include clinical audit, structured judgement review, healthcare variation analysis, and clinical benchmarking systems. These mechanisms support us in ensuring that the care we provide is based on evidence-based best practice and that we continually seek to make improvements. Clinical audit can lead to direct improvement in patient care through measurement of actual clinical practice against evidence-based standards, thus providing a focus for change where necessary. Our annual programme of clinical audit is based on:

- National Clinical audit for improvement programme - each year a prioritised and comprehensive Trust Clinical Audit Programme is agreed. National audits enable us to not only compare our performance with peers but to also compare with our own previous performance as we seek to build on our culture of continuous quality improvement.
- National Institute for Health and Care Excellence (NICE) guidance implementation - the Trust has a proactive approach to the implementation of NICE guidance and audits relating to NICE are considered high priority for the Trust.
- Local clinical audit for improvement programme – the inclusion of Trust, delivery unit, and ICS priorities in our annual audit programme ensures a focus on the most important topics. Trust priorities are identified in a number of ways including the triangulation of data across incidents, inquests, claims, and complaints. At unit level, each specialty has a Clinical Audit Lead to steer the direction of the clinical audit programme, based on local priorities. Working together, there is a shared responsibility for ensuring that the annual programme is delivered.

There is individual and organisational learning from the Medical Examiner scrutiny of every death and referral of cases for Structured Judgement Review (SJR) This process enables us to learn and to act on potential issues which could result in harm to other patients. Triangulating data with information from other sources, including incidents, inquests and complaints, enables us to maximise learning.

The review of clinical effectiveness benchmarking data from sources including Getting it Right First Time (GIRFT), also provides data to focus quality improvement interventions.

In 2023 the Trust achieved GIRFT Elective Hub accreditation, our improvement priorities will include the implementation of the improvements identified through the accreditation process, particularly in relation to our pre-operative assessment services.

2. Improvement Priorities

Over the next 3 years we aim to build on our current work to deliver the following:

2.1. Continuous measurement and improvement of the effectiveness of our services

We are committed to delivery of the National Clinical Audit for improvement programme and to our annual Trust Clinical Audit Programme, which is informed by national priorities

Clinical Effectiveness

and Trust data including patient safety events, inquests, complaints, and claims. Through this, we are able to measure our performance against our peers, provide assurance that we are providing high quality clinical care, and identify opportunities for improvement.

We will:

- Provide high quality, evidence based and multi-professional clinical audit which drives learning and improvement.
- Ensure our processes for clinical audit are streamlined to provide timely reporting and actioning of results, including risk assessment or escalation of any issues of concern.
- Strengthen the links between audit and quality improvement, ensuring that audit data inform new and existing QI programmes.
- Demonstrate compliance with NICE Technology Appraisal guidance and evidence implementation of NICE Guidelines, Quality Standards and Medical Technology Guidance in support of clinical excellence.
- Work collaboratively to identify new priority themes or issues for clinical audit and deliver audits which lead to improvement.
- To continue to improve national Patient Reported Outcome Measures (PROMs) participation rates and be able to demonstrate improved health gains.

2.2. Triangulation of available data sources

We are committed to triangulating audit data with other sources of clinical effectiveness information to maximise opportunities for learning and to demonstrate continuous improvement over time.

We will:

- Continue to use existing and develop new approaches to gathering and reviewing clinical effectiveness information, including data available from the Model Health System.
- Use clinical experts to inform the interpretation of data and potential solutions to improvement.
- Ensure the timely review of all available clinical effectiveness information by appropriate stakeholders to support informed decision making.

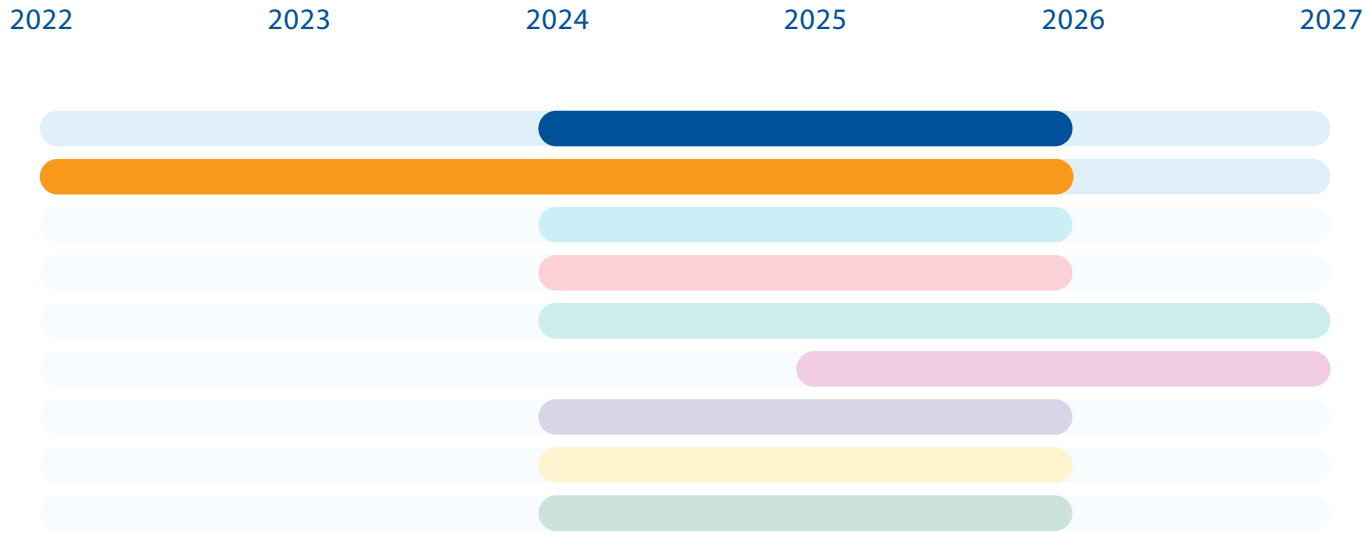
4.3 Learning and sharing of learning

We are committed to continually learning and sharing learning to optimise patient outcomes and reduce avoidable harm. Learning can be transferred between specialities, organisations and across the wider health service. We believe in the importance of keeping up to date with the latest evidence, innovation and research and employing effective mechanisms and processes for implementing these safely, with continuous monitoring.

We will:

- Support clinicians to develop realistic SMART action plans.
- Provide training to help equip Trust staff with the necessary competency and support to participate in clinical audit, or confidently choose an alternative quality improvement method to obtain information and assurances on local performance and clinical care.
- Link organisational improvement routes where applicable.
- Keeping abreast of innovation and research, with the correct governance processes in place, ensures we are able to provide treatment and care based on the best available evidence. We will use clinical audit methodology for testing the achievement of best practice guidance implementation.

Roadmap



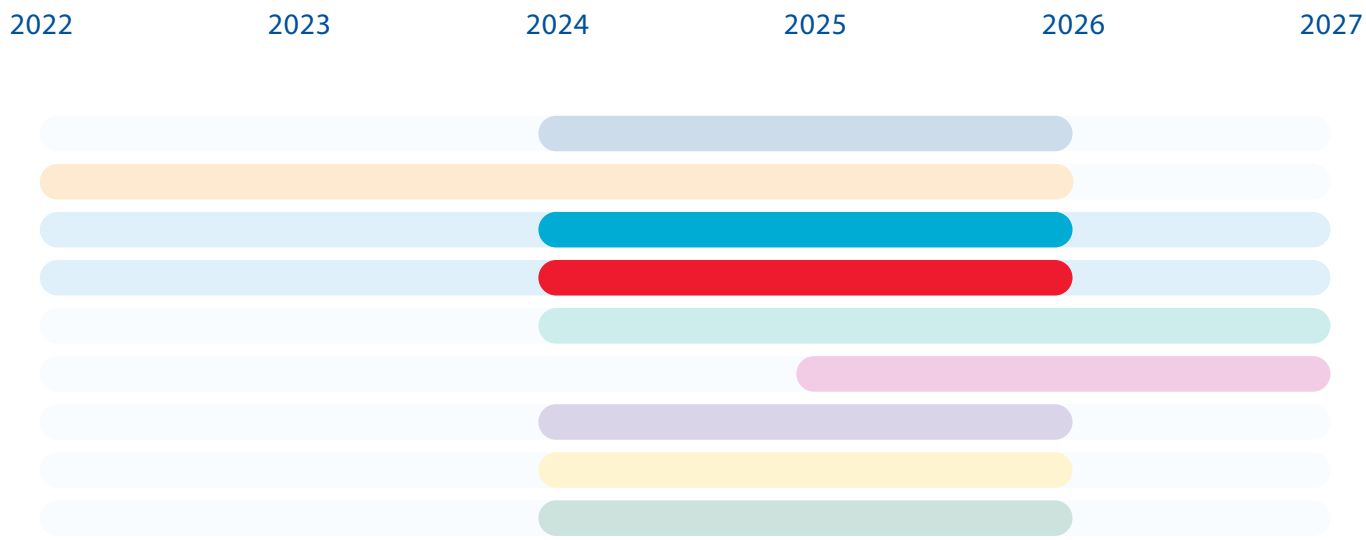
Ensure the trust takes a system-based approach to learning from patient safety events, promoting a just and learning culture

Action	Date
To ensure the principles of the Patient Safety Incident Response Framework (PSIRF) are embedded across the organisation	2024
Launch of revised Human Factors training to educate staff in systems thinking for patient safety	2024
Ensure that Organisational Development focuses on applying the principles of a just and restorative culture	2025

Continue to improve on patient and carer experience through delivery of the patient experience strategy

Action	Date
We will in partnership with our patients and actively involve them in decisions about their care	2022/23
We will communicate to our patients in a manner that is accessible and appropriate to their own individual needs whilst listening to our patients about their priority of care and what matters most to them	2023/24
We will involve our patients and services users and the public generally in decisions regarding the way we deliver services and any future developments	2023/24
We will engage with our patients to facilitate patients to manage their own health conditions and get the best out of their wellbeing	2023/24
We will further develop the role of volunteers to ensure we maximise their input to enhance patient experience	2024/25

Roadmap cont'd



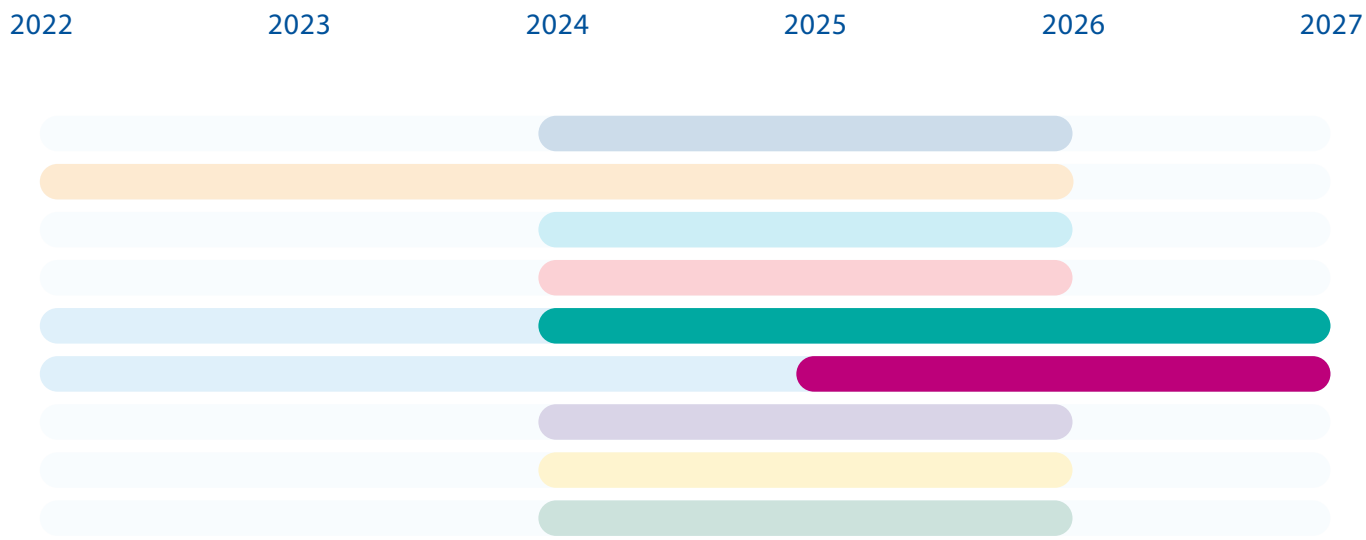
Implement a Quality Accreditation Programme that enables effective and sustainable change in the most important areas

Action	Date
Develop a ward/departmental quality accreditation programme that provides assurance on the quality of care provided and focuses areas for improvement	2024/25
For all ward/departmental to be supported one cycle of the quality accreditation programme	2024/25
Launch of the Quality Improvement Framework and associated training, so people have the skills to apply quality improvement in their everyday work.	2025/25

Work collaboratively with patients, system partners and third sector organisations to ensure our services meet the five national priorities for tackling health inequalities

Action	Date
A health inequality working group will be established to outline a plan for delivering on the five national priorities for tackling health inequalities outlined by NHS England. 1. Restoring NHS services inclusively 2. Mitigating against digital exclusion 3. Ensuring datasets are complete and timely 4. Accelerating preventative programmes 5. Strengthening leadership and accountability	2024/25

Roadmap cont'd



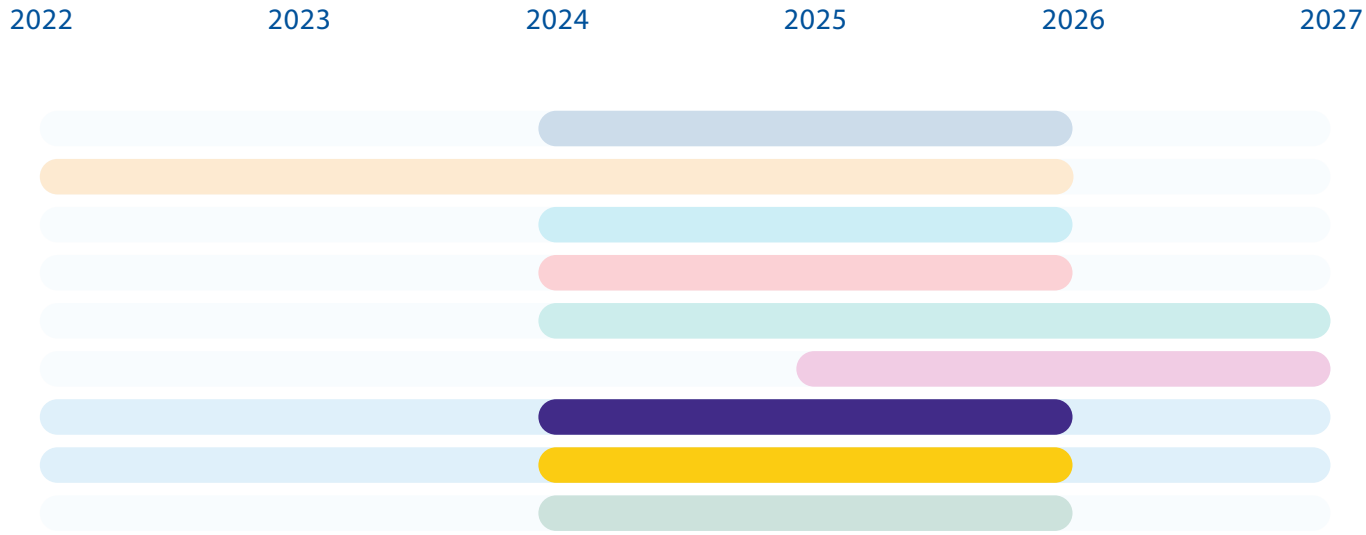
Provide our workforce with the opportunities to ensure our services are clinically led and patients are at the heart of what we do (Nursing and AHP strategy)

Action	Date
Support the delivery of the Nursing and AHP strategy - Provide Outstanding Care - Leadership and a strong professional voice - Improvement and Innovation - Develop and invest in our workforce - Well-being and valuing our people	2024-26

Through delivery of the quality strategy, patient experience, and nursing AHP strategy, prepare RJAH to commence application for pathway to excellence accreditation

Action	Date
Complete a self-assessment of Pathway to Excellence standards to understand areas of improvement required ahead of application	2025-26
Develop a project plan to commence the pathway to excellence accreditation process, outlining resources and funding required	2025-26
Apply for Pathway to Excellence recognition status	2025-26

Roadmap cont'd



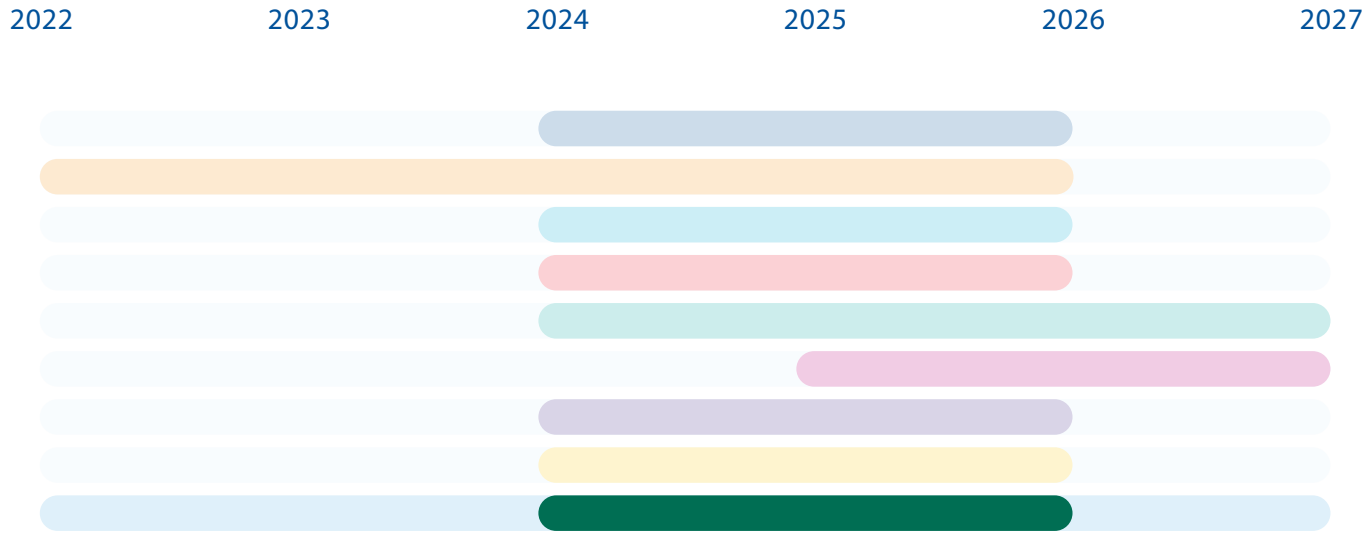
Continuous measurement and improvement of the effectiveness of our services

Action	Date
Provide high quality, evidence based and multi-professional clinical audit which drives learning and improvement	2024-25
Ensure our processes for clinical audit are streamlined to provide timely reporting and actioning of results, including risk assessment or escalation of any issues of concern	2024-25
Strengthen the links between audit and quality improvement, ensuring that audit data inform new and existing QI programmes, through development of the 'innovation hub'	2024-26
Demonstrate compliance with NICE Technology Appraisal guidance and evidence implementation of NICE Guidelines, Quality Standards and Medical Technology Guidance in support of clinical excellence	2024-25
Work collaboratively to identify new priority themes or issues for clinical audit and deliver audits which lead to improvement	2024-25
To continue to improve national Patient Reported Outcome Measures (PROMs) participation rates and be able to demonstrate improved health gains	2024-25

Triangulation of available data sources

Action	Date
Continue to use existing and develop new approaches to gathering and reviewing clinical effectiveness information, including data available from the Model Health System	2024-25
Use clinical experts to inform the interpretation of data and potential solutions to improvement	2024-25
Ensure the timely review of all available clinical effectiveness information by appropriate stakeholders to support informed decision making	2025-26

Roadmap cont'd



Learning and sharing of learning

Action	Date
Support clinicians to develop realistic SMART action plans.	2024-25
Provide training to help equip Trust staff with the necessary competency and support to participate in clinical audit, or confidently choose an alternative quality improvement method to obtain information and assurances on local performance and clinical care	2024-26
Link organisational improvement routes where applicable	2024-25
Keeping abreast of innovation and research, with the correct governance processes in place, ensures we are able to provide treatment and care based on the best available evidence. We will use clinical audit methodology for testing the achievement of best practice guidance implementation.	2024-26

Trust Board - People & Workforce
January 2024 – Month 10

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.

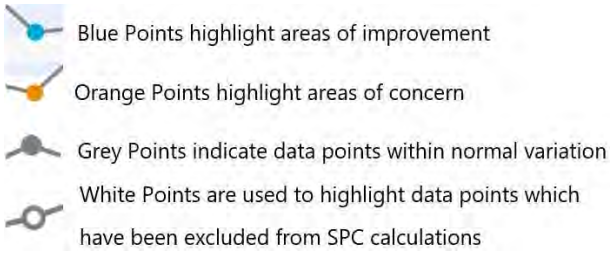
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

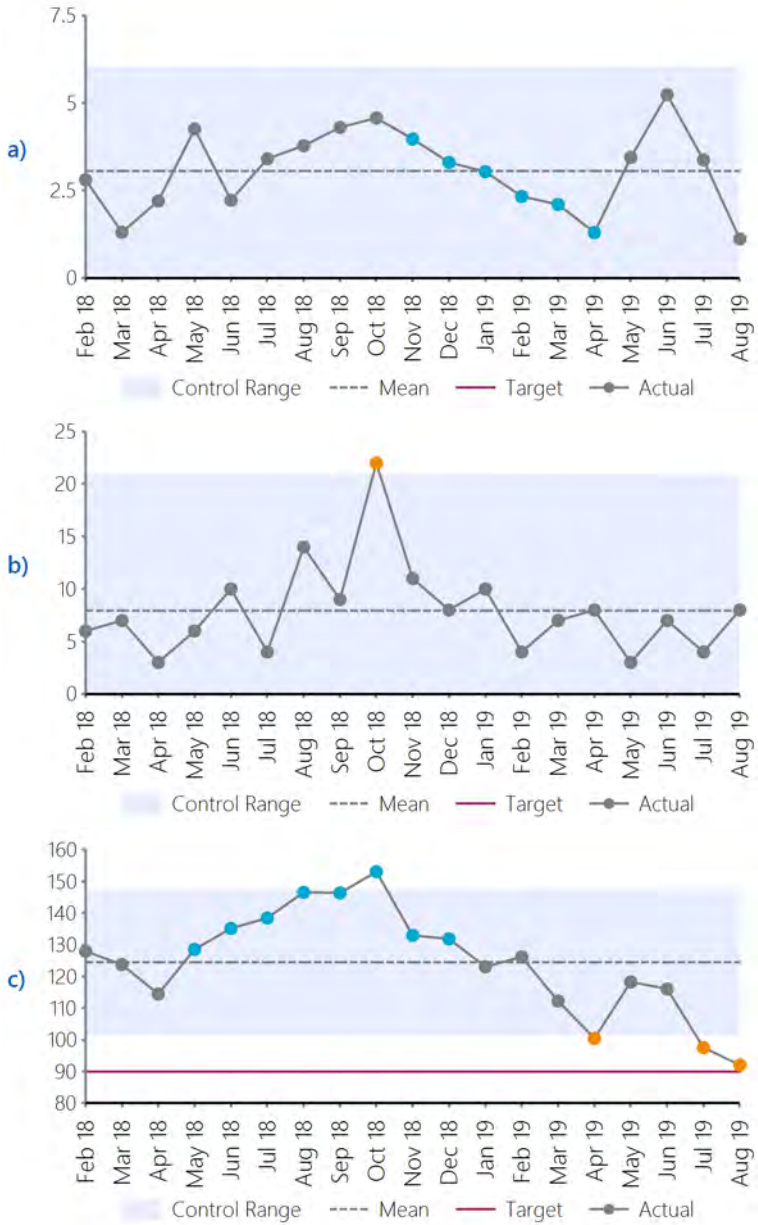


Some examples of these are shown in the images to the right:

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	4.40%	5.41%			Moving Target	+	05/12/23
Staff Turnover - Headcount	11.00%	8.02%			Moving Target	+	
In Month Leavers	10	14			Moving Target		
Vacancy Rate	8.00%	3.13%				+	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	258.00	165.10		N/A to SPC	Moving Target		
Agency Core - Off Framework	0.00	42.40		N/A to SPC	F	+	

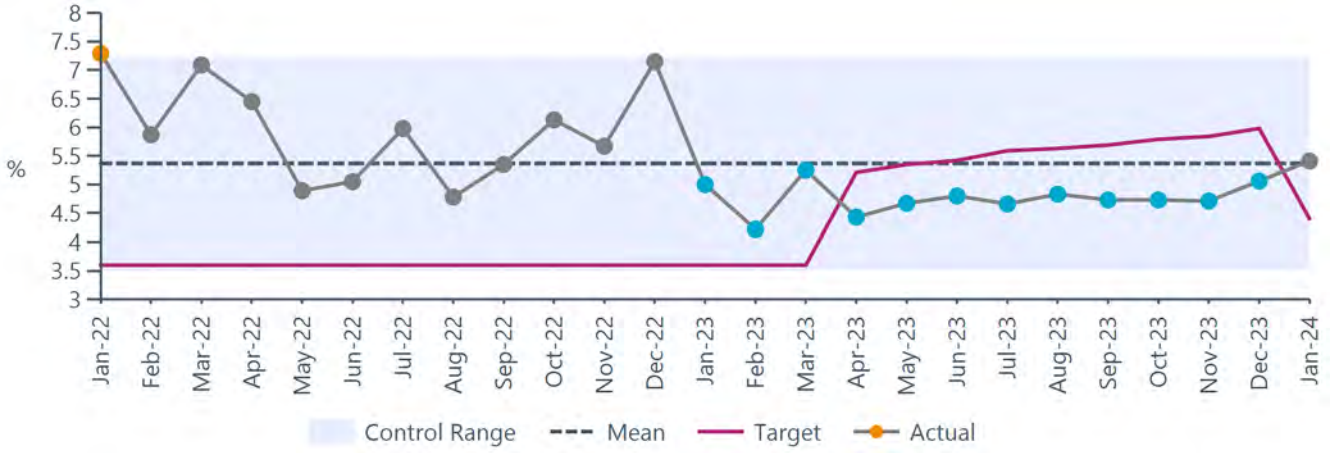
Sickness Absence

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

Exec Lead
Chief People Office

Target/Plan	Latest Value	Variation	Assurance
4.40%	5.41%		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The sickness absence rate for January is reported at 5.41%. This rate remains within our normal variation but is above target this month. It must be noted, the target has reduced from 5.98% in December to 4.40% in January. The target forms part of the Trust's operational planning and was profiled in line with historical data.

'Anxiety/stress/depression/other psychiatric illnesses', 'Other musculoskeletal problems' and 'Back problems' are the top three reasons for absence throughout the month. The hotspot areas for sickness this month were:

* Housekeeping 13.85%
* Kenyon Ward 12.01%
* Sheldon Ward 11.86%
* DEXA 10.76%
* Theatre Scrub 10.50%

Actions

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
5.00%	4.22%	5.25%	4.43%	4.67%	4.80%	4.66%	4.83%	4.73%	4.73%	4.71%	5.06%	5.41%

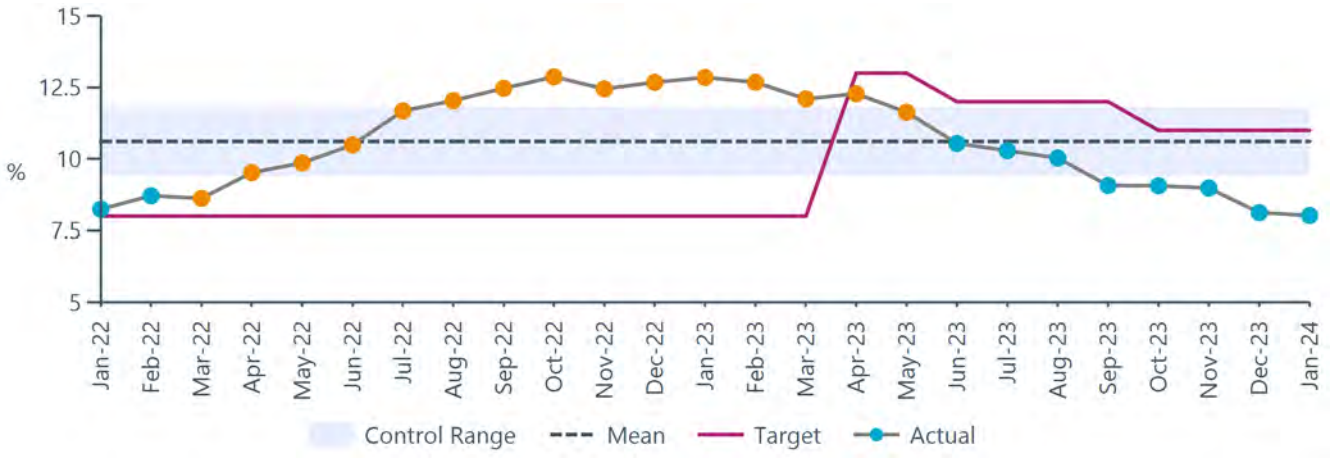
Staff Turnover - Headcount

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

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
11.00%	8.02%	L	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Staff Turnover is reported at 8.02% for January and included as special cause variation due to the sustained improvement with month on month reduction throughout this financial year.

This metric relates to the leavers over the past twelve months. For the period of February-23 to January-24 there have been 145 leavers as a proportion of the month end headcount.

Actions

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
12.85%	12.68%	12.10%	12.28%	11.63%	10.54%	10.29%	10.03%	9.07%	9.06%	8.98%	8.12%	8.02%

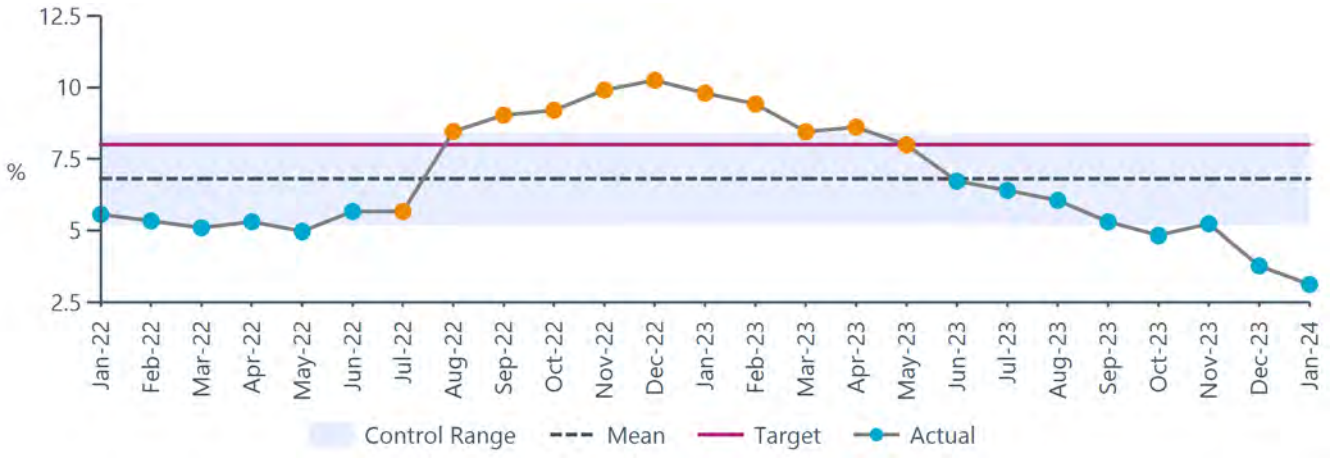
Vacancy Rate

% of Posts Vacant at Month End 211183

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	3.13%	L	?

Trajectory



What these graphs are telling us

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

Narrative

The Trust-wide vacancy rate for January month-end is reported at 3.13%. It is included as an IPR exception due to the graph displaying sustained special cause variation of an improving nature. The latest data point is the lowest reported position over the last two years.

Despite the improved position at Trust-level, focus must remain on specific areas where there are high volumes of vacancies. The positions for Theatres are outlined in the Workforce Report that accompanies the IPR to People Committee. The five areas with the highest levels of vacancies, other than Theatres, are outlined below:

* MCSI Inpatients - 9.81 WTE vacant, equating to 10.83%
* Anaesthetic Medical Staff - 4.85 WTE vacant, equating to 16.30%
* Kenyon Ward - 4.51 WTE vacant, equating to 16.62%
* SOOS Administration Staff - 4.18 WTE vacant, equating to 37.39%
* Pharmacy - 3.10 WTE vacant, equating to 11.20%

Actions

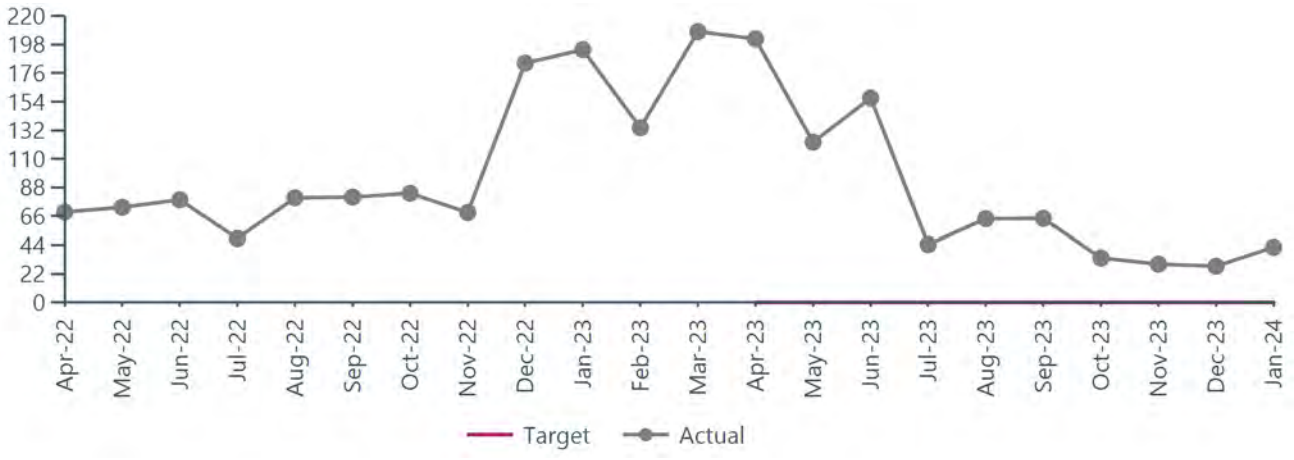
Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
9.80%	9.42%	8.45%	8.61%	7.99%	6.72%	6.40%	6.05%	5.30%	4.83%	5.23%	3.78%	3.13%

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
0.00	42.40	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 16%, driven by 1:1 nursing support for MCSI patient.

Actions

- Continued engagement with NHSE/ICS regarding future arrangements given that this spend can not be tolerated within Agency limits

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
194	134	208	202	122	156	44	64	64	34	29	27	42

Chair's Assurance Report
People and Culture Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	06 March 2024
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	01 March 2024
Paper Reviewed by:	Martin Evans, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

The Trust Board has established a People and Culture Committee. According to its terms of reference: *"The purpose of the People and Culture Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:*

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

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

3. Assurance Report from People and Culture Committee

This report provides a summary of the items considered at the People and Culture Committee on 25 January 2024 and 28 February 2024. 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.

Responsible Officer and Revalidation Annual Report

The Committee endorsed the annual report which was presented to the private board meeting on 06 February to align with submission timeframes. The Committee were assured that the Trust remains compliant with the standards and requirements for medical appraisals and revalidation.

Gender Pay Gap Report 2024

The Committee were assured with the report presented to the meeting and is circulated to the

Board for oversight. The Trust will commence embedding actions which have been identified.

Public Sector Equality Duty Report
The Committee noted the high quality and content of the report which highlights the significant progress which the Trust has made over the last 6 to 12 months. The report was endorsed by the Committee, and it is recommended for Board approval. Further considerations to be given on how the EPR system can support the Trust in identifying and understanding valuable patient equality and diversity information.

Freedom to Speak Up Q3 Report
The Committee were assured with the processes in place to support staff in raising concerns. It was noted there have been no common theme or trends identified and no concerns to be raised to the Committee. The report was supported for oversight by the Board.

Guardian of Safe Working Hours
The Committee were assured with the processes in place to support junior doctors within their role. It was noted there have been no exception reports within the quarter however the Trust continue to liaise with North Wales Trusts to support in ensuring staff are complaint. It was noted an electronic reporting system to support in capturing the data would be beneficial. The report is circulated to the Board for oversight.

Governors Comments
The Committee received positive feedback from the Governors in attendance – the scrutiny and progress made was noted along with the support which is offered to staff and patients across the Trust.

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:

Board Assurance Framework (BAF)
The Committee held discussions at both meetings relating to current strategic risks that should be considered within the revised framework. These were noted as:

- Retention of intentional recruit and cultural aspects to be considered.
- Recruitment pipeline, with the need for accurate predicted planned delivery aligned to actual recruitment levels.

The Committee also discussed the revised workforce tolerance score of 12, this was following a discussion at the Board of Directors meeting in January and acknowledged the importance of using this as an opportunity to do some things differently moving forward.

Corporate Risk Register
The Committee reviewed and approved the risk register and there were no material changes or emerging risks to escalate to the Board.

Agency Update
The Committee were assured with the actions implemented to support the reduction in agency usage. It was noted that off-framework agency continues a downward trend and continue to be on track to be under the annual core agency spend. The committee were provided an overview of the focused work taking place around the longest serving agency workers. The Committee commended the work of the agency improvement group for driving the noticeable improvements.

Time to Recruit Deep Dive
The Committee received a report on a deep dive that had been undertaken around the recruitment timeline and processes. They noted improvements that have been implemented to support the time to hire process which include a welcome call, a dedicated onsite recruitment team, face to face identify checking and a weekly sit-rep meeting that has been established between RJAH and MLCSU. Although the committee acknowledged that there were further improvements to be made it noted and acknowledged the quarterly benchmarking from the Trac provider that placed the Trust

19th out of 182 organisations, with an average processing time for employment checks of 20 weekdays. It was agreed that this quarterly benchmarking data will be incorporated into the Committees KPIs.

DBS Compliance Report
The Committee took assurance from the revised report which highlighted a completion target for the outstanding DBS checks as March 2024. The Trust will be engaging with staff and communications will be shared to highlight the reasons for the request. A progress report has been requested for April 2024.

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.

Workforce Dashboard
The Committee welcomed a live demonstration on the workforce dashboard which has been developed to include additional information which now provides a richer picture of resourcing information across the Trust. It brings together key sets of data such as establishment and actual resourcing numbers, a brake down of reasons for absence, numbers of agency and Bank resources which can all be drilled down to team, shift, past, current & future. The committee commended the information that has been developed and recognised its value in supporting the Trust to deliver on recruitment and performance delivery moving forward.

Workforce Performance Report
The committee reviewed the December and January Workforce Performance reports. There were no areas of concern to raise. The Trust continues to report a positive position in relation to the following:

- KPI's continued to be maintained.
- Vacancy rates are reported below target at 3.13%, this being the lowest reported position in that last 2 years. Statutory and mandatory training compliance have improved and continuously reached the target since March 2023.

Personal development reviews remain below target at 90.6% with 133 staff outstanding and the committee were assured on the work ongoing to address this.

Sickness Performance Deep Dive
The Committee were provided with an overview of the deep dive that has been undertaken into sickness levels across the organisation. The report identified lessons learnt and further areas for improvement which are planned for implementation. The Committee took assurance from the work that has been carried out which had identified opportunities for improvement but also acknowledged that the Trust is already delivering relatively low levels of sickness. The committee agreed to receive quarterly updates on progress against the action plan.

Powys Ward Action Plan
The Committee members received an update on the work that had been carried out, the follow up meeting that had taken place with staff and noted that the action plan was now complete. The committee highlighted the significant work which had been undertaken and improvements that have been made and agreed that the Ward is now functioning as 'business as usual'.

WRES/WDES Q4 Report
The Committee reviewed the report and were pleased to hear that all staff networks have been established all of which are led by a member of the Executive team. The Committee was assured with the contents of the report.

Safe Staffing
The committee received an overview of safe staffing for December and January. Following a request from the January meeting, the Committee received an update on international recruitment in February. It was noted that long term accommodation remains a risk for staff however the short-term accommodation risk is now removed, as there is enough accommodation available for 3 months as included as part of the recruitment package. The committee were pleased to hear that a

'rent a room' request that had gone out to staff has generated a good level of interest.
The Committee noted that the Trust will not succeed in recruiting the full cohort of 18 international nurses by April 24, as 4 individuals have withdrawn their applications. 3 of these vacancies have been filled at short notice but unfortunately 1 of the vacancies has remained unfilled.
The Committee took assurance from both months' reports that the organisation has fulfilled its obligations in relation to Nurse safer staffing.

Nursing Associates Report
At the request of the committee, an overview was provided on the role of the nursing associate and how the role compared to that of a registered nurse. The committee acknowledged the value of this role and how it could support and encourage individuals to progress within their chosen career.

Theatre Workforce Approach
The Committee were provided an update on the work that is ongoing to review the intricacies of roles across the theatre workforce to see what opportunities there could be improve potential and activity. The report on findings will be received at the March committee.

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

e-Rostering and e-Planning Report
The Committee were assured with the report – commending in the Trust for achieving the level 4 targets as planned by the end of December 2023.

EDI Update
The Committee were assured by the work ongoing as highlighted and contained in the reports that are presented to Board.

Chair Report from sub-meetings:

- EDI Meeting (January and February) - the Committee noted the assurance report – no concerns were raised in either January of February meeting.
- Non-Medical Staff Group (January and February) - the Committee noted the assurance report – no concerns were raised in either January of February meeting.
- Chair Report Nursing Staff Safety Group (February) - the Committee noted the assurance report – no concerns were raised.
- Chair Report Joint Consultancy Group (February) - the Committee noted the assurance report – no concerns were raised.

ICS People Committee
Ongoing discussions are taking place in relation to the additional support requested for System meetings and how they link with the Trusts people and workforce agenda. For oversight, the Trust agreed to share a governance reporting structure of meetings with the committee to highlight the current workstream which the teams are supporting. This will be reported to the March committee.

Policy Tracker
The policies for the Committee continue to be tracked and plans are in place for all overdue polices to be presented to the relevant meeting.

Work Experience Policy
The Committee approved subject to the following amendments being incorporated:

- Robust statement on the use of social media
- Strengthened statement in relation to encouraging applicants from underrepresented groups.

The Committee felt the work experience was another opportunity for the Trust to support workforce growth and welcomed an update on the current work experience initiatives in place.

Study Leave Policy The Committee approved the policy.

4.0 Conclusion / Recommendation

The Board is asked to:

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

Freedom to Speak Up Q3 Report

Committee / Group / Meeting, Date

Board of Directors Meeting, 05 March 2024

Author: **Contributors:**

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

Report sign-off:

Paul Kavanagh- Fields, Chief Nurse and Patient Safety Officer
People and Culture Committee, 25th January 2024

Is the report suitable for publication?

Yes

Key issues and considerations:

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

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

Key Points; -

This quarter FTSU has received a total of 14 concerns.

Two concerns were anonymous, both concerns related to attitudes and behaviours issues. There were three patient safety concerns, two worker safety concerns, three concerns with an element of bullying and harassment and three with an element of attitude or behaviours concerns raised were raised this quarter. Out of these concerns, seven of the people who raised their concerns, with the Guardian, required advice and seven concerns were escalated to the appropriate person / department.

Please note that some cases can fit several categories. For example, one case may have elements of patient safety and attitudes and behaviour. The NGO has requested that although this is one case, the concern should be recorded in both categories.

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

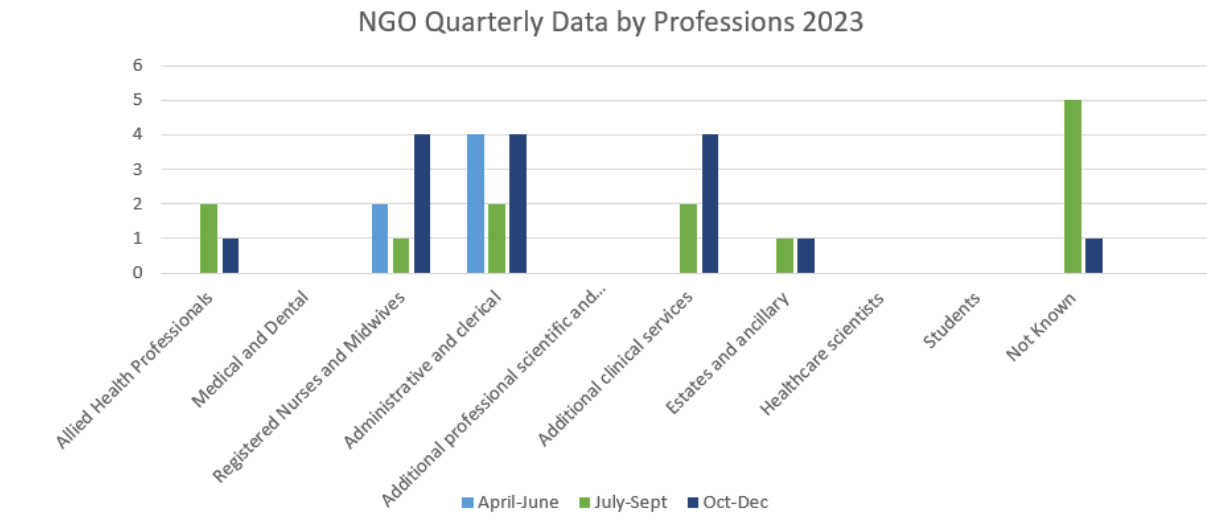
The FTSUG attends monthly regional meetings and events organised by the NGO.

Monthly meeting has been scheduled with the Employment Relations Teams from People service to compare soft intelligence and discuss what and how we can improve cultural behaviours and attitudes and implement improvements.

1.1 **Assessment of cases**

The number of cases raised this quarter has been 14. Graph 1, below, shows the professional groups, as required by the NGO, who have raised concerns. The graph also draws a comparison with the previous 2023 quarters.

Graph 1

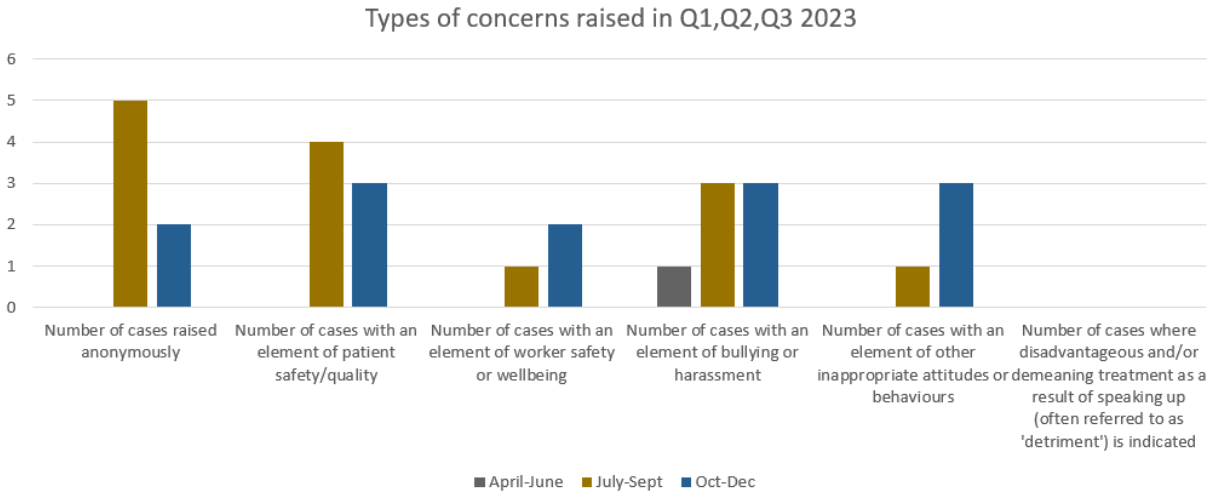


There has been a marked reduction in the number of staff not wanting to state their occupation within the Trust.

Registered Nurses, Admin, and additional clinical services (HCA's) raised an equal number of concerns this quarter.

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

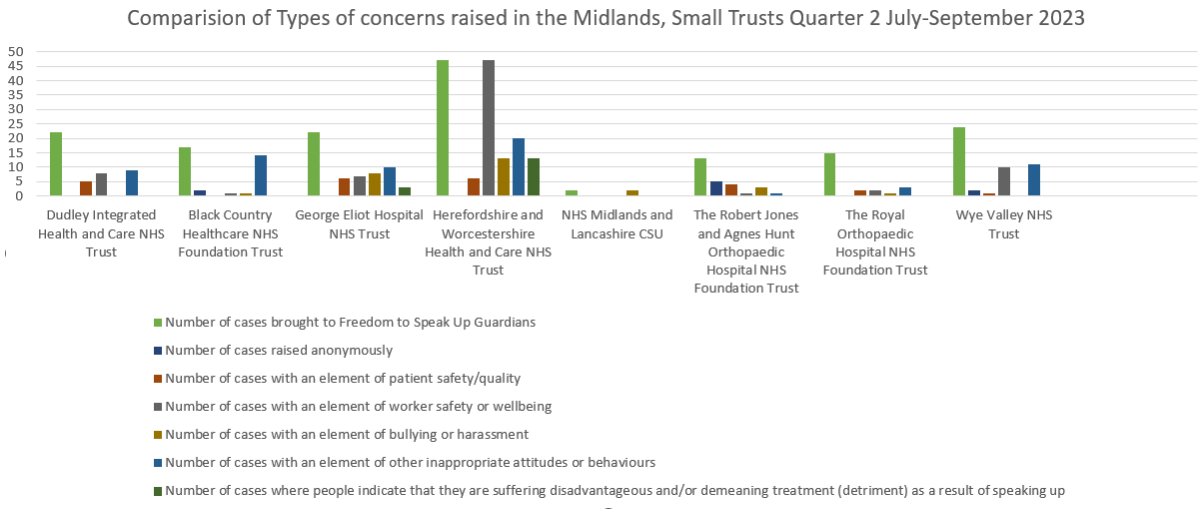
Graph 2



From this graph it is noted that there is an increase in the number of cases raised with an element of inappropriate attitudes or behaviours. An additional three cases of bullying and harassment cases has been raised this quarter.

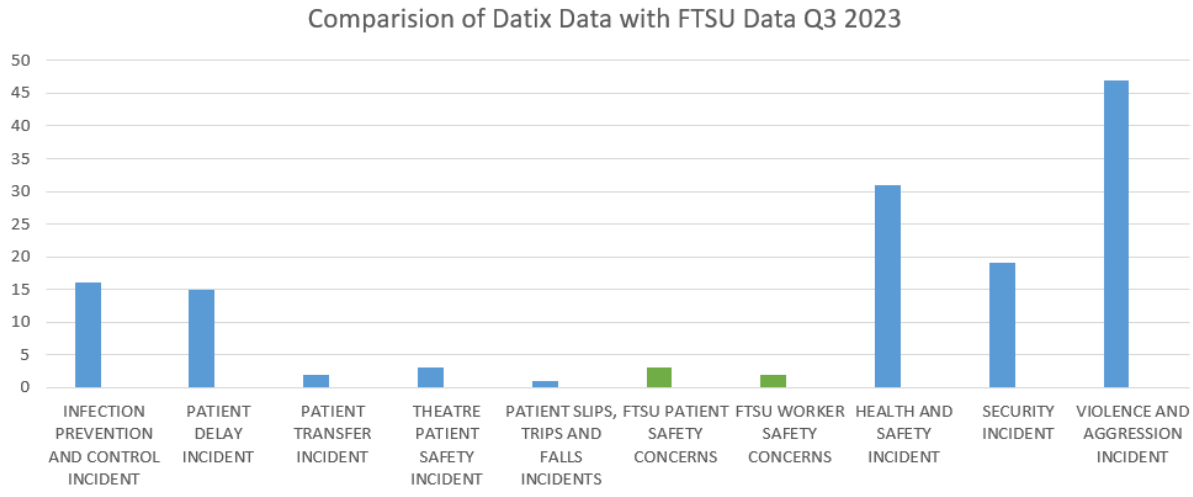
Graph 3 compares some NHS Foundation Trust in the Midlands who are in the small (5,000 and below) category. Please note that the RJAH main comparator for size and acute specialism is The Royal Orthopaedic Hospital in Birmingham. This data is compiled with the latest NGO data available for Quarter 2 July- September 2023.

Graph 3



Graph 4 is a comparison with the RJAH Datix data to the RJAH FTSU data for Q3 October-December 2023. It is difficult to draw any conclusive comparison between the data as the majority of data, especially around violence in the workplace, refers to patients' behaviours towards staff. FTSU concerns are usually concerned with staff-to-staff behaviours and highlighting area for improvements for patient care.

Graph 4



Learning and Improvement

As part of the mandatory training for FTSU, staff are asked to review the latest FTSU Trust policy and find out who their Guardian is in the Trust. Several staff have emailed the Guardian and given positive feedback on the new policy format, saying that they find it easy to read and understand.

In January the process around detriment due to Speaking Up has been highlighted to all staff via Comms and the Equality, Diversity, and Inclusion newsletter. The guidance for the process is available on the Trust intranet, 'Percy', In the resource section, under the sub heading of FTSU Best Practice

Actions

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

Monthly one to one meeting has been arranged with the Lead for EDI and the Employment Relations Team in People Services to compare soft intelligence and discuss what and how we can improve cultural behaviours and attitudes and implement improvements.

Implementation of the Reflection and Planning tool.

Monthly updates about FTSU via Comms.

Recruitment for additional Champions from the staff networks.

Strategic objectives

RJAH has just launch its five-year strategic objectives. FTSU concerns, work towards the delivery of high-quality clinical services by ensuring that the concerns raised around patient care are escalated and improvements introduced where applicable. FTSU empowers departments to encourage staff to Speak up about improvements and ensure that all staff are treated fairly, impartially and in confidence by the Guardian. This supports and contributes to the objectives of the RJAH strategic objectives.

Conclusion

This quarterly paper to the People Committee assures the Committee that the FTSU Data is triangulated against other Trusts and in-house data, concerns are categorised as required by the NGO and analysed against previous quarterly data to highlight where improvement can be made.
The Board is asked to note the paper.

Acronyms

FTSU* =*Freedom to Speak Up

NGO = National Guardian Office

NHS = National Health Service

HCA = Health Care Assistant

EDI = Equality, Diversity & Inclusion

Safe Working Hours: Doctors in Training Q4

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	25 January 2024
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee – 25/01/2024	Paper Ref:	N/A
Forum submitted to:	Board of Directors 05/03/2024	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the January 2024 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. During negotiations on the junior doctor contract, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS (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.

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period October 2023 – Data not updated by HR

Specialty	Contract	Headcount
Orthopaedics	Training posts	18
	Of which Doctors in training on 2016 contract	16
Rehabilitation/Spinal Injuries	Training posts	2
	Of which Doctors in training on 2016 contract	1

3.2.2 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 no exception reports in this period.

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

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

3.2.3 Work schedule reviews

Please see above.

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

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Please see Appendix 1

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Oct 23	1
Nov 23	0
Dec 23	0

Vacant shifts

Oct 23	7
Nov 23	3
Dec 23	8

Total cost - £13650

Medicine

Number of Vacancies (12 posts)

Oct 23	Unknown
Nov 23	Unknown
Dec 23	Unknown

Vacant shifts

Oct 23	25
Nov 23	10
Dec 23	44

Total Cost £37687.50

MCSI

Number of Vacancies (9 posts)

Oct 23	2
Nov 23	1
Dec 23	0

Vacant Shifts

Oct 23	14
Nov 23	4
Dec 23	6

Total cost - £ 5—5.2

Long Term Vacant Shifts

T&O and MCSI currently have no vacancies. No data for Medicine

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 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 requires a diary exercise repeated which will be over a 20-week period to ensure information

is captured for two rota cycles.

TOIL has been provided to address the previous exception report issues. We are awaiting the outcome of the diary exercise.

Job Planning

Actively engaged with HR and Spinal Disorders to ensure job planning and rota's for fellows are appropriate and accurate.

Software System

We still do not have a go live date.

Associated Risk

We need to establish an electronic reporting system.

Next Steps

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

3.4. Conclusion

The Trust has had no exception reports this quarter.

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

Christopher Marquis

Guardian of Safe Working

Gender Pay Gap Report 2023/24

Committee / Group / Meeting, Date

Board of Directors, Wednesday 6th March 2024.

Author:

Name: Amber Scott
Role/Title: **Senior EDI & OD Advisor**

Contributors:

Name: Tina Powell
Role/Title: Workforce Information Lead

Report sign-off:

Name: Carline Nokes-Lawrence
Role/Title: Associate Chief People & Culture Officer

Is the report suitable for publication?:

YES

This report must be reported annually before 30th March.

The report and the required data must be published on the UK Government's gender pay gap reporting service website.

The Trust must also publish pay data on the website in a manner that is accessible to employees and the public, and to ensure that it remains for at least three years.

Key issues and considerations:

The gender pay gap (GPG) reporting regulations came into effect in April 2017, and require organisations in England, Scotland and Wales with more than 250 employees to calculate and publish the pay gap between male and female employees on an annual basis. The regulations apply to both private and public sector employers.

- This pay gap report shows a reduction of 0.11% in the mean hourly pay and a decrease in 0.87% in the median hourly pay from 2022
- Our pay gap exists of 36.15% when expressed as a mean average and 21.08% as a median average, therefore there is more work to do, however this slightly lower than in 2022.
- There is currently a difference of £3.69 in the median hourly rate.

The regulations for public bodies relate to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

All data has been collated from the Electronic Staff Record (ESR) system.

Strategic objectives and associated risks:

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

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	

Recommendations:

It is recommended that the report is reviewed and approved for publication.

Report development and engagement history:

The EDI and OD team have met with the Workforce information team to review and understand the data collated, to allow an accurate report to be produced.

Next steps:

The Board are asked to review the content on the report and approve for publication.

Acronyms and Definitions

Mean

The mean hourly rate is the average hourly wage across the entire organisation so the mean gender pay gap is a measure of the difference between women's mean hourly wage and men's mean hourly wage.

Median

The median hourly rate is calculated by ranking all employees from the highest paid to the lowest paid, and taking the hourly wage of the person in the middle; so the median gender pay gap is the difference between women's median hourly wage (the middle paid woman) and men's median hourly wage (the middle paid man)

Pay Gap

Difference in the average pay between two groups.

Mean Gap

Difference between the mean hourly rate for female and male employees. Mean is the sum of the values divided by the number of values.

Median Gap

Difference between the median hourly rate of pay for female and male employees. Median is the middle value in a sorted list of values. It is the middle value of the pay distribution, such that 50% of employees earn more than the median and 50% earn less than the median.

Mean bonus Gap

Difference between the mean bonus paid to female and male employees. Mean is the sum of the values divided by the number of values.

Median Bonus gap

Difference between the median bonus pay paid to female and male employees. Median is the middle value in a sorted list of values. It is the middle value of the bonus pay distribution, such that 50% of employees earn more than the median and 50% earn less than the median.

Bonus Proportions

Proportions of female employees who were paid a bonus, and the proportions of male employees who were paid a bonus.

Quartile Pay Bands

Proportions of female and male employees in the lower, lower middle, upper middle and upper quartile pay bands. Quartile is the value that divides a list of numbers into quartiles.

Equal Pay

Being paid equally for the same/similar work.

Difference between Gender Pay and Equal Pay

Equal Pay

Equal pay deals with pay differences between men and women, who carry out the same jobs, similar jobs or
work of equal value

Gender Pay

Gender pay gap shows the differences in the average pay between men and women

equality diversity inclusion

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

RJAH Gender Pay Gap Report 2023

Introduction

The gender pay gap (GPG) reporting regulations came into effect in April 2017, and require organisations in England, Scotland and Wales with more than 250 employees to calculate and publish the pay gap between male and female employees on an annual basis. The regulations apply to both private and public sector employers.

The gender pay gap is calculated by taking all employees in an organisation and comparing the average pay between men and women. By contrast, equal pay looks at the difference in men and women's pay for the same or similar work. Gender pay gap calculations are based on employer payroll data drawn from a specific date each year, called the "snapshot" date.

The snapshot date each year is 31st March for most public authority employers. These employers must report and publish their gender pay gap information by 30th March of the following year.

The requirements of the legislation are that employers must publish six calculations:

- average gender pay gap as a mean average;
- average gender pay gap as a median average;
- average bonus gender pay gap as a mean average;
- average bonus gender pay gap as a median average;
- proportion of males receiving a bonus payment and proportion of females receiving a bonus payment;
- proportion of males and females when divided into four groups ordered from lowest to highest pay.

Fostering and supporting a diverse and inclusive workforce is at the forefront of our Trust's plans to be the employer of choice to enable on-going delivery of outstanding patient care. Our organisation is 76% female, **and our results show that like the majority of other NHS organisations we continue to have a gender pay gap.**

This pay gap report shows a reduction of 0.11% in the mean and an decrease in 0.87% in the median pay gap. Our pay gap exists of 36.15% when expressed as a mean average and 21.08% as a median average, therefore there is more work to do. This equates to a difference of £9.12.

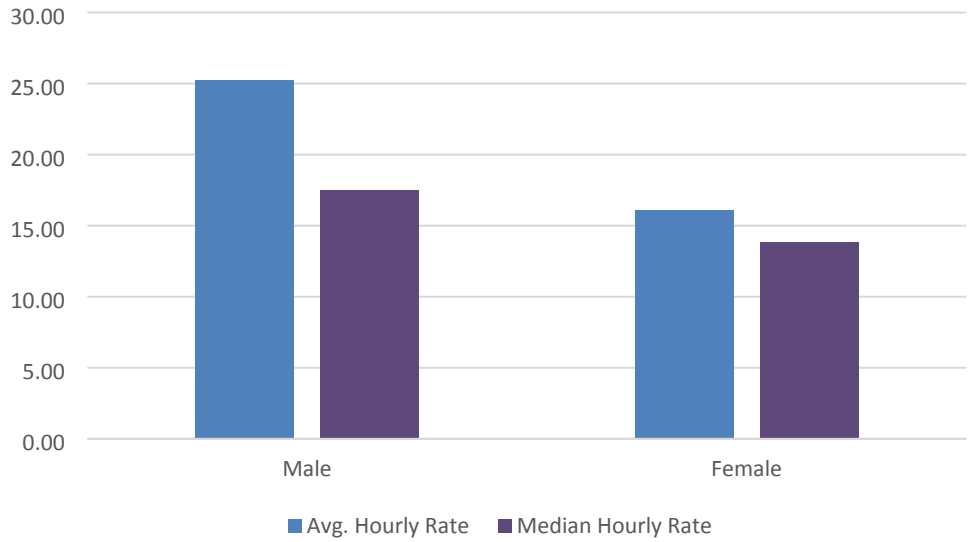
Gender Pay Gap Actions

i) As a Trust we remain committed and driven to support women with their career progression within the organisation. Through the support of our Staff Networks, we aim to ensure representation on leadership, development, and talent management programmes and it is hoped that this will have a positive impact upon the number of women in senior posts within the organisation.

ii) We will continue to support women in making the workplace more equitable through support in returning to work following maternity leave, reviewing the Flexible Working Policy and looking at supporting women with their health issues in the workplace.

iii) We have delivered lots of work on menopause through raising awareness and implementing the Menopause and Hormonal Changes policy, and we will continue to increase opportunities and reduce inequities, so we can become the employer of choice.

Hourly Pay Gap



In the Trust women earn £3.69 per hour less than men when comparing the median hourly rate. Their median hourly pay is 21.08% lower than men's.

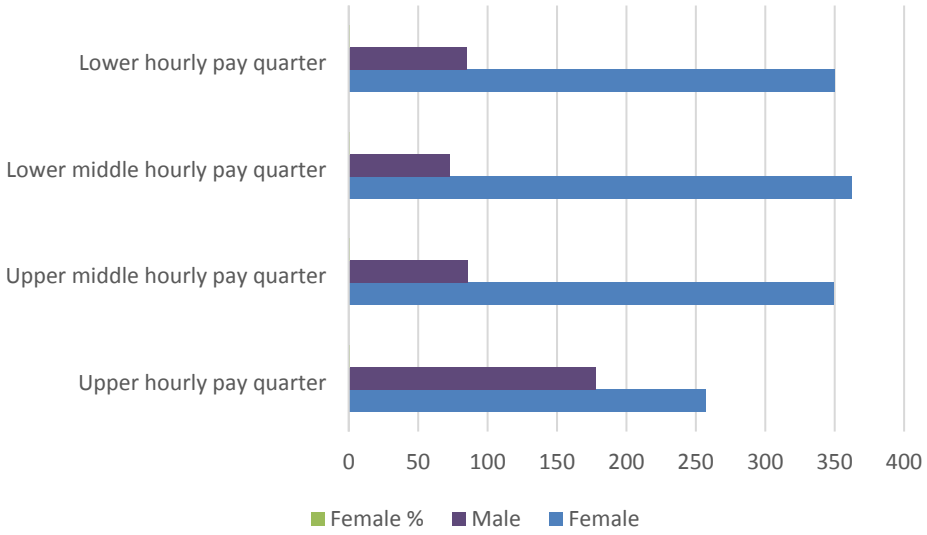
When comparing mean (average) hourly pay, women's mean hourly pay is 36.15% less than men's.

This means that for every £1.00 earnt by men, women earn £0.79.

Median Gender Pay Gap - Hourly Pay.

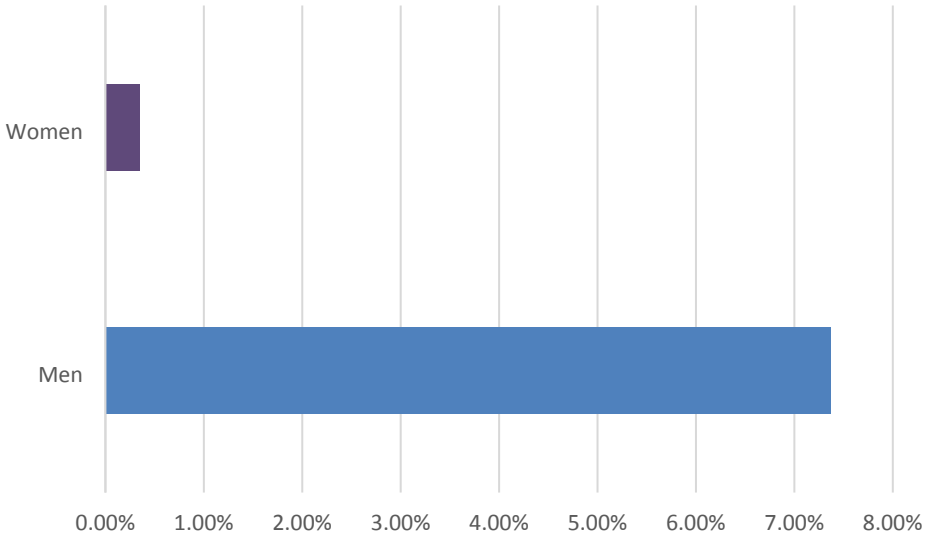
Mean Gender Pay Gap - Hourly Pay.

Percentage of Women in Each Pay Quarter



In the Trust, women occupy 59.08% of the highest paid jobs and 80.46% of the lowest paid jobs.

Bonus Pay Gap



When comparing bonus pay, 0.35% of women received bonus payment, compared to 7.37% of men, although women received 50% more overall bonus pay than men as demonstrated above.

The increase in gender pay gap bonus mean and average is due to female doctor being in receipt of Bronze national CEA award.

Committee / Group / Meeting, Date

Board of Directors, Wednesday 6th March 2024.

Author:	**Contributors:**
Name: Amber Scott Role/Title: Senior EDI & OD Advisor	People Services Team Communications Team Workforce Information Lead Procurement Team

Report sign-off:

Name: Caroline Nokes-Lawrence
Role/Title: Associate Chief People & Culture Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

This report reflects the equality programme of work for staff and patients at, RJAH, during this reporting period and how, as a Trust, we have considered and evidenced our Equality Act and Public Sector Equality Duty (PSED) responsibilities.

The data covers the period 31st March 2023 to 30th March 2024. As part of the Trust's Public Sector Equality Duty (PSED), equality data for staff and patients must be made available to the public via the website, following review and sign off by Trust Board members.

The information is linked to the nine protected characteristics themes under the Equality Act 2010.

Any exceptions have been noted and this information will be included in the annual Equality and Diversity report.

Strategic objectives and associated risks:

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

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	

Recommendations:

It is recommended that the Board review and approve the report.

Report development and engagement history:

The EDI and OD team have engaged with teams across the Trust to gain evidence relating the to the report, to showcase how the Trust is supporting the Equality Duties.

Next steps:

Following approval of the report, this will be published onto the intranet and the Trust website for the public to review.

Acronyms

PSED	Public Sector Equality Duty Report
EDI & OD	Equality, Diversity and Inclusion and Organisational Development

equality diversity inclusion

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

Public Sector Equality Duty (PSED) Equality, Diversity, and Inclusion Annual Report

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

2023/24

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Introduction

This report reflects the equality programme of work for staff and patients at, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, during this reporting period and how, as a Trust, we have considered and evidenced our Equality Act and Public Sector Equality Duty (PSED) responsibilities. We will continue to advance EDI through a range of initiatives, activities and collaborations, which this report will highlight.

The data covers the period 31st March 2023 to 30th March 2024. As part of the Trust's Public Sector Equality Duty (PSED), equality data for staff and patients must be made available to the public via the website, following review and sign off by Trust Board members.

The information is linked to the nine protected characteristics themes under the Equality Act 2010. These nine protected characteristics are:

- Age
- Gender
- Religious belief
- Ethnicity
- Disability
- Marital and Civil partnership
- Pregnancy and Maternity
- Sexual orientation
- Gender Reassignment

Any exceptions have been noted and this information will be included in the annual Equality and Diversity report.

Primary Legislation

Equality Act 2010 and it's Public Sector Equality Duty (PSED)

The Public Sector Equality Duty (The Equality Act 2010 (Specific Duties) Regulations 2011 (legislation.gov.uk)) came in to force in April 2011 (s.149 of the Equality Act 2010) and public authorities like the NHS are now required, in carrying out their functions, to have due regard to the need to achieve the objectives set out under s149 of the Equality Act 2010 to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Act 2010 (Specific Duties) Regulations 2011 require the Trust to:

- Publish information to show compliance with the PSED, at least once a year.
- Produce Equality Objectives at least every four years.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to make sure that an individual's basic needs as a human being are recognised and met. Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act. It is unlawful for a healthcare organisation to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy – known as the FREDA principles.

Read more about The Human Rights Act | EHRC (equalityhumanrights.com).

Associated Legislation

Health and Social Care Act 2022

Statutory obligations on Organisations under the NHS Act 2006 (as amended by the Health and Care Act 2022)

Section 14Z35 of the 2006 Act (as added by section 25(2) of the 2022 Act) imposes the general inequality duty on an Organisation that it: must, in the exercise of its functions, have regard to the need to:

- Reduce inequalities between persons with respect to their ability to access health services.
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3).

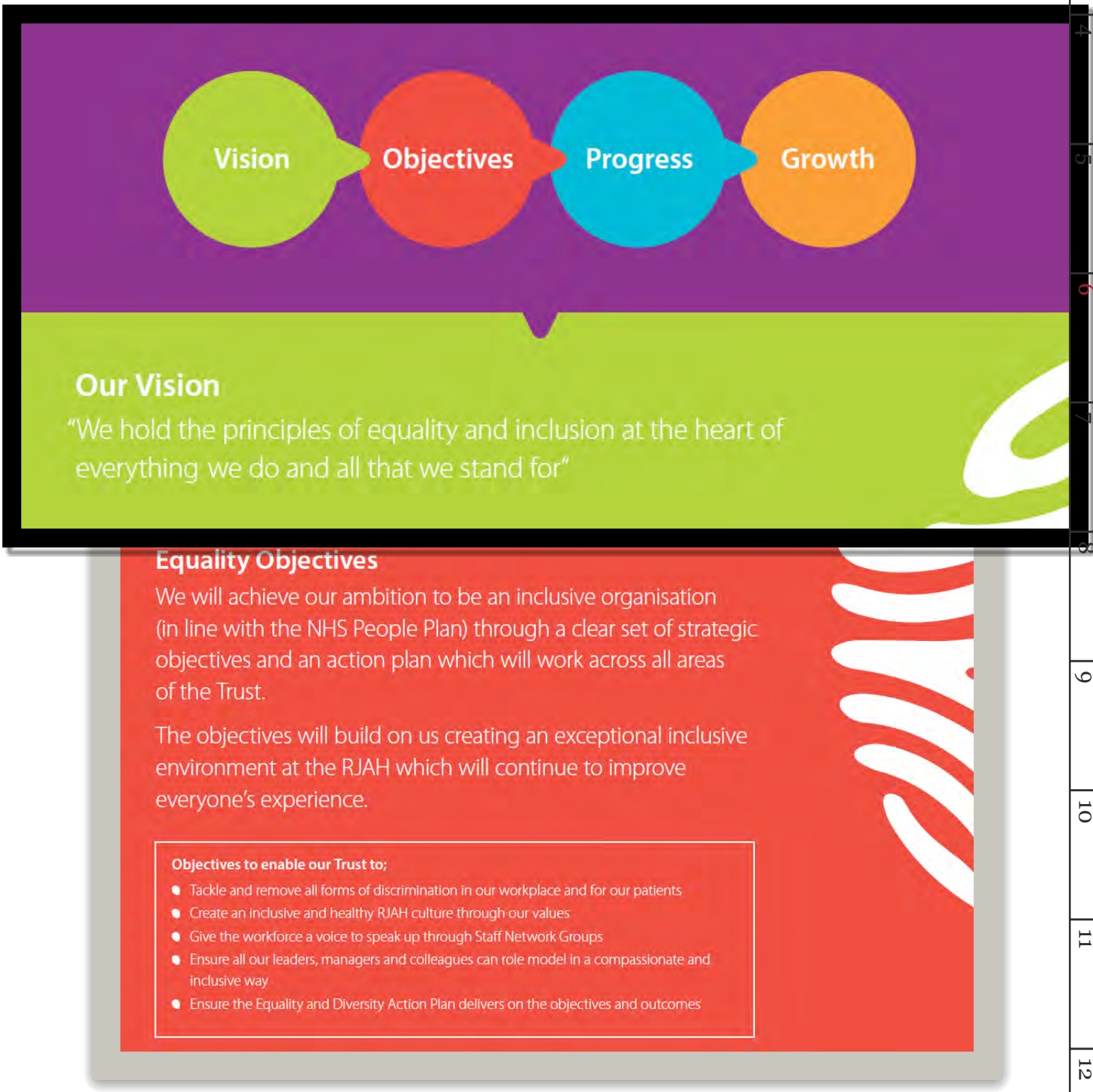
Modern Slavery Act 2015

The Modern Slavery Act 2015 applies to all organisations in the United Kingdom with a turnover of £36 million or above. A key element of the Act is the 'Transparency in Supply Chains' provision, which requires businesses above a certain threshold to produce a 'Slavery and Human Trafficking Statement' outlining what steps they have

taken in their supply chain to ensure slavery and human trafficking is not taking place.

[Trust Response to the Requirements of the Modern Slavery Act 2015.docx (rjah.nhs.uk)](#).

RJAH EDI Objectives 2022 – 2025



Our progress and achievements so far

- Received 52% response for our Staff Survey
- Published WRES, WDES, Workforce Report and Gender Pay Gap report
- Developed EDI mandatory training on e-learning modules
- Used feedback from staff induction to launch a development session in relation to LGBTQ+
- Held Staff listening events to help shape this strategy and a platform for staff to share experiences

How we can grow in this space

- Develop an RJAH EDI pledge
- Develop communication channels for training offers and networking
- Support the SAND project (Safe Ageing No Discrimination)
- Commit to align resources of staff to support the inclusion objectives and actions
- Create an EDI newsletter
- Develop and grow Trust Staff Network Groups
- Involvement in reverse mentoring
- Review the EDI elements of our induction process & leadership programme
- Board Development Sessions

EDS2 Domains

As a Trust we will continue to work to the regulatory NHS measures as required. These are provided in summary below and we will review these against our action plan for the greatest effect on Inclusion at our Trust.

National NHS staff survey

All Trusts are required to undertake the staff survey which is completed during October and November on an annual basis. Feedback can highlight and provide key issues and opportunities, across different teams but also in diverse groups. The staff survey information is used across the Trust in many different ways.

National NHS Frameworks

The Trust is required to work under the Public Sector Equality Duty (PSED) of the Equality Act 2010. One of these requirements is for the Trust to share the content of this report with the public through our ROH website. This information includes:

Workforce Race Equality standards (WRES)
Workforce Disability Equality standards (WDES) standards
Gender Pay gap
EDS 2 framework

Meeting our public sector equality duty

Under the Equality Act 2010 as a public body we have a general public sector equality duty to:

Eliminate unlawful discrimination
Promote equality of opportunity
Foster good relations between people with different backgrounds

Workforce Race
Equality Standard (WRES)

Since 2015, all NHS Trusts have been required to collect and publish data on their progress around delivering race equality for staff.

Workforce Disability Equality Standard (WDES)

Since 2017, all NHS Trusts have similarly been required to collect and publish data on their progress around delivering equality for staff with disabilities and long-term health conditions.

Gender Pay Gap

The mandatory gender pay gap analysis requires us to report workforce data across gender and pay bands and develop an action plan to address any gaps or over/under representation.

Equality Delivery System

The Trust utilises the Equality Delivery System 2 as a performance improvement framework to deliver and monitor our progress against our statutory requirements. NHS providers are expected to use EDS2 to help them improve their equality performance for patients, communities and staff, as well as helping them to meet the Public Sector Equality Duty.

The EDS2 has four goals which are:

- Better health outcomes
- Improved patient access and experience
- A representative and supportive workforce
- Inclusive leadership

RJAH Objectives

In December 2023, the Board of Directors agreed a set of strategic objectives for the period to 31 March 2028. These are summarised below. In January 2024, the Board also agreed a revised risk appetite statement.

The Board Assurance Framework (BAF) – as the expression of risk to the delivery of the Trust's strategic objectives and statutory obligations is continuously reviewed against the revised objectives, taking account of the updated risk appetite.

The Trust agreed the following strategic objectives:

	RJAH Objective	
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre of excellence	✓
3	Integrate MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system:

	STW System Objective	
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	✓

Statutory and Mandated Requirements

The following key reporting tools and mechanisms were used in an annual reporting period:

- NHS Accessible Information Standard
- NHS Equality Delivery System 2023
- Workforce Disability Equality Standard
- Workforce Diversity Profile Report
- Race Disparity Ratio
- RJAH Annual Equality Action Plan
- RJAH Equality Strategy and Objectives
- Gender Pay Gap
- Workforce Race Equality Standard
- PSED Equality Diversity and Inclusion Annual Report
- NHSE EDI Improvement Plan

Throughout this reporting period, we have published legal and mandated information about equality on our dedicated equality webpages and staff intranet pages. We will refresh these webpages and intranet pages as required and review them annually.

Commissioning and Procurement

The Trust procures from a variety of sources and wherever possible it uses Nationally Agreed Framework Agreements. These Frameworks will have been subject to robust procurement processes, including the nationally agreed supplier selection questionnaire, which takes account things such as Modern Slavery, Equality, Diversity & Inclusion in terms of any legislative breaches which may result in the bidder being marked down or rejected. Social Value is also a mandatory requirement in Public Sector Procurement and specific questions will have been included in all Frameworks and can be tailored dependent upon the requirement, based on a set of nationally agreed themes. The Trusts largest contracts are for Orthopaedics which are procured under an NHS Supply Chain Framework.

In a wider context the Equality and Health Inequalities Impact Assessment applies more so to Healthcare Contracting agreements, where the Trust is procuring (or being commissioned) services, none have been required within this reporting period.

Equality Health Inequality Impact and Risk Assessments (EHIIRA)

Equality and Health Inequalities Impact and Risk Assessments (EHIIRAs) are a well-established and embedded tool in the Trust. Using EHIIRAs helps ensure that services, policies and day-to-day functions are fair, accessible and inclusive. Through a process of questions and data analysis, EHIIRAs help to identify gaps and potential risks and highlight opportunities to improve staff and patient, access, experience and outcomes.

EHIIRAs are evidence-based tools, requiring stakeholder engagement. A Stakeholder is an individual or group that has an interest and a say in any decision or activity of an organisation and can include staff, patients, the public, support groups or business partners.

During this reporting period a total of 13 assessments were completed and approved, ranging from Human Resources and Organisational Development (HR/OD) policies to commissioning system-wide services.

Improving Patient Experience and Health Outcomes

The NHSI Learning Disability Standards for NHS Trusts provide a benchmark against which all trusts can measure their performance in delivering services to people with learning disabilities and autistic people, which in turn drives quality

improvement. This is a three-pronged approach:

- Organisational level collection.
- Staff Survey.
- Service User Survey.

This provides a holistic view of the workforce, activity, service models and quality of services provided to people with learning disabilities and autistic people.

The four LD standards are:

- Respecting and protecting rights.
- Inclusion and engagement.
- Workforce.
- Specialist Learning Disability Services.

Current Performance

Standard 1 - Respecting and Protecting Rights

	Improvement Measure	RJAH current practice	
1.	Trusts must demonstrate they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or both can access highly personalised care and achieve equality of outcomes.	• Modified communication tools such as pain scores available • Hospital Passport in use • Double appointment slots offered in outpatient services • Carer's policy and passport to be relaunched	
2.	Trusts must have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services	• No trust wide flagging system available • Radiology have generic flags that can be used on CRIS • Pre-op generate manual pre-op alerts that flag admission of person with LD&A to ward area and CSMs • SG team working with Apollo to create system	

3.	Trusts must have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations.	• Learning from Deaths lead • Mortality and morbidity group	
4.	Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism or both.	• All DOLs reported on Datix • Safeguarding team have created database to monitor and quality check referrals	
5.	Trusts must have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.	• Care of Adults with a LD on admission to RJAH guidelines in place for staff to follow with key information (SOP032)	

Standard 2 - Inclusion and engagement

	Improvement Measure	**RJAH current practice**	
1.	Trusts must demonstrate processes that ensure they work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.	• Signed up to NHS benchmarking project in 2023 that collects feedback from patients with LD&A • Aim to include service users on T&F group once relaunched	
2.	Trusts must demonstrate that their services are 'values-led'; for example, in service design/improvement, handling of complaints, investigations, training and development, and recruitment.	• RJAH core values in place for staff • Complaints policy in place, PALs signpost to Healthwatch for Shropshire outpatients or will visit ward to facilitate complaints process for inpatients • Oliver McGowen mandatory training rolled out November '23 • Values based recruitment	

		• EDI strategy and Staff networks launched	
3.	Trusts must demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers	• Patients not currently involved in reviewing services/pathways	
4.	Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families and carers throughout these processes.	• RCA process in place to identify lessons learnt from mortality reviews and investigations • Complaints policy encourages engagement with complainant • Limited trust wide learning from complaints and incidents at present	
5.	Trusts must be able to demonstrate they empower people with learning disabilities, autism or both and their families and carers to exercise their rights.	• Mechanisms in place for access to advocacy services (Healthwatch) • POL179 to be reviewed to incorporate Best Interest meetings • Not currently able to demonstrate that people's rights are explained to them in a meaningful way – Inpatient survey results to be reviewed '24 • LD&A patients may need improved visiting access for family – needs reviewing re: reasonable adjustments	

Standard 3 – Workforce

	Improvement Measure	**RJAH current practice**	
1.	Based on analysis of the needs of the local population, trusts must ensure staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism or both who access and use their services, as well as those who support them.	• Links to SATH and Community Specialist LD advice • Regular attendance at LeDeR steering group	

		and governance meetings • Improved awareness for RJAH staff required incorporating – Percy page update	
2.	Staff must be trained and then routinely updated in how to deliver care to people with learning disabilities, autism or both who use their services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.	• LD and autism training available- Oliver McGowan training rolled out 2023	
3.	Trusts must have workforce plans that manage and mitigate the impact of the growing, cross-system shortage of qualified practitioners with a professional specialism in learning disabilities.	• Safeguarding practitioner roles in place • Nursing workforce strategy in development • Link with MPFT LD team	
4.	Trusts must demonstrate clinical and practice leadership and consideration of the needs of people with learning disabilities, autism or both, within local strategies to ensure safe and sustainable staffing.	• Links to SATH and Community Specialist LD advice if required. • Designated lead for LD to be identified - Adult safeguarding named nurse starting March '24	

Next steps for the Trust are to encourage the uptake amongst staff to partake in current data collection with 4 staff surveys completed out of a potential 150 within the last reporting period.

A task and finish group will be reinvigorated with clear objectives to improve current practices against the three core standards.

The Trust will continue communicating with Apollo team regarding efficacy of alert system Due to the maturity of the current PAS system the Trust have in place, there is no element to allow recording of patients admitted with learning disabilities or autism. There is an upgrade of the system due to be launched in July 2024, called Apollo, which will allow for such data to be captured and this will be included in future reporting, to note the number of:

- Adult patients admitted with learning disabilities or autism.
- Children and Young People admitted with learning disabilities or autism.
- Ethnic Minority background patients admitted with learning disabilities or autism.

Workforce Diversity Profile and Reporting

We aim to employ a diverse workforce that is representative of our local communities, as we believe this will improve our decision making in the development of health and care services.

This section of the report illustrates the demographics of the Trust' workforce as of 30 September 2023. The Trust will use this data as a baseline to measure the diversity of our staff across the full range of NHS pay grades and in future workforce planning. The table below provides a summary of the key findings.

Protected Characteristic	Narrative
Age	Our highest % age range is between 30 and 65 years, with below 20 years and age 66 - >71 years being our lowest represented age groups.
Sex	Males are considerable underrepresented within our Trust with just 24% of our workforce being male and 76% being female.
Race	The Trust are currently working on declarations of ethnicity through ESR to offer a more accurate reflection of our workforce. 84% of staff are declared as White British with 4% not stating their ethnicity.
Disability	74% of the Trust workforce have declared no disability with a high rate of 18% unspecified. There is an ongoing project to support staff in declaring disabilities through ESR to enable the Trust to support individuals.
Marriage / Civil Partnership	There are only 4 staff who have chosen not to specify their marital status, with 55% being married and 32% being single.
Sexual Orientation	A total of 84% of staff identified as heterosexual or straight. 4% of staff preferred not to state their sexual orientation. With 9% unspecified this makes it difficult to establish if the workforce is representative of the national estimated LGBTQIA+ figure of 3.1% of the population over 16 years of age.

Gender Re-Assignment	This data is not currently captured within the Trust.
Maternity / Pregnancy	A total of 1.66% of the workforce were absent due to maternity leave in March 2023, the position for January 2024 is 2.29%.
Religion / Belief	The percentage of staff who identify as Christian is 52%. Non-disclosure among staff is 11% overall. Atheism is at 16% with other religions and beliefs being low in representation.
Part Time and Full Time Working Arrangements	Age, disability, religion and belief, race, pregnancy and maternity are all determining factors to consider in better understanding the dynamics of full and part-time working arrangements. While ensuring organisational day to day functions are being met. 54% of the Trust workforce are part-time and equality of opportunity should be given to ensure that these staff are afforded the same opportunities as their full-time counterparts.

Recruitment Process Data by Protected Characteristics

Going forward recruitment data will be analysed by protected characteristics on a quarterly basis by the EDI Team. The information provides a breakdown of applicants by protected characteristics and how they fared in the recruitment process. Due to the record retention policy of our current recruitment system Trac, it is only possible to provide data from Quarter 3.

During October to December 2023 (Quarter 3)

Protected Characteristic	Applicants	Shortlisted	Interviewed	Appointed
Age	137	36	20	6
Sex	137	36	20	6
Gender Re-Assignment	0	0	0	0
Marriage / Civil Partnership	132	32	16	2
Maternity / Pregnancy*	N/A	N/A	N/A	N/A

Disability	6	4	2	0
Race	80	5	0	0
Religion / Beliefs	115	24	12	2
Sexual Orientation	130	31	16	2

As this is the first time the Trust has produced and published this information, no clear messaging, analysis or comparisons can be drawn from this first set of data. It should be used as a baseline for identifying any future trends where potential disparities between certain protected groups may exist during the recruitment process, where any such disparities might be mitigated or rationalised.

Although we have recruited 25 international nurses since March 2023, the recruitment process has been completed via an agency and therefore data is unable to be captured via our internal program.

*Maternity / Pregnancy data is not currently collated using our current system.

Workforce Race Equality Standards 2023 (WRES)

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).

View our Workforce Race Equality Standard (WRES) - RJAH here.

Workforce Disability Equality Standards 2023 (WDES)

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 2023. 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.

View our Workforce Disability Equality Standard (WDES) - RJAH here.

Gender Pay Gap Reporting 2023

We can use the results of this Gender Pay Gap report to assess:

- The levels of gender equality in our workplace.
- The balance of male and female employees at difference levels.
- How effectively talent is being maximised and rewarded.

Through analysis of the report's findings the requirement from NHSE is to reduce any gender pay gap. However, the gender pay gap should not be confused with equal pay. Equal pay deals with the pay difference between male and females who carry out the same jobs, similar jobs, or work of equal value.

It is unlawful to pay people unequally because of their gender. The Roberts Jones and Agnes Hunt Hospital NHS Foundation Trust supports the fair treatment and reward of all staff irrespective of gender or any other protected characteristics.

The gender pay gap shows the difference between the average (mean and median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is valuable tool for assessing levels of equality in the workplace, female, and male participation, and how effectively talent is being maximised.

If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those areas are. In some cases, the gender pay gap may include unlawful inequality in pay, but this is not necessarily the case.

	Average and Median Hourly Rate					
	Average Hourly Rate	2023	2022	Median Hourly Rate	2023	2022
Men		25.24	24.25		17.49	16.84
Women		16.11	15.46		13.80	13.14
Difference		9.12	8.79		3.69	3.70
Pay Gap (%)		36.15%	36.26%		21.08%	21.95%

Number of Employees (Q1 = Low | Q4 = High) Highest rate of pay at 31/03/2023

Quartile	Female	Male	Female %	Male %
1	257.00	178.00	59.08%	40.92%
2	362.00	73.00	83.22%	16.78%
3	349.00	86.00	80.23%	19.77%
4	257.00	178.00	59.08%	40.92%

Bonus Pay Figures at 31/03/2023 (CEA's)

	Average Pay	Median Pay
Male	8982.71	6032.04
Female	15230.81	9048.00
Difference	-6248.10	-3015.96
Pay Gap %	-69.56%	-50.00%
	Employees Paid Bonus	Total Relevant Employees
Female	5.00	1435.00
Male	33.00	448.00

The increase in gender pay back bonus mean and average is due to a female doctor being in receipt of Bronze National CEA award.

Grievance, Disciplinary & Capability Issues

The data below shares the formal cases from March 2023 to March 2024, only the protected characteristics identified within each case have been presented for ease of review. The Human Resources team within People Services continue to monitor the cases received and review any anomalies or areas of concern, ensuring continuous support is offered to those involved.

Grievance Disciplinary Capability	Open Closed	Gender	Race/Ethnicity	Age Band	Religion/Belief	Sexual orientation
G	**C**	F	White - British	36-40	Christianity	Heterosexual
G	**O**	Coll	Coll	Collective	Collective	Collective
G	**C**	F	White - British	36-40	Christianity	Heterosexual
C	**C**	M	White - British	56-60	Unspecified	Unspecified
D	**C**	F	White - British	26-30	Other	Heterosexual
D	**C**	F	White - British	46-50	Christianity	Heterosexual
D	**O**	F	White - British	31-35	Unspecified	Unspecified

D	**O**	F	White Welsh	51-55	I do not wish to disclose my religion/belief	Heterosexual
D	**O**	F	White - British	31-35	Christianity	Homosexual
D	**O**	F	White - British	36-40	Atheism	Heterosexual

Leavers and the reasons for departure

The Trust continually review leavers data to analyse any patterns or trends, and to put additional processes in place to support staff in alternatives to leaving. PDR compliance is monitored monthly by Committee to ensure that staff are in communication with their managers and to support in any areas of concern or any areas of learning and development. Regular catch-up meetings between managers and their teams are also encouraged on a regular basis ensuring that motivating the workforce continues to be a focus with particular emphasis on stay conversations to explore development and motivation of our people as a priority of the HR and wider People Services team.

Leaving Reason (Leavers March 23 to January 24)	Headcount
Death in Service	1
Dismissal - Capability	3
End of Fixed Term Contract	25
End of Fixed Term Contract - Other	1
Flexi Retirement	13
Retirement Age	22
Voluntary Early Retirement - no Actuarial Reduction	1
Voluntary Early Retirement - with Actuarial Reduction	1
Voluntary Resignation - Adult Dependants	2
Voluntary Resignation - Better Reward Package	2
Voluntary Resignation - Child Dependants	2
Voluntary Resignation - Health	8
Voluntary Resignation - Incompatible Working Relationships	1
Voluntary Resignation - Lack of Opportunities	4
Voluntary Resignation - Other/Not Known	26
Voluntary Resignation - Promotion	9
Voluntary Resignation - Relocation	13
Voluntary Resignation - To undertake further education or training	8
Voluntary Resignation - Work Life Balance	21
Grand Total	163

The data should be seen in the context of the continued return to a more 'normal' labour market after the disruption of Covid in 2020-2022.

The data reflects that since April 2023 there has been more resource, and more focus on absence and performance management, likely to have had a push effect on staff leaving, and voluntarily resigning, as alternatives to participating in formal management processes.

The national staff turnover rate for the NHS was 8.1% in August 2023. Staff turnover in RJAH in August 2023 was 10.22% before falling to 8.02% Trust wide in January 2024. This in turn has mirrored a reduction in vacancy rates.

The vacancy rate has fallen from 10.69% at year-end 2022/2023 to 3.13% in January 2024. Renewed focus on recruitment, and increased resource, allied to actions from the People Services team has supported progress in this area.

Managers are continually encouraged to be flexible with staff retiring and returning, supporting implementation of aspects of the NHS's People Plan.

As of January 2024, the Trust has 136 staff on fixed term contracts, this is a rise from 114 staff on fixed term contracts at year end 2022/2023.

Where the data is opaquer is the number of voluntary resignations for the category 'other/not known' which will be the focus of further review and refresh around exit interview process.

RJAH Equality Policy

The Equality, Diversity and Inclusion Policy and its impact on equality have been reviewed in consultation with the trade union and other employee representatives in line with an Equality Impact Assessment. The purpose of the assessment is to minimise and, if possible, remove any disproportionate impact on employees on the grounds of race, sex, disability, age, pregnancy and maternity, marriage and civil partnership, gender reassignment, sexual orientation, religious or other belief.

The Trust is committed to embedding equality, diversity, and inclusion across the organisation rather than it being viewed as an isolated agenda. Ensuring that fair treatment and social inclusion is at the heart of what we do and how we do it.

Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and, the extent to which they feel valued and included.

The Trust is committed to providing a working environment that is welcoming, inclusive, respectful and is free from unlawful discrimination. We have implemented our Equality Strategy and Action Plan to support with this and to making positive changes within the Trust.

View the full policy here, Equality, Diversity & Inclusion Policy - Percy (interactgo.com).

RJAH Staff Networks

During 2023/24, staff networks were established to provide a platform for staff to support, express and voice a range of experiences. Information and feedback from these network groups progress through the governance process with the aim of influencing Trust policies, procedures and day-to-day functions. Each network has an Executive Sponsor, and a small budget for the year. All the network groups welcome allies to attend the meetings

Disability and Neuro-diverse Staff Network

Bio of the Staff Network Chair

> "We wish to inform all staff that effective help is available and ensure it is provided. Awareness is key."

"Hello I'm Ellie.

I am an apprentice Health Care Assistant and the chair of the new Staff Disability Network. I have a huge passion regarding equality and diversity and especially when it comes to visible and invisible disabilities.

I love my job, it has always been my dream to help others, provide support and learn new skills.

Despite there being principles regarding equality and diversity, there are often gaps that can lead to personal and professional limits.

I have epilepsy, and through experience I have faced discrimination, generalisation, and stereotyping when it comes to my own and other people's disabilities. Having epilepsy is not a definition of who I am, in fact, I live with my lovely wife and will never turn down a mocha! It can however influence how others see me.

I want to work with other staff members to patch up those missing gaps, minimise limits and promote equality of opportunity for all staff with conditions and disabilities. Everyone is different."

The network has been successful in encouraging more staff to attend the meetings and to communicate outside of the meetings, building support networks and safe spaces to gain advice or somebody to listen.

During the short time the network has been established, funding was sought to run an Event called ‘This is Me’, to encourage staff to have the confidence to be who they are and to speak up if reasonable adjustments are required or additional support is needed. The event saw 3 guest speakers attend on the day and several charities offering advice and support. The aim of the event was to build confidence in staff, to raise awareness and to raise the disability declaration rates of the Trust.

Additionally, to this, many actions have been progressed, to implement the following.

- One Page Profiles.
- Sound eliminating Headphones available to all staff.
- Wellbeing portal to be established.
- Support network and safe space to be open.
- Funding for the network to attend training or events to develop.

In the future the network wish to continue expanding and offering support to as many staff as possible. A parent network has been suggested as a separate space to offer advice and support to parents with disabled and neuro-divergent children.

Ethnic Diverse Staff Network

Bio of the Staff Network Chair

“I have a vision to foster better acceptance of diverse cultural characteristics.”

“It is a privilege to work in this top-class hospital and with such wonderful people.

I come from Bombay, a true melting pot of the diverse cultures of the Indian sub-continent. Having grown up in such rich ethnic diversity, I came to understand the beauty this brings to life.

I was fortunate to experience working in Saudi Arabia before coming to the United Kingdom. This further made me understand how we belong to “one world”.

I am deeply interested in human origins, cultures, history. This has shown to me a common thread of human aspirations, expectations, and desire for happiness.

RJAH has always had strong international relations and has increasingly attracted staff from all over the world. The current workforce is represented by a large number of staff from ethnic minority.

Being an overseas trainee myself, I fully empathise with those who try to integrate with the local population and struggle to make a life in the UK.

Many times, difficulties in them progressing and giving their best to patients can be traced to a lack of understanding of diverse cultures. Ultimately it is the patient then who suffers in such an uncomfortable work environment.

Barriers in communication can affect both the ethnic minorities and majorities as well.

I have a vision to foster better acceptance of diverse cultural characteristics. I can do this by representing staff from diverse cultures. I am sure you would feel comfortable in opening out to me with your experiences. I would be grateful if all of you would attend the monthly meetings for discussion in an open environment and meet me anytime during other times.

Apart from these, I will try to come and meet as many of you as I can to hear your experiences and suggestions for improvement.

I am sure your involvement in my vision would make this wonderful hospital and even happier place to work."

As a newly established network the Trust are working with staff to create a framework for the group so that there is a Trust and assurance that should issues be raised, these will be dealt with and actioned following process and procedure. The network members have been open and honest with issues that are ongoing within the Trust and actions will be taken to resolve these, although there is a mutual understanding that some areas of concern will take time.

Moving forward further and more detailed Communications are to be shared with all staff to gain further engagement from the workforce, to enable diverse discussions that include all staff areas.

LGBTQIA+ Staff Network

"It would be my hope that together we can shape the Forum into something that meets all our needs as LGBT Health and Social Care workers, mixing together interactive information and support meetings with enjoyable social evenings." Paul Kavanagh-Fields, Chief Nurse, Chair of the LQBTQIA+ staff network.

Our LGBTQIA+ staff network launched in January 2024, with good engagement across the Trust. As the network is in it's initial stages improvements and actions are undergoing discussions. One focus for the network is to raise awareness and understanding of the SAND Covenant the Trust signed up to in 2023. Staff are being encouraged to review the training to allow more open discussions and a better awareness of the difficulties the community may face, and to create stronger allyship moving forward.

Menopause Staff Network

Our Menopause staff network has now been running for 5 months, meeting monthly to discuss any concerns or improvements staff would benefit from. Additionally, we have regular guest speakers attending the meetings to offer advise on various subjects.

Guest Talks;

- Menopause & Diet – Trust Dietician
- Pelvic Support – Trust Physiotherapist
- Sanitary Products – Hey Girls founder

The network has made several improvements to support staff across the Trust, with further sanitary products due to be included in free sanitary product boxes for all staff and the Estates and Facilities team taking over the stock of this. Further information and resources are now available via Percy to support staff outside of work. The network have also secured funding of £300 to support with further training, or initiatives throughout the year.

It is key for all of the Trust staff networks to have a Chair in place who will set an agenda and be a point of contact for any issues to be raised. The EDI and OD team will continue to promote the opportunity to be the Chair which will also allow for further engagement with the wider system.

Human Resources, Organisational Development and Inclusion

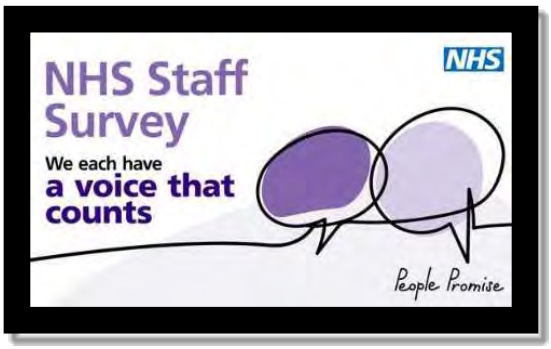
In March 2023 the Trust held Listening Events to gain insight to what our staff wanted to form part of our EDI strategy, the interactive sessions allowed our staff to have a voice and feel included in the decision making of the Trust. Alongside this staff have had access to various support and communication mechanisms including:

- Sexual Safety Charter - Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or

harmful sexual behaviours within the workplace and to take appropriate actions.

- Freedom to Speak Up Guardian. More information on how staff are being supported in the Trust.
- SAND Training – Safe Ageing No Discrimination, LQBTQIA+
- Oliver McGowan Training
- Manager's Briefings – Held hybrid with the Chief Executive Officer and Exec Team to update senior management on any changes or information required to share with staff further.
- Question Time – Held hybrid with the Chief Executive Officer and Exec Team to update all staff on any changes or information required to share with staff further.
- Chat with Harry – Meetings held face-to-face with the Chair to discuss any issues or concerns.
- PDR Training – To raise awareness of the importance of having regular conversations and catch-ups with your team and to support in any further training or changes required to support in their work.

NHS Staff Survey 2023/24



The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust had an overall response rate of 52.3% (907 respondents from an eligible 1742 staff). The average response rate for similar organisations 51.7 %. Everyone will own the Action Plan for the Staff Survey, with Staff Survey discussions being a new standing item on the EDI formal meeting each month. The data is currently being collated and analysed and will be published and presented to all staff, these actions will be added to the Trust EDI Action Plan which will be presented to the People and Culture Committee which will have oversight of the document and gain assurance on progress.

Accreditations

SAND Covenant - RJAH signed a covenant with the charity, committing to understand and respond to the needs of older LGBTQIA+ people in Shropshire, Telford and Wrekin.

The covenant consists of five pledges, which we have committed to at RJAH.

The pledges are:

- Providing the best possible quality services for older and old LGBTQIA+ people;

- Learning what life can be – and has been – like for different LGBTQIA+ people;
- Vocally and visually supporting groups working with and for older and old LGBTQIA+ people;
- Creating meaningful opportunities for LGBTQIA people and groups to influence;
- Assessing and evidencing change, including work carried out to engage with LGBTQIA+ people.
-

Data Quality Provider - The Trust celebrated after being named as a National Joint Registry (NJR) Quality Data Provider, after successfully completing a national programme of local data audits.

This is the fifth year running that The Robert Jones and Agnes Hunt Orthopaedic Hospital has been awarded as a Quality Data Provider, which was introduced to offer hospitals a blueprint for reaching high-quality standards relating to patient safety.

NHS Exemplar Trusts Programme for Catering - following a national independent review of hospital food, where the team was recognised as one 21 NHS Trusts in the country to be hailed as exemplar. The Catering Team at the Trust are responsible for providing and serving meals to inpatients, as well as the day to day running of the onsite restaurant, Denbigh's.

NHS Pastoral Care Quality Award - International recruitment efforts and commitment to providing gold standard quality pastoral care at Shropshire's specialist orthopaedic hospital was recognised by a prestigious national award from NHS England.

Launched in March 2022, the NHS Pastoral Care Quality Award – which aims to standardise the quality and delivery

of pastoral care internationally educated nurses and midwives across England – was presented to the team at The Robert Jones and Agnes Hunt Orthopaedic Hospital.

Neuromuscular Team Centre of Excellence Award from MDUK - Our Neuromuscular Centre received a prestigious Centre of Excellence award from leading national charity Muscular Dystrophy UK.

The charity who supports more than 110,000 children and adults in the UK living with one of over 60 muscle wasting and weakening conditions awarded the team for providing outstanding care, promoting best practice locally and nationally and demonstrating their commitment to improving health and care for people living with muscle wasting and weakening conditions.

Veteran Aware - We're a member of the Veterans Covenant Hospital Alliance (VCHA) - a network of over 20 NHS hospitals that have volunteered to share and drive the implementation of best practice for those who service or have served in the UK Armed Forces, and their families, in line with the Armed Forces Covenant.

- We are committed to applying the Armed Forces Covenant and giving special consideration where appropriate.
- Staff should be able to explain the health commitments of the Covenant.
- All relevant staff will be trained and educated in veteran needs.
- Staff will ask patients if they or a close family member serve or have served in the UK Armed Forces, so we can best support their care needs and refer to other services.

GIRFT - 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 is another positive confirmation of that. It is endorsed by the Royal College of Surgeons, which is another marker of its value and importance.

Initiatives

- Free Sanitary Products for all staff
- Free breakfast for all staff
- Denbigh's Lunch Deal
- Money Matters financial education session
- Money Matters financial education 121 sessions
- Free tea, coffee, milk, and sugar to all departments
- Free staff car parking continues
- Bank that bonus (although now ended)
- Bank weekly pay

Equality Statement

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHSFT embraces diversity, equality and inclusion and our aim is to be diverse in age, gender identity, race, sexual orientation, physical or mental ability and ethnicity.

We are committed to ensuring disabled workers aren't disadvantaged when applying for and doing their jobs and offer an interview to all applicants with a disability who meet the minimum criteria for the advertised post. Reasonable adjustments under the Equality Act 2010 will be considered upon request.

EDI Staff-related Training and Development Opportunities

- RJAH Leadership Programme
- Improvement Advocates
- Access to Oliver McGowan Training
- Partner on the Diversity in Healthcare Programme 2023/24
- Freedom to Speak Up Training
- PDR Awareness
- Holistic Skills Academy
- Human Factors Training

Following the recent successful award from NHSE in relation to WDES innovation funding, we have set-up 3 training sessions to be run during Neuro-Diversity Celebration week.

- Neuro-Diversity Awareness Training – A webinar open to up to 100 participants, to support in raising awareness and understanding, aimed for all staff.

- Disability Awareness Training – A 3-hour session open to up to 20 participants, aimed at senior managers to support their teams and the overall workforce.
- Neurodiversity and Autism Awareness Training – A 3-hour session open to up to 20 participants, aimed at senior managers to support their teams and the overall workforce.

The below identifies access to non-mandatory training, continuing professional development and other learning opportunities, supporting our staff in development and career progression.

Staff group	Successful	Unsuccessful	Total number of applications
Study Leave (non-medical staff)	55	7	62
CPD (Registered health care professionals)	86		86
Medical study Leave (Consultants and Medical Doctors)	325		325
Total Number of applications	**466**	**7**	**473**

Communications and Involvement

Patients and the Public

RJAH communicates regularly with patients and the public in a variety of ways:

- Social media
- Website
- Patient Participation Group
- Surveys

RJAH has social media profiles on the following platforms:

- Facebook: @RJAH.NHS
- X (formally Twitter): @RJAH_NHS
- Instagram: @rjah_nhs
- LinkedIn: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- YouTube: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Staff

SAND Covenant

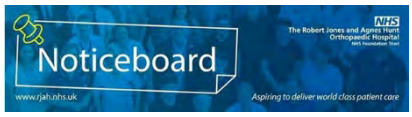
RJAH signed Safe Ageing No Discrimination's (SAND) covenant, committing to understand and respond to the needs of older LGBTQIA+ people in Shropshire, Telford and Wrekin.

SAND are a community organisation who aim to improve the experiences and lives of the ageing LGBTQIA+ community across the county.

Following signing the covenant, RJAH launched dedicated training for staff to open their hearts and minds to the issues the ageing LGBTQIA+ community face. The training included appropriate questions, how best to phrase language and pronoun use. Following the training, staff felt like they can effectively signpost and support colleagues to the relevant resources, and also help colleagues embrace more supportive language and questions.

Sexual Safety Charter

As a Trust, we committed our support to the Sexual Safety Charter launched by NHS England. This means we commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace and to take appropriate actions.

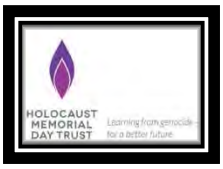


Regular Staff Messaging

Email messages are sent out from the Communications Team, on average three times a week, to keep staff updated on news and topics from across the Trust. These messages are also shared with staff via the closed Staff Facebook group, intranet and through briefings known as Question Time (for all staff) and Managers' Briefing (for managers).

Some of the EDI events and themes the Trust has shared information with staff includes (but not limited to):

- Nutrition and Hydration Week
- Easter
- Pride Month
- Armed Forces Week and Reserves Day
- Freedom to Speak Up Month
- Time to Talk Day
- Race Equality Week
- A series of religious festivals such as Bodhi, Diwali, Hanukkah and more



Intranet The RJAH staff intranet – Percy – is a digital resource which holds a wealth of information, including articles, events and useful resources, on topics such as health and wellbeing and equality diversity and inclusion.

RJAH Priorities 2023/2024				
Reference	**Action**	**By When**	**Comments/ Updates Outside of the Meetings**	**Status**
Growing for the Future	High Potential Scheme with SSOT	**Year 1**	*Cohort 2 successfully received placements.*	COMPLETED
Growing for the Future	Promotion of Visible Leaders Network (VLN) for BAME Staff Leaders	**Year 1**	*Promoted regularly on Staff comms.*	ONGOING
Growing for the Future	Development of Staff Networks	**Year 1**	*All networks have Exec Sponsor, still need Chairs for Menopause and LGBTQIA+.*	ONGOING
Belonging in RJAH	Inclusion for all, not just protected characteristics	**Year 1**	*Inclusion Strategy Action plan refers to support for staff.*	ONGOING
Belonging in RJAH	Implementing Staff surveys for our people	**Year 1**	*Completed for 2023, await outcomes in Feb/March 2024.*	ONGOING
Belonging in RJAH	A Trade Union/Partnership forum	**Year 1**	*In place.*	COMPLETED
Belonging in RJAH	Creating, Reviewing and extending our Vision and values	**Year 1**		ONGOING
Looking after our People	A coherent approach to our people's wellbeing	**Year 2**		
Looking after our People	Provision of support for caring responsibilities and elder care or childcare	**Year 2**		

New ways of working and strategic workforce planning	A set of key workforce metrics for all employee groups	**Year 1**	*IPR set up and KPI's regularly monitored through focus groups and assurance sought from People & Culture Comm.*	COMPLETED
New ways of working and strategic workforce planning	We will have a consistent approach to the provision of high-quality Occupational Health services	**Year 2**	*Regular monthly meetings with current provider Optima.*	ONGOING

Trust Board - Performance
January 2024 – Month 10

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.

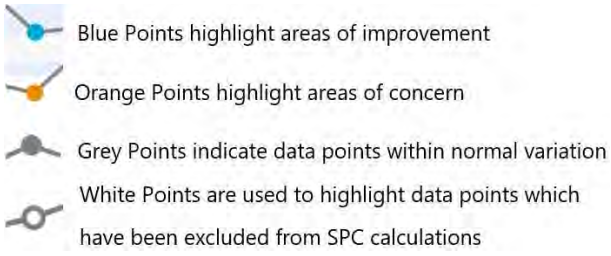
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

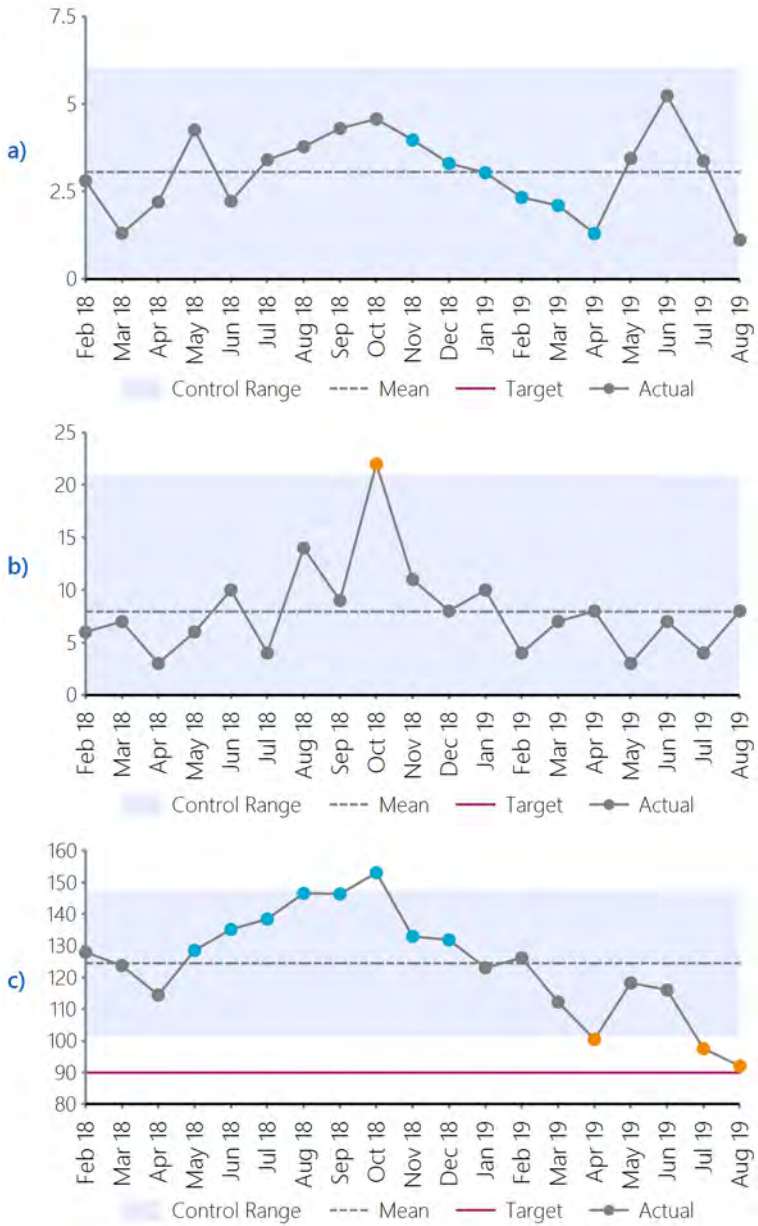


Some examples of these are shown in the images to the right:

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
31 Day General Treatment Standard*	96.00%	100.00%			P		
62 Day General Standard*	85.00%	100.00%			?		
28 Day Faster Diagnosis Standard*	75.00%	97.22%			?		12/09/23
18 Weeks RTT Open Pathways	92.00%	46.45%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,284	927	L	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,049		H	No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	14	0	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		249		L	No Target	+	
Patients Waiting Over 104 Weeks - English	0	0		L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		66			No Target	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Overdue Follow Up Backlog	5,000	9,925				+	
6 Week Wait for Diagnostics - English Patients	85.00%	78.22%				+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	87.10%				+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,299	1,032			Moving Target	+	24/06/21
Overall BADS %	85.00%	83.73%			?		
Total Outpatient Activity against Plan (volumes)	16,076	14,237			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	5.00%	4.12%			Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,646	2,629			Moving Target		

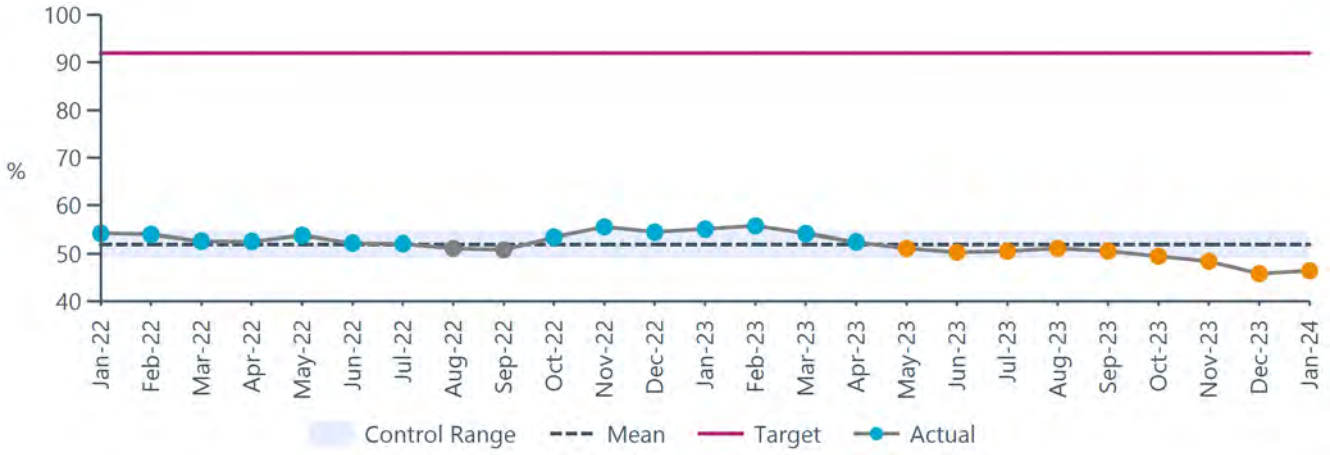
18 Weeks RTT Open Pathways

% 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%	46.45%	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 January performance was 46.45% 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 – 7612 patients waiting of which 2787 are breaches
* MS2 - 1559 patients waiting of which 1121 are breaches
* MS3 - 5558 patients waiting of which 3979 are breaches

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

The Trust is still working with the 2023/24 operational planning guidance. Industrial Action, Operational pressures and ongoing Estates works have impacted original delivery plans. The original guidance stipulated:
* 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 .
We expect 2024/24 planning guidance imminently.

Actions

Planning assumptions for 2023/24 included increases in capacity throughout the year aligned to productivity, workforce and estates programmes of work. Delivery of activity levels has continually been monitored within the Trust against these programmes of work. Planning for 2024/25 has begun, this includes demand and capacity assessments of our services.

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

The Trust is supporting the System to address waiting list pressures. The Trust accepted 72 long wait patients from Shropshire Community and is supporting Shrewsbury & Telford Hospitals by providing Elective Orthopaedic Theatre capacity. Industrial Action impacts continue to be monitored with clinically urgent and long waits being prioritised, where possible, during the periods.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
55.09%	55.74%	54.18%	52.44%	51.12%	50.33%	50.55%	51.15%	50.57%	49.49%	48.43%	45.84%	46.45%

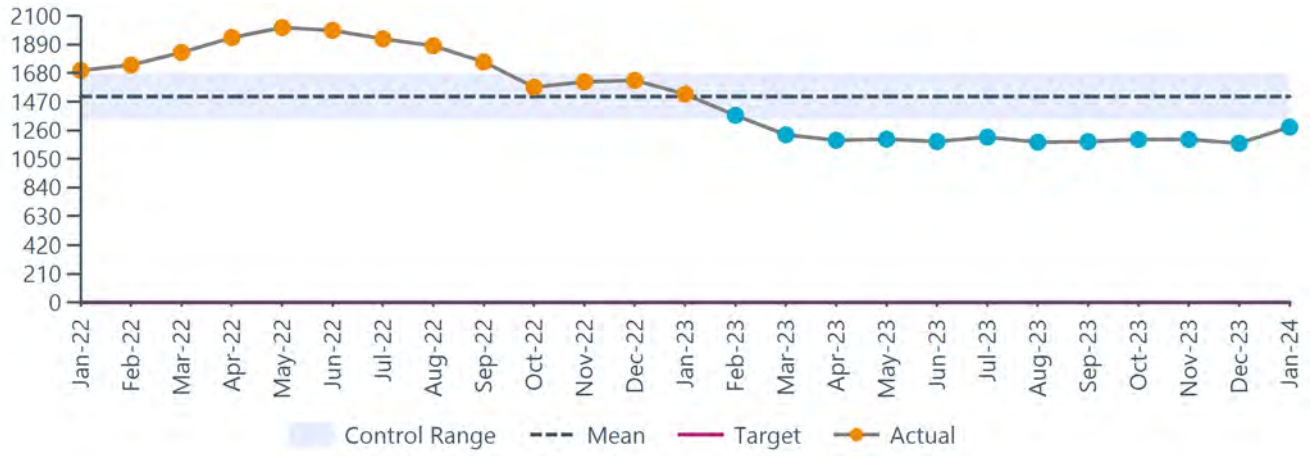
Patients Waiting Over 52 Weeks – English

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	1,284	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 January there were 1284 English patients waiting over 52 weeks; above our trajectory figure of 927 by 357. The patients are under the care of these sub-specialities; Arthroplasty (546), Knee & Sports Injuries (216), Spinal Disorders (208), Upper Limb (147), Foot & Ankle (120), Paediatric Orthopaedics (13), Metabolic Medicine (9), Orthotics (7), ORLAU (6), Neurology (4), Rheumatology (3), Tumour (2), SOOS GPSI (2) and Physiotherapy (1).
Patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 931 patients
* >65 to <=78 weeks - 339 patients
* >78 to <=95 weeks - 14 patients
* >95 to <=104 weeks - 0 patient

Actions

The national planning requirements for 2023/24 stipulate that Trusts should eliminate waits of over 65 weeks for elective care, by March-24 (except where patients choose to wait longer or in specific specialties). The Trust is currently putting plans in place to achieve this by end of quarter one 2024/25.

A mutual aid co-ordinator, harms reviews process and validation resource are in place. The Trust has put in place a digital solution to support with validation that went live in early December. Cohort one for Patient Initiated Digital Mutual Aid had very small volumes of patients who were transferred to other Providers and rollout of further cohorts under National review. Internal Operational meeting are in place to further monitor progress. Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible during the periods.

The Trust is supporting the System to address waiting list pressures. The Trust accepted 72 long wait patients from Shropshire Community and is supporting Shrewsbury & Telford Hospitals by providing Elective Orthopaedic Theatre capacity. The Trust is also involved in discussions with other Providers to support with Paediatric Orthopaedic long waits.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
1526	1370	1227	1187	1195	1178	1210	1173	1177	1192	1193	1165	1284

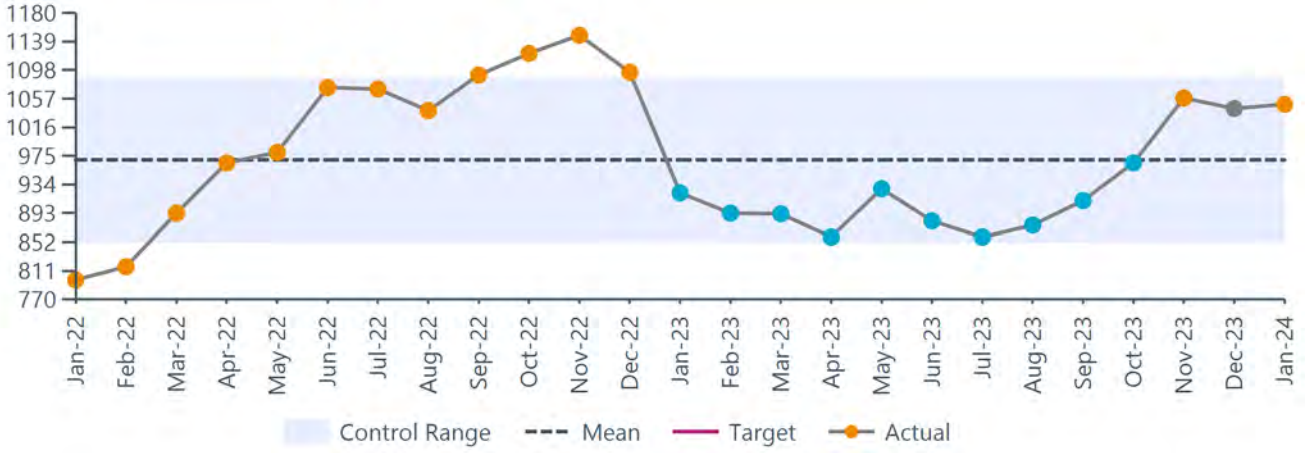
Patients Waiting Over 52 Weeks - Welsh (Total)

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	1,049	H	No Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of January there were 1049 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (405), Arthroplasty (234), Knee & Sports Injuries (190), Upper Limb (106), Foot & Ankle (82), Veterans (15), Paediatric Orthopaedics (12), Metabolic Medicine (2),Tumour (1), Physiotherapy (1) and Neurology (1).

Patients are under the care of the following commissioners: BCU (570), Powys (448), Hywel Dda (28), Cwm Taf (1), Cardiff & Vale (1) and Abertawe Bro Morgannwg (1). The number of patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 513 patients
* >65 to <=78 weeks - 287 patients
* >78 to <=95 weeks - 147 patients
* >95 to <=104 weeks - 36 patients
* >104 weeks - 66 patients

Actions

The Welsh guidance differs from NHS England guidance. The Trust continues to monitor equity across our commissioners whilst recognising guidance and differences in pathway monitoring. The Trust has now received confirmation (w/c 16th October) from BCU & Powys that RJAH can utilise mutual aid for their patients. The Trust is liaising with Walton to facilitate and transfer appropriate patients.

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

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
922	893	892	859	928	882	859	876	911	965	1058	1043	1049

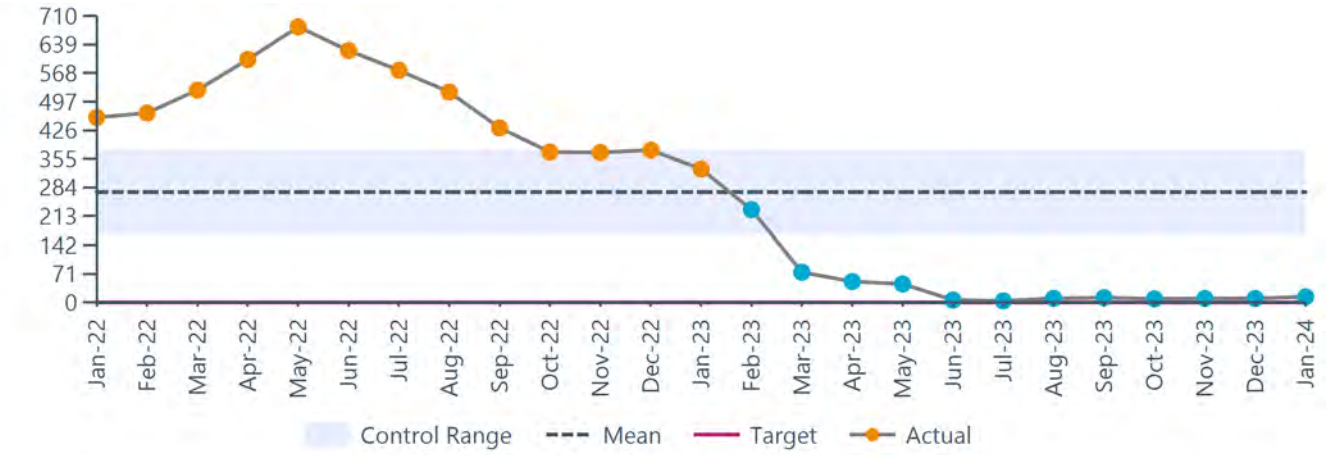
Patients Waiting Over 78 Weeks - English

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	14	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 January there were 14 English patients waiting over 78 weeks; 14 above our trajectory of 0. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Arthroplasty (7), Spinal Disorders (6), and Knee & Sports Injuries (1).

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

The Trust is still working with the 2023/24 operational planning guidance. Industrial Action, Operational pressures and ongoing Estates works have impacted original delivery plans. The original guidance stipulated:
* 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 .
We expect 2024/24 planning guidance imminently.

Actions

The Trust is now reporting against this standard by exception with the Trust making significant improvements during 23/24. In line with national planning expectations the Trust aims to further reduce long waits to less than 65 weeks. The Trust is putting plans in place, with the aim to achieve this, end of Quarter one 24/25.

A mutual aid co-ordinator and validation resource are in place. The Trust has put in place a digital solution to support with validation that went live in early December. Cohort one for Patient Initiated Digital Mutual Aid had very small volumes of patients who were transferred to other Providers and rollout of further cohorts under National review.

Internal Operational meeting are in place to further monitor progress.

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
330	229	75	52	46	6	4	10	12	9	10	10	14

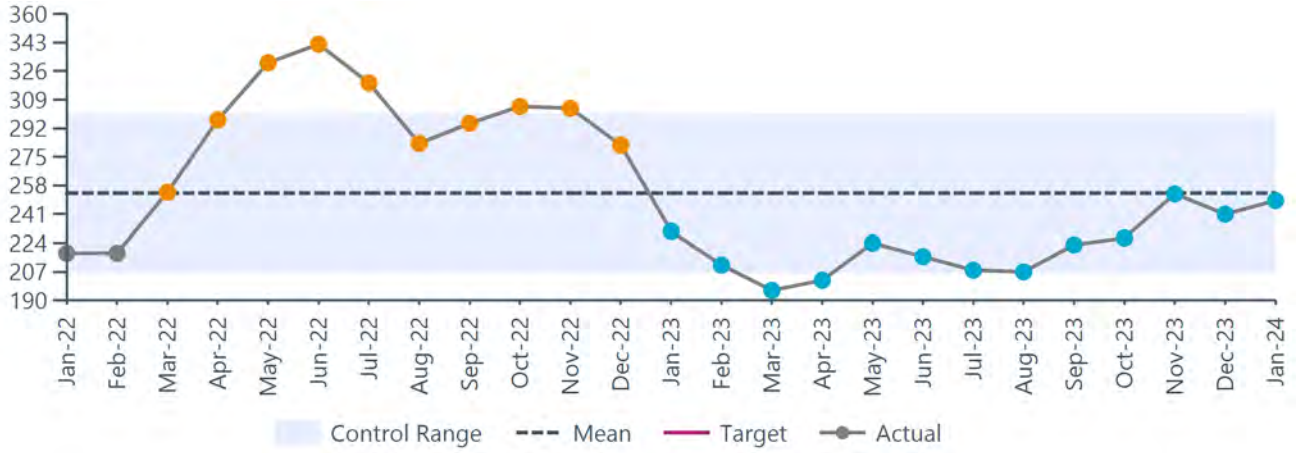
Patients Waiting Over 78 Weeks - Welsh (Total)

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
-	249	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 January there were 249 Welsh patients waiting over 78 weeks.

The patients are under the following sub-specialties; Spinal Disorders (101), Knee & Sports Injuries (67), Arthroplasty (47), Foot & Ankle (16), Upper Limb (12), Veterans (3), Neurology (1), Physiotherapy (1) and Paediatric Orthopaedics (1).

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients. The Trust continues to treat Welsh patients alongside English patients, balancing both long waits and clinical urgency. The Trust has now received confirmation (w/c 16th October) from BCU & Powys that RJAH can utilise mutual aid for their patients. The Trust is liaising with Walton to facilitate and transfer appropriate patients.

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

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

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
231	211	196	202	224	216	208	207	223	227	253	241	249

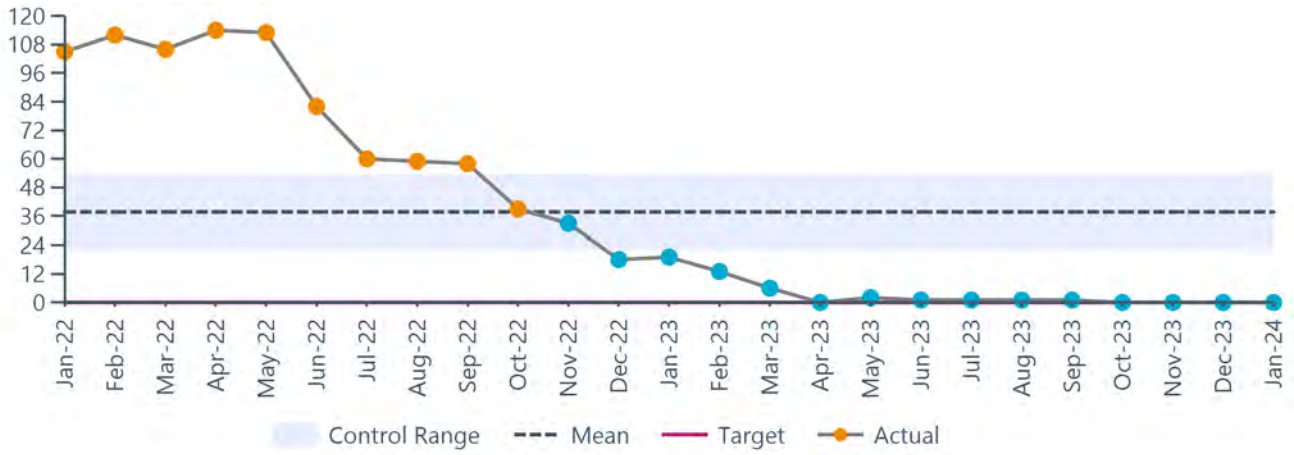
Patients Waiting Over 104 Weeks - English

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	0	L	F

Trajectory



What these graphs are telling us

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

Narrative

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

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

Actions

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
19	13	6	0	2	1	1	1	1	0	0	0	0

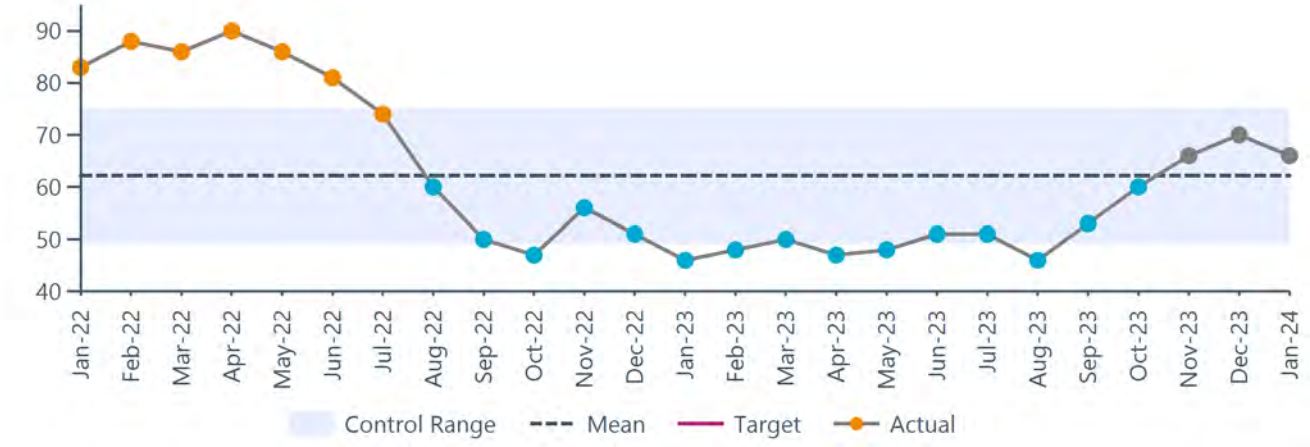
Patients Waiting Over 104 Weeks - Welsh (Total)

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	66		No Target

Trajectory



What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

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

The patients are under the care of the following subspecialties:
* Spinal Disorders (54)
* Knee & Sports Injuries (9)
* Foot & Ankle (1)
* Arthroplasty (1)
* Neurology (1)

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward. The majority of breaches are now attributable to our most challenged sub-specialty. The Trust has now received confirmation (w/c 16th October) from BCU & Powys that RJAH can utilise mutual aid for their patients. The Trust is liaising with Walton to facilitate and transfer appropriate patients.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
46	48	50	47	48	51	51	46	53	60	66	70	66

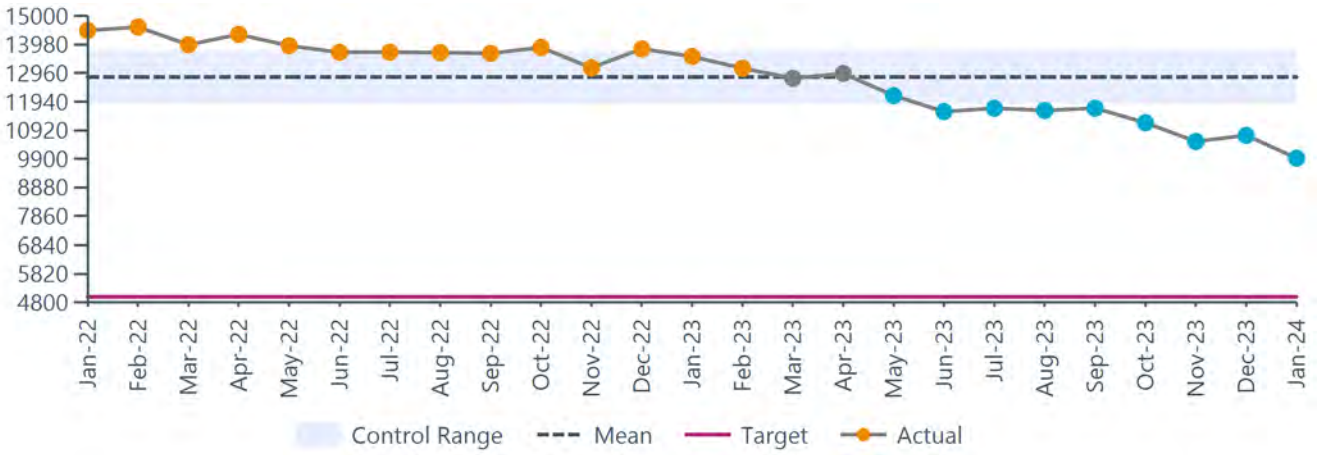
Overdue Follow Up Backlog

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	9,925	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 of the 31st of January, there were 9,925 patients overdue their follow up appointment. This is broken down by:
- Priority 1 - 6306 with 1171 dated (19%) (priority 1 is our more overdue follow-up cohort)
- Priority 2 - 3619 with 1066 dated (29%);

* The backlog has decreased by 23% since April. The teams with the biggest reduction this month were Veterans (-176), Spinal Disorders (-136), Upper Limb (-105). A decrease in all but 4 teams was seen in January.

* Of the 9,925 patients overdue, 53% are diagnostic follow ups.
* Of all the patients on a non-diagnostic follow up, 17% are overdue.
* Of all the patients on a diagnostic follow up, 36% are overdue.
* The sub-specialities with the highest volumes of overdue follow ups are: Arthroplasty (1,653), Rheumatology (1,436) and Spinal Disorders (1,186).
* 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

Work on the follow up reduction plan remains ongoing:
* An action to identify & agree the no-go cohorts within each subspecialty has now been completed
* It is recognised that lists need to be validated from an administrative perspective before proceeding with DrDoctor text validation to ensure the exercise is carried out on appropriate cohorts of patients.
* Bank support of one day per week to validate follow ups commenced on the 7th of February.
* Further validation of diagnostic follow ups is required.
* Clinical Engagement within Rheumatology and MCSI to utilise continuous PIFU.
* 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.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
13554	13132	12777	12949	12158	11589	11707	11630	11710	11190	10522	10740	9925

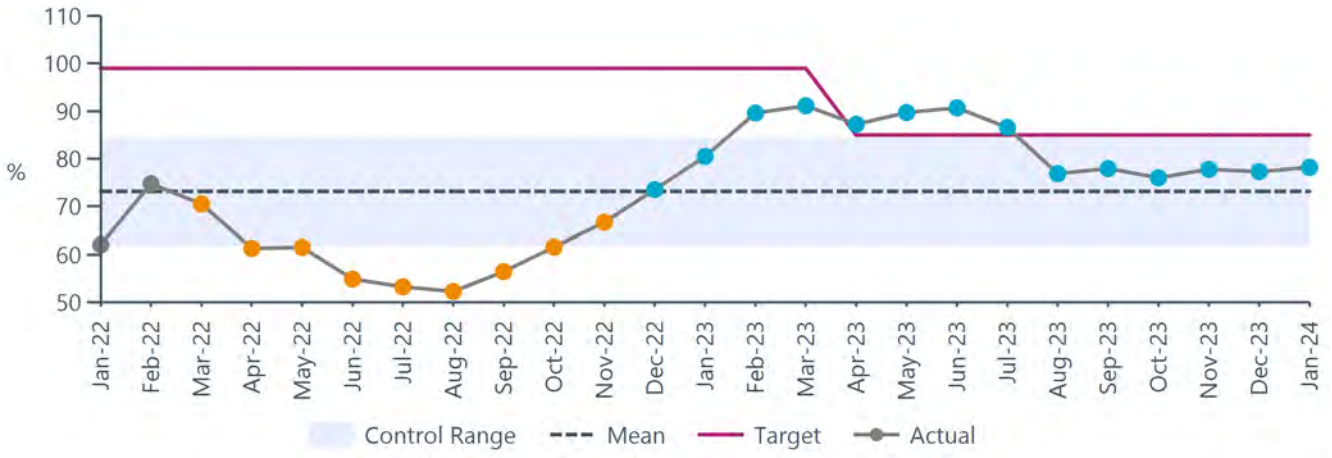
6 Week Wait for Diagnostics - English Patients

% 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%	78.22%	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 December position is reported at 78.22% below the 85% target. Reported performance equates to 235 patients who waited beyond 6 weeks. Of the 6-week breaches; 66 are over 13 weeks (Ultrasound). Breakdown below outlines performance and breaches by modality:

* MRI – 99.47% - D2 (Urgent - 0-2 weeks) - 1 dated
* CT – 99.30% - D4 (Routine - 6-12 weeks) – 1 dated
* Ultrasound – 57.27% - D2 (Urgent - 0-2 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 230 with 88 dated
* DEXA Scans - 100%

To support the percentage of patients receiving a diagnostic test within 6 weeks, NHSE are increasing focus on >13 weeks. National expectations to have no 13 weeks by end of June 2023 and by March 2024 the ambition is to achieve 85% against the 6-week standard within all modalities. It must be noted that both MRI and CT are already achieving the 6-week standard.
The trust continues to treat by clinical priority. MRI activity plans were met in January.

Actions

* Business case for additional Radiologists to be completed by Clinical Director is still in progress. Focus is on offsetting OJP and high tariff procedure lists.
* 'Case of Need' for bank/locum Radiologist to run Ultrasound diagnostic all day Saturday lists has been agreed and clinics starting in January was delayed and now due to commence in February.
* Additional ultrasound clinics still in place in core week.
* New Fellow started in January so interventional/diagnostic lists to be adopted after a short period of mentorship.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
80.51%	89.63%	91.15%	87.27%	89.74%	90.71%	86.61%	76.91%	77.97%	76.04%	77.80%	77.33%	78.22%

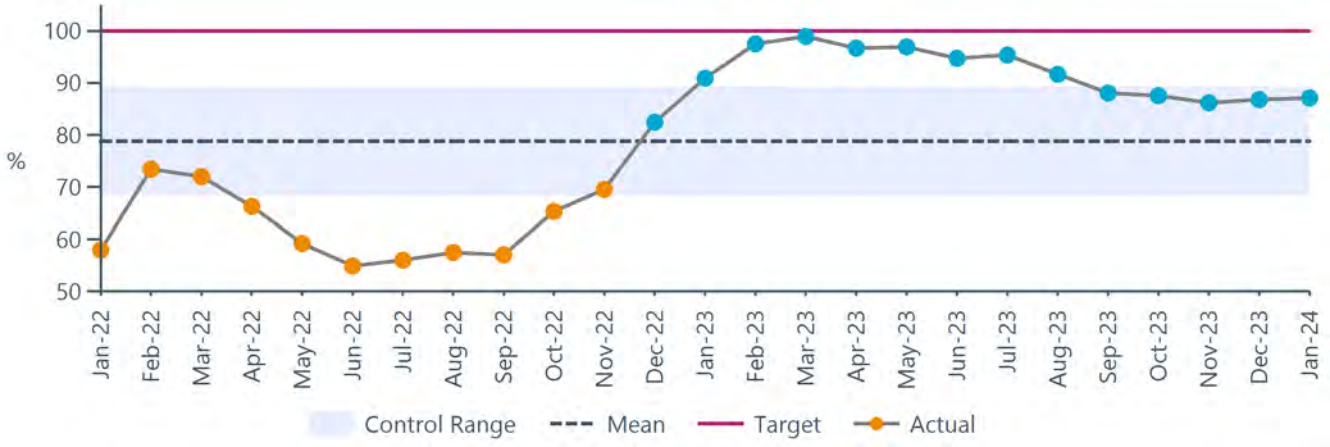
8 Week Wait for Diagnostics - Welsh Patients

% 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%	87.10%	H	F

Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics was not achieved this month and is reported at 87.10%. Reported performance equates to 44 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:

* MRI – 98.94% - (D2 (Urgent – 0-2 weeks) – 1 dated
* CT – 96.67% - (D4 (Routine - 6-12 weeks) - 1 dated
* Ultrasound – 65.55% - (D4 (Routine - 6-12 weeks) - 41 with 13 dated
* DEXA Scans - 100%

The trust continues to treat by clinical priority. MRI activity plans were met in January.

Actions

* Business case for additional Radiologists to be completed by Clinical Director is still in progress. Focus is on offsetting OJP and high tariff procedure lists.
* 'Case of Need' for bank/locum Radiologist to run Ultrasound diagnostic all day Saturday lists has been agreed and clinics starting in January was delayed and now due to commence in February.
* Additional ultrasound clinics still in place in core week.
* New Fellow started in January so interventional/diagnostic lists to be adopted after a short period of mentorship

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
90.92%	97.52%	98.94%	96.69%	96.92%	94.74%	95.38%	91.67%	88.06%	87.54%	86.18%	86.80%	87.10%

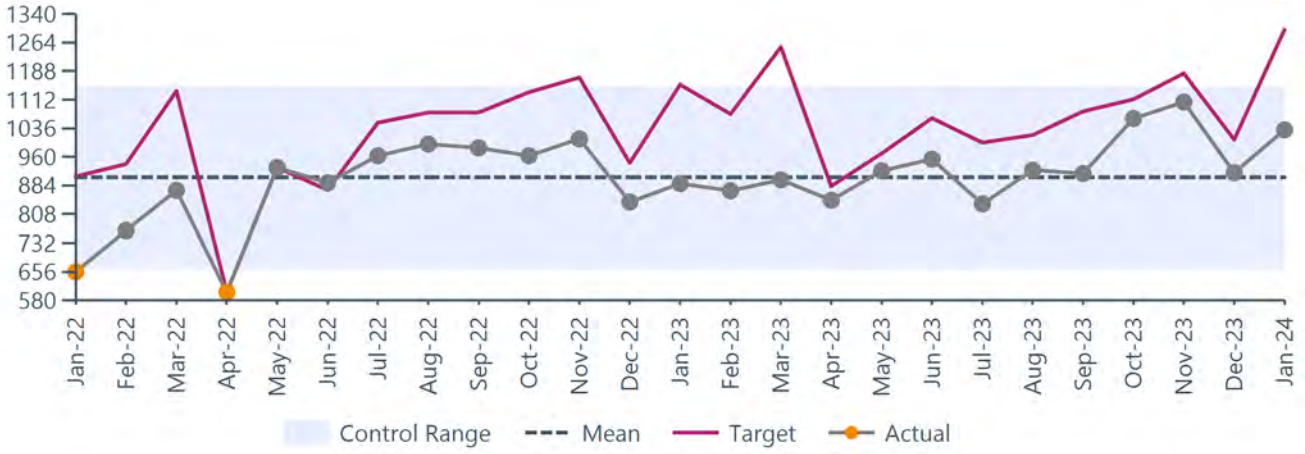
Elective Activity Against Plan (volumes)

Total elective activity rated against plan. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,299	1,032		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 1299 in January was 1032, shortfall of 267 (79.45%).
Elective spell activity is broken down as follows:
- Elective patients discharged in reporting month following operation - plan was 1111; 776 delivered (69.85%)
- Elective patients discharged in reporting month, no operation - plan was 188; 256 delivered (136.17%)
- Non-theatre activity accounted for 24.73% of elective spells this month; plan was 14.47%.

Elective activity remains above the mean and within normal variation this month.

Actions

* Greater focus on Theatre Improvement programme:
- early session starts currently reporting four all day sessions across two Consultants in February.
- Sunday working currently equating to 38 theatre cases across three Sundays in February.
- standardisation of cases per session in accordance with GIRFT guidance of 4 arthroplasty joint lists continues in February following engagement by the arthroplasty lead. Bluespier currently reporting 20x four joint lists undertaken and booked through February involving 11 surgeons.
- focus on reducing cancellations and opportunities for improvement identified and implemented.
- The Trust is taking action to support the winter capacity in the system by offering theatre capacity, where available, continuing in February with 3x all day and 3x morning and 2x afternoon sessions currently scheduled this month.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
889	870	899	845	923	954	835	925	916	1062	1106	918	1032

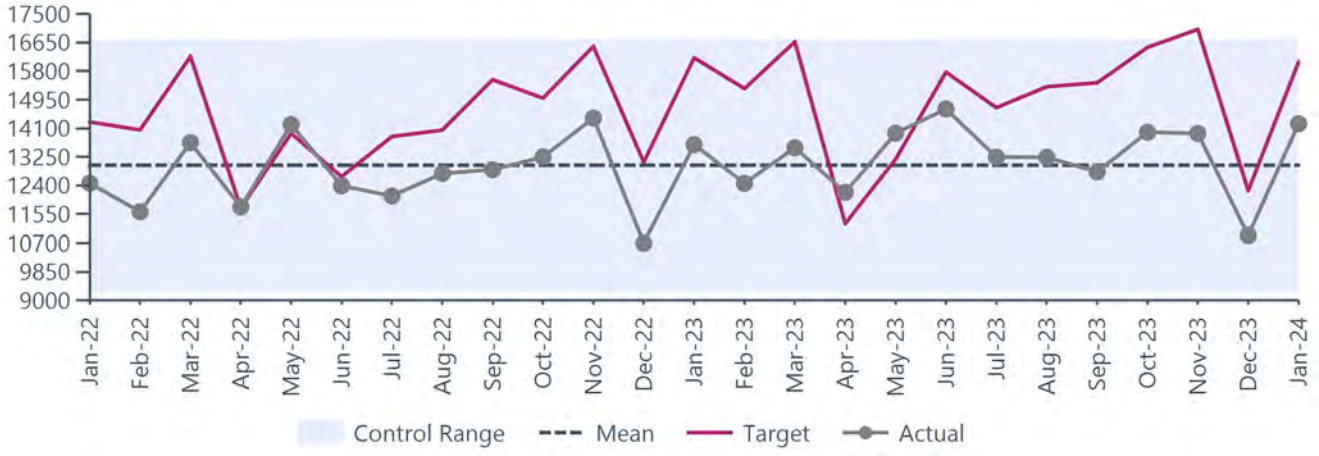
Total Outpatient Activity against Plan (volumes)

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
16,076	14,237		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Total outpatient activity undertaken in January was 14,237 against the 2023/24 plan of 16076; a shortfall of 1,839 that equates to 88.56% of plan. Due to the transition of services for SOOS & Therapies, if we were to exclude SOOS & Therapies from both the Plan and Activity delivered, the Trust position for January would be at 102.04% (250 above 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.
* Service Managers profiling and understanding activity at subspecialty level, keeping exception notes on changes and impacts to activity as and when they occur.
* Requirement to revisit plans at sub-speciality level.
* Plans being reviewed for 23/24 and 24/25.
* The impact of MUSST service is under assessment.

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
13613	12466	13521	12197	13956	14676	13244	13240	12805	13983	13949	10925	14237

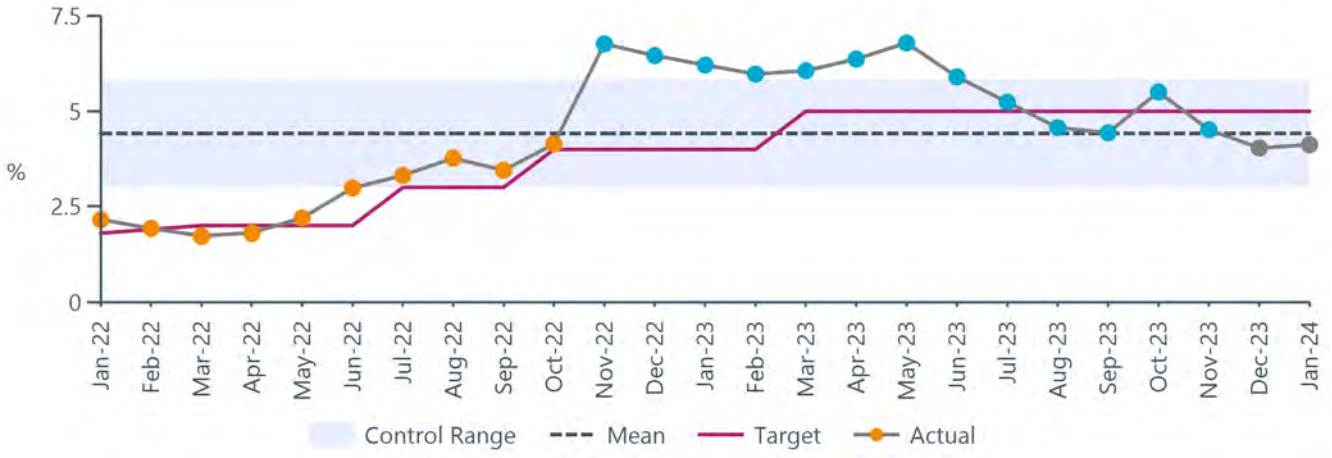
Total Outpatient Activity - % Moved to PIFU Pathway

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%	4.12%		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The target for the number of episodes moved to a PIFU Pathway is 5% of all outpatient attendances.

The % of patients moved to PIFU pathway for January was 4.12% equating to 587 patients.

The Teams with the highest achieving PIFU rate are:
Upper Limb (13.38%), Paediatric Orthopaedics (11.47%), & Occupational Therapy (8.14%).

Actions

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

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
6.21%	5.98%	6.06%	6.37%	6.79%	5.90%	5.24%	4.57%	4.44%	5.51%	4.52%	4.04%	4.12%

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

RJAH Long Waiters - 2023/24

Trust Board

7th March 2024

Aspiring to deliver world class patient care

2023/24 January and February** Performance

		Plan	Actual	Difference
January	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	66	
	English 78+ Weeks	0	14	14
	Welsh 78+ Weeks	-	249	
	English 65+ Weeks	390	353	-37
	Welsh 65+ Weeks	-	536	

		Plan	Forecast*	Difference
February**	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	73	
	English 78+ Weeks	0	7	7
	Welsh 78+ Weeks	-	280	
	English 65+ Weeks	340	320	-20
	Welsh 65+ Weeks	-	605	

NHS England Updates:

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

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

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

NHS Wales Updates:

2023/24 – Awaiting confirmation on targets.
Mutual aid being progressed following recent agreements.

**Forecast position.

2023/24: - Trajectories.

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Original Trajectory	365	321	303	196	0
Revised Trajectory V1 (Nov 23)	379	378	518	503	457
Revised Trajectory V2 (Jan 24)			390	340	305

M10 Financial Position Update

Aspiring to deliver world class patient care

I&E Position

Performance Against Plan £'000s											
Category	Annual Plan	In Month Position					23/24 YTD Position				
		Plan	Reforecast adj	Reforecast Plan	Pass through Adj Actual	Variance	Plan	Reforecast adj	Reforecast Plan	Pass through Adj Actual	Variance
Clinical Income	128,966	12,225	617	12,842	11,849	(993)	105,786	(1,655)	104,131	101,293	(2,838)
Private Patient income	6,354	588	203	791	794	3	5,263	701	5,964	6,011	47
Other income	7,302	609	(62)	547	730	183	6,084	391	6,475	6,297	(178)
Pay	(87,125)	(7,406)	79	(7,327)	(6,858)	469	(72,287)	(480)	(72,767)	(72,042)	725
Non-pay	(48,801)	(4,670)	159	(4,511)	(4,269)	242	(39,744)	(1,806)	(41,550)	(39,848)	1,702
EBITDA	6,696	1,346	996	2,342	2,246	(96)	5,102	(2,849)	2,253	1,711	(542)
Finance Costs	(7,341)	(622)	53	(569)	(489)	80	(6,095)	695	(5,400)	(5,247)	153
Capital Donations	150	0	0	0	6	6	125	0	125	79	(46)
Operational Surplus	(495)	724	1,049	1,773	1,763	(10)	(868)	(2,154)	(3,022)	(3,457)	(435)
Remove Capital Donations	(150)	0	0	0	(6)	(6)	(125)	0	(125)	(79)	46
Add Back Donated Dep'n	836	69	0	69	62	(7)	695	(25)	670	657	(13)
Control Total	191	793	1,049	1,842	1,819	(23)	(298)	(2,179)	(2,477)	(2,879)	(402)

- Overall **£1,819k surplus in month, £23k adverse position to forecast trajectory**, this includes;
  - £1m system support funding for industrial action M1-8
  - £0.5m non recurrent mitigations (Job plan risk accrual & rev to cap transfer).
  - **Underlying position £322k surplus, £471k adverse to forecast trajectory** (within £562k tolerance allowable for Industrial Action).
- **YTD £2,879k deficit, £402k adverse to forecast trajectory** (within £862k tolerance allowable for post November Industrial Action)
- Clinical Income £993k adverse to plan:
  - Industrial action impact £562k adverse (104 cases)
  - Theatre activity shortfall £401k adverse (80 cases)
- Other Income £183k favourable driven by interventions
- Pay £469k favourable including non-recurrent mitigations, material cost pressures include:
  - Wards £167k adverse driven by bank spend
  - Theatre staffing £37k adverse including supernumerary staff in training
- Non-Pay £242k favourable including balance sheet support and mitigations, material cost pressures include:
  - Theatres Implants/consumables £167k adverse underlying casemix pressure offsetting volume reductions
- Finance costs £80k favourable driven by interest receivable and TIF delay.

Forecast Out-turn

	Income £m	Cost £m	Total £m
Required Forecast Position (revised plan) :			
Agreed Deficit with NHSE			**-2.9**
System Support Funding Confirmed	1.0	0.0	1.0
Revised Target Deficit	**-1.9**	**-0.2**	**-1.9**

Latest Forecast Position		**YTD Deficit**	**-2.9**
M11&12 theatre performance deterioration	-1.1	0.2	-0.9
M11 Industrial action impact (TBC)	-0.5	0.1	-0.4
NHSE Baseline ERF error	-0.8	0	-0.8
ERF pricing alignment to national reporting	1.0	0	1.0
NHSE MCSI bed day non recurrent adjustment	0.4	0	0.4
Revised Forecast Deficit	**-1.0**	**0.3**	**-3.6**

Further Mitigations Under Consideration :			**Total £m**	**RAG**
NHSE baseline ERF non recurrent support	0.8	0.0	0.8	A
Job planning compliance accrual risk release	0.0	0.3	0.3	G
Annual leave accrual further adjustment	0.0	0.2	0.2	G
Update of employment provisions	0.0	0.2	0.2	A
Total	**0.8**	**0.7**	**1.5**	

- Target (before impact of Industrial Action) £1.9m deficit
- Industrial Action variance tolerance for 3 further rounds (Dec-Feb) £1.3m
- Latest forecast is £3.6m deficit. This is £1.7m adverse to target of which £1.3m can be tolerated leaving a shortfall of £0.4m.
- Potential mitigations identified total £1.5m.

Elective Activity Monitoring

Elective activity recovery is monitored through a 'Weighted Activity Unit' currency for 23/24 against the revised 100% 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.

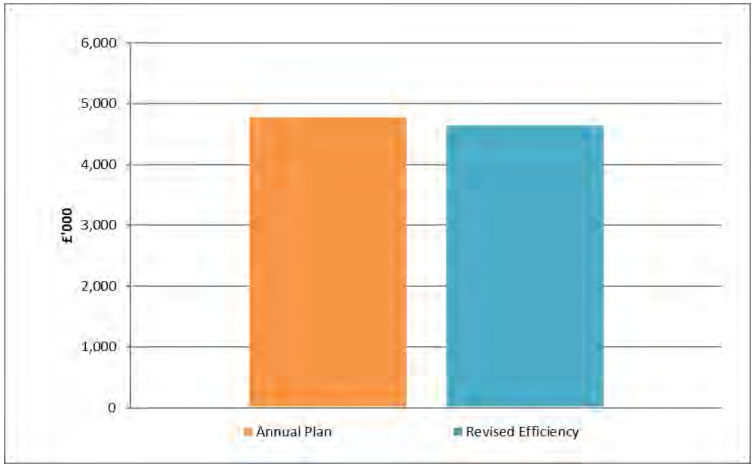
The Trust carries out an internal calculation of elective activity to monitor our performance before the national data release to give a forward look of performance included in the IPR.

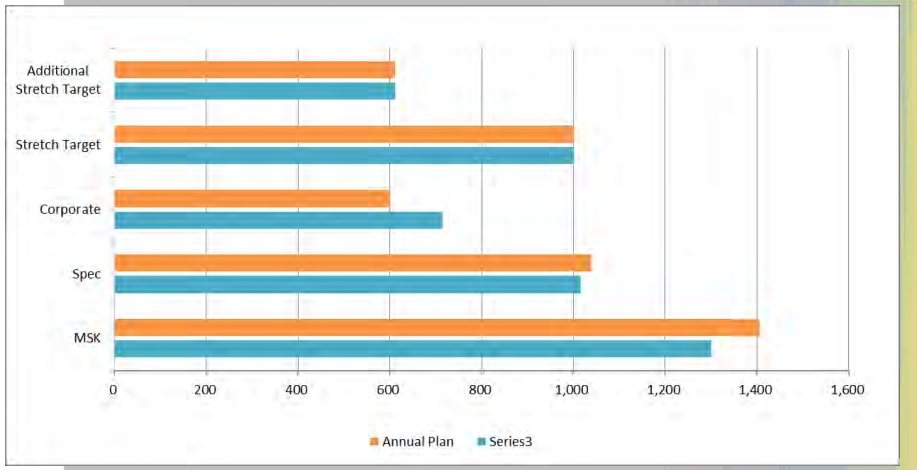
Current position to date is 89.1% of 19/20 baseline

All English ICBs & NHS England

Month	% Planned of ERF Baseline	% Achieved of ERF Baseline	% Difference	Source
April 2023	81.6%	92.4%	10.8%	External
May 2023	82.6%	85.7%	3.1%	External
June 2023	104.2%	82.7%	-21.5%	External
July 2023	85.2%	92.1%	6.9%	External
August 2023	96.0%	83.4%	-12.6%	External
September 2023	86.3%	81.9%	-4.3%	External
October 2023	90.1%	88.7%	-1.4%	External
November 2023	108.4%	96.9%	-11.5%	Internal
December 2023	93.0%	89.5%	-3.5%	Internal
January 2024	125.2%	95.3%	-29.9%	Internal
Month 10 Year to Date	93.7%	89.1%	-4.6%	Internal

Efficiencies Forecast



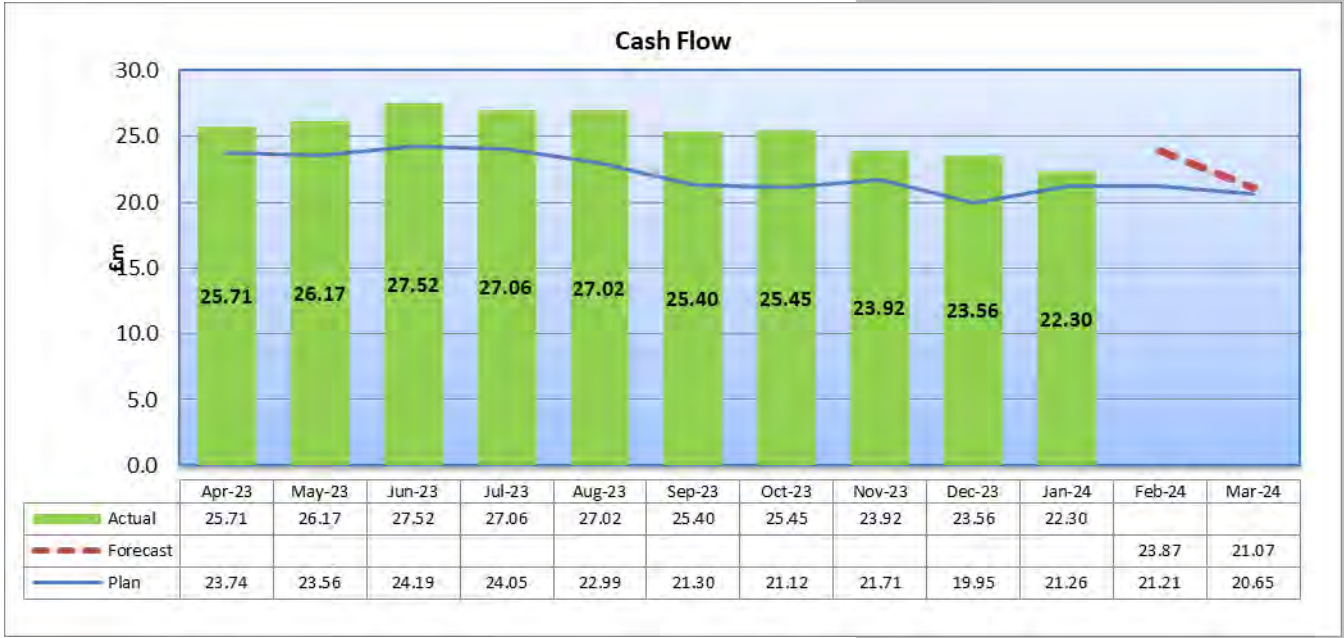


Annual plan requirement of £4.7m (3.7%) including initial stretch of £1m (to take us from 2.2% national target to c3.1%) and extra stetch of £0.6m (to take us from c3.1% to 3.7% as part of final plan submission).
Forecast is £4.6m of which £0.5m is amber RAG rated and £0.4m is non recurrent.

Unit	Annual Plan	£'000s		
		Recurrent	Non Recurrent	Forecast
CORPORATE	2,329	1,906	420	2,326
SPEC	1,039	1,016	0	1,016
MSK	1,405	1,301	0	1,301
Total	4,773	4,223	420	4,643

RAG	Forecast
g	4,186
a	456
r	0
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	25.45	23.92	23.56	22.30		
Forecast											23.87	21.07
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 is ahead of plan by £1.1m due to profiling differentials of the 2 major capital schemes (Theatre replacement and Apollo EPR implementation) offset by the I&E deficit.

The forecast is for cash balances to outturn at £21.1m, this is the effect of the forecast deficit of £3m being largely offset by capital creditors for the theatre development and EPR Apollo projects which will likely be paid in the new financial year.

Capital

Position as at	2324-10		Capital Programme 2023-24						
Project	Submitted Annual Plan £000s	Revised Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
Backlog maintenance	430	430	35	10	25	360	438	-78	525
I/T investment & replacement	600	600	0	182	-182	600	269	331	588
Capital project management	130	130	11	11	-0	108	114	-6	137
Equipment replacement	750	750	100	-74	174	700	791	-91	791
Diagnostic equipment replacement	500	300	0	0	0	250	13	237	248
IPC & safety compliance	170	170	10	30	-20	150	148	2	294
Estate reconfiguration	100	100	8	0	8	83	16	67	50
EPR planning & implementation (PDC)	4,600	4,600	114	727	-613	2,511	2,918	-407	5,188
Invest to save	300	300	0	0	0	200	37	163	37
Theatre replacement strategy	4,380	4,380	0	412	-412	4,380	1,552	2,828	4,380
Donated medical equipment	150	150	0	26	-26	125	99	26	99
Leases (IFRS16)	120	120	0	0	0	120	66	54	90
Contingency	0	200	0	4	-4	100	27	73	56
Other PDC funded schemes	0	0	0	0	0	0	0	0	215
Total Capital Funding	12,230	12,230	278	1,327	-1,049	9,687	6,489	3,199	12,698
Less donated medical equipment	-150	-150	0	-26	26	-125	-99	-26	-99
NHS Capital Funding - Charge to CDEL	12,080	12,080	278	1,301	-1,023	9,562	6,390	3,172	12,599
Less PDC funded schemes	-4,600	-4,600	-114	-727	613	-2,511	-2,918	407	-5,403
Charge to System Operational Capital	7,480	7,480	164	574	-410	7,051	3,472	3,579	7,196

The capital programme for the year is £12.2m with the Theatre replacement and Apollo EPR implementation being the most significant schemes.
The YTD underspend is £3.2m, mainly due to the profiling of the Theatre scheme.
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). The forecast is now showing an underspend of £284k against the system operational capital.
Additional funding of £0.6m has been secured for the EPR Apollo implementation and £0.2m to support radiology developments.

Risks to the financial plan not in forecast

Risk Type	Risk name	Risk Description	Estimated Value	Risk ID	FURTHER POTENTIAL RISK NOT IN FORECAST £'000	Likelihood	Consequence	Risk Rating	Mitigations / actions
External	Inflationary Environment	Tariff funding has been devolved for 5.5% so potential for further pressures to arise in year if current inflationary environment continues.	Risk based on further extrapolation of YTD inflationary pressures on non pay above level factored into forecast.	2886	£ 133	3	3	9	Procurement steering group monthly review of inflation pressures. Robust management of inflation proposals from supplies and strategic use of inflation reserve. Robust negotiation of controllable costs under contracts and pricing challenges.
Internal	Injury Cost Recovery (ICR) / Road Traffic Accident Income (RTA) income notification reductions	Injury Cost Recovery (ICR) previously known as Road Traffic Accident (RTA) is a passive income source to the Trust linked to the treatment of patients who have been involved in a road accident. This income is unpredictable and reductions in notifications impact the bottom line.	Value is based on H1 income notifications and withdrawals continuing in 23/24 which RJAH has no control of.	3084	£ 133	3	3	9	Closely monitor income notifications and withdrawals through the ICR system ensuring prompt recognition and avoid duplications. Where possible identify non recurrent income sources to mitigate in year impact.
				Total	£ 267				

- The remaining risk is c£0.3m not included in the forecast

Trust Board - Finance
January 2024 – Month 10

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.

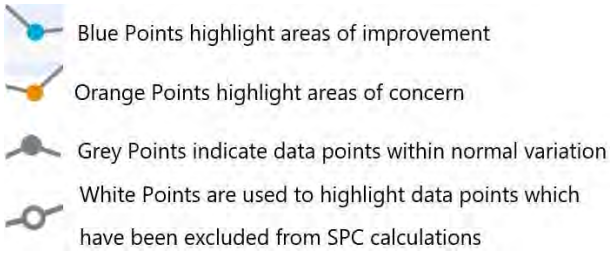
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

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:

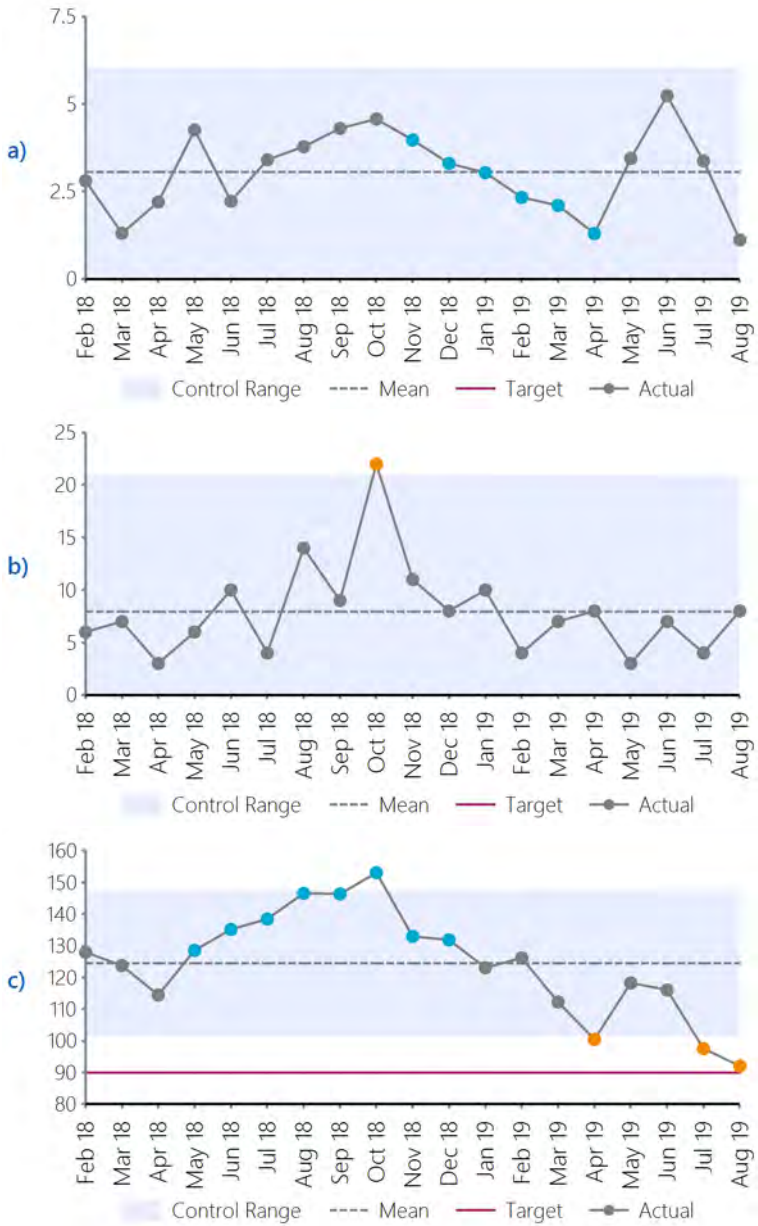


Some examples of these are shown in the images to the right:

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 Finances

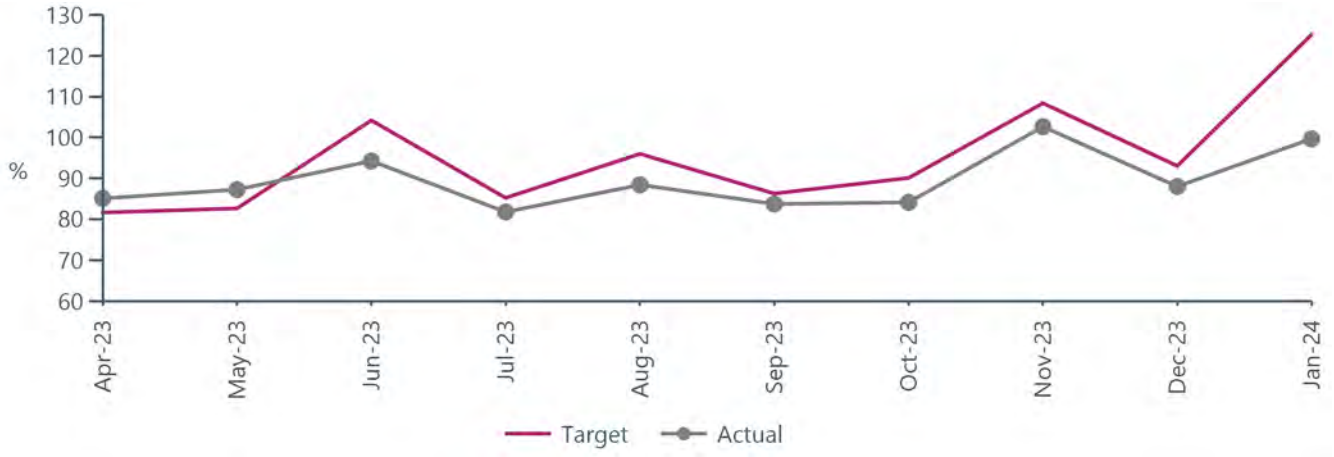
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	793	1,822		N/A to SPC	Moving Target		
Income	13,422.58	13,695		N/A to SPC	Moving Target		
Expenditure	12,629.35	11,929		N/A to SPC	Moving Target		
Efficiency Delivered	466	488		N/A to SPC	Moving Target		
Cash Balance	21,256	22,304			Moving Target		
Capital Expenditure	278	1,327		N/A to SPC	Moving Target		
Value Weighted Assessment	125.17%	99.68%		N/A to SPC	Moving Target	+	

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 Office

Target/Plan	Latest Value	Variation	Assurance
125.17%	99.68%	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 industrial action activity losses and underlying shortfalls in activity for theatres and outpatients due to workforce constraints.

Actions

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
			85%	87%	94%	81%	88%	83%	84%	102%	88%	99%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance and Performance Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	06 March 2024
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	01 March 2024
Paper Reviewed by:	Martin Newholme, Deputy Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors – Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

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

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

3. Assurance Report from Finance and Performance Committee

This report provides a summary of the items considered at the Finance and Performance Committee on 26 February 2024. It highlights the key areas the Finance and Performance Committee wishes to bring to the attention of the Board.

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

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

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

Performance Report

- The shortfall in theatre activity includes the impact of the delay in the new theatre which had been planned to be operational from January.
- The theatre activity delivered was in line with the revised forecast trajectory.
- In Job Plan continues to show a shortfall but the percentage of OJP used in month reduced.
- Safety measures relating to increased weekend working are under review.

The Committee asked for additional areas to be reported in the OPOD ahead of the next meeting:

- In Job Plan
- Value weighted activity performance recognising this is how the Trust is measured externally.

- Focus on pinch points with theatre staff and looking forward what is the impact on activity if not addressed.

Long Waiters Presentation
The Committee were informed:

- That due to industrial action and underperformance the Trust will not reach the 65 weeks waits target (0 by end of March) until the end of August.
- The Trust is working towards validating pathways over 12 weeks as part of a data cleanse.
- Children and young people performance was brought to Committee attention highlighting this is stronger than the overall waiting list in terms of the number of patients waiting over 65/78 weeks.
- There remains an ongoing issue with Spinal Disorders capacity which the Trust continue to explore.
- The Committee acknowledged the continued hard work which the Trust undertake to support patients and were reassured that patients do not lose their place on the waiting list if they decline the mutual aid offer however, patients are then excluded from the national counting and are monitored through the Trust's internal processes.

Financial Performance Report
The Committee were assured by the in-month position and noted a £1.8m surplus which included backdated Industrial Action support of £1m and support from the balance sheet of £0.5m. The revised forecast agreed with NHSE was on target for delivery but would require further mitigation support from the list identified and support from NHSE for the impact of Industrial Action since November. In the interim the Industrial Action costs are being reported as a tolerated variance.

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:

Corporate Risk Register
The Committee considered the register which reported 3 risks high risks aligned to the meeting. The Committee asked for the wording of risk 3027- variable income performance linked to elective activity performance to be reviewed.

Contracts/Investment Register
The Trust reported 53 contracts are out of date and a task and finish group is to be established to resolve. It was noted that there is minimal financial risk and operational risks are being mitigated. Progress will be tracked by the Trust Performance Group as a standing agenda item.

Draft Financial and Draft Operational Plan – 2024/25
The Committee acknowledged the plans are still at an early phase and as the official NHSE planning guidance is still awaited details of a flash submission to NHSE were shared and the following was noted.

- New Theatre capacity assumed to be live from October 2024.
- No service disruption from LLP or Industrial Action but an allowance for reduced activity during EPR implementation.
- Productivity measures amounting to 5% theatre activity improvement.
- Weighted Value activity of 111% against ERF threshold of 103% but noting that TIF 2 business case requires 110%.
- No increase in PP activity.
- The Trust is anticipating compliance in 104 and 78 week waits and for a 65 weeks expect to achieve target by end of August.

Following discussion, the Committee requested further consideration on the following areas:

- To provide clarity on the impact of the key enablers for the 20% more weighted value activity in next year's plan compared to this year's position with clarity on the key actions needed to ensure all deliverable

- To review the income presented on the financial bridge so that it was clearer what contribution the additional activity was making and what the associated incremental costs are (eg new theatre).

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.

MSK Unit Efficiency Report

The Trust reported a £104k adverse variance to plan in the year end forecast for the unit. Areas of ongoing focus include:

- Enhanced Recovery - flex down of beds pending increase in activity.
- ACI

Chair Reports from the sub-meetings which report into the Committee:

- MSK Transformation Board – there were no concerns to escalate to the Committee.
- Trust Performance and Operation Improvement Group – there were no concerns to escalate to the Committee.
- Sustainability Working Group – there were no concerns to escalate to the Committee.
- Procurement Working Group – there were no concerns to escalate to the Committee.
- Financial Recovery Group – there were no concerns to escalate to the Committee that had not already been discussed.
- Capital Management Group – the Committee were informed the theatre business case has been paused and the go live date for the new theatre had been delayed further.

The following papers were circulated to the Committee for information only:

- STW Productivity Opportunities

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
Digital, Education, Research, Innovation and Commercialisation Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	06 March 2024
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	**Paper written on:**	01 March 2024
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, Innovation and Commercialisation Committee (DERIC) on 25 January 2024 and 22 February 2024. It highlights the key areas DERIC 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.

EPR Implementation Assurance Meeting

The Committee have approved the functioning of the EPR Implementation Assurance meeting at the January Committee meeting. The terms of reference for the meeting were endorsed by the Committee and the first meeting is scheduled for 08 February. The meetings will solely concentrate on the EPR agenda for the Trust and gain assurance on the implementation of the system. The remaining digital items will continue to be reported through DERIC.

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:

Board Assurance Framework
The Committee held a discussion on the current strategic risks which should be reflected into the revised framework – the following was noted:

- Cyber security and events
- EPR, innovation and research business
- System pressures and management
- Comparation to similar providers

Corporate Risk Register
The Committee received an extract of risks from the Trust DATIX system which were recorded as 15 of above. The Trust secretary confirmed the risks are currently under reviews through the risk management process.

Chair Report for the EPR Implementation Assurance
The Committee received the first chair assurance report from the newly establishment meeting

- Assurance was received that relationships have improved with System C.
- Achievement comparison piece to original business case plan is ongoing.
- NHSE are conducting an external review.
- Finance work currently in development will return to the EPR Implementation Assurance meeting and Finance and Performance Committee as necessary.
- System testing sessions have now started with wider staff groups and have been well received.
- Dates of meeting may need to be altered to ensure equal gaps between EPR meeting and Digital Transformation Programme Board.

Chair Report – Digital Transformation Programme Board
The Committee received an update on the following key points:

- Stage 2 criteria
- Concerns noted in relation to the number to amber rated actions.
- Financial Forecast will continue to be presented at the Finance and Performance Committee.
- Training schedule has been completed and due to commence.
- Newly appointed System C programme manager is working well with the Trust.
- CCN go live date has been confirmed and communicated.

It was noted that the chair report will be discussed in further detail at the first EPR Implementation Assurance Meeting where assurance will be sought on EPMA, exit gateway requirements, implementation and testing.

Internal Audit – IT Threat and Vulnerability Review
The Committee were informed all recommendations following the review have been completed however, MIAA (internal audit) have the majority of actions recorded as outstanding on the follow up report which is presented to the Audit and Risk Committee for assurance. The Trust confirmed the Director of Digital is consulting with MIAA directly to provide the assurance required. An update will be tabled for the next DERIC meeting.

Research and Innovation Strategy
It was noted that the paper presented was a business case for the development of the Innovation Team rather than the Research Strategy which is a separate document. The Case continues to be a work in progress. Further work is to be completed in relation to the innovation team and aligning all improvement aspects across the Trust, this would include (but not limited to) audit, outcomes, research, PROMS and improvement. It was noted that this would go through an executive committee in the first instance and then be presented at the DERIC meeting in April.

The Committee is to strengthen the links between education and research which would ultimately raise the profile for research. A detailed discussion was held in relation to this, and the Chair of the meeting agreed to liaise with relevant staff across the organisation outside the meeting to explore ways in which this can be developed.

Education Strategy Update
The Committee welcomed the work being done on the education strategy and the update position presented which outlined educational aims and objectives. Further work is being undertaken by the team in relation to the long-term plan for the Trust and the scoping of all areas of education across the organisation including post graduate medical education. The Committee requested an update at the DERIC meeting in June.
The Trust demonstrated collaborative working with the System with confirmed attendance at the preceptorship programme. The Committee requested information to be included in future reports regarding collaborative working.

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.

Digital Security Report
The Committee were assured with the processes in place in relation to data security and patching programme which reported to have progressed. A focus area for the team includes the roll out of multifactorial authentication which is on track for completion and cyber security alerts which are reported to be completed timely. The Committee acknowledged the main associated risk RSK-1511 – Compromise to patient data due to cyberattack. This will remain a longstanding highly rated risk, as although the likelihood can be reduced, attacks are received daily, and if an attack did breach security it could cause a largescale issue.

Chair Report – Research Meeting
The Committee were assured with the process embedded to support the patients who have been informed of the recall on the total knee replacement prothesis – polyethylene. All patients have been reviewed at a face-to-face appointment and the appropriate follow up process in place. The detail of the recall has previously been reported via the Quality and Safety Committee.
The Committee discussed adding human tissue viability to the workplan along with realigning the regulatory oversight group to report to the Committee – this is to be considered with the Quality and Safety Committee Chair.

Innovation Club
The Committee received a report from the Innovation club which outlined the purpose of the meetings. The members of the meeting commended the Trust for having an open forum for staff to share ideas for improvement.

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:**	06 March 2024
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	01 March 2024
Paper Reviewed by:	Martin Newsholme, 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 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 06 February 2024. 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.

Standing Financial Instructions (SFI) and Scheme of Delegation
The Committee considered and endorsed the policy. The policy is presented to the Board of Directors for approval.

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:

Declaration of Interest and Hospitality Register

Concerns were raised that staff may return documents without noting all conflicts of interest. The Committee were reassured that the Trust are taking steps to address and review the conflict-of-interest process including a review of the policy and relaunching the information available via creating a dedicated space on the Trust's intranet page. The Committee suggested:

- For each meeting to support in strengthening the awareness by discussing declarations at the start of the meeting.
- Declaration of interest forms to be aligned to Executive Directors for oversight.

Code of Governance

The Committee noted the report and asked for further assurance on the following:

- Remuneration Committee - terms of reference in relation to the senior managers/VSM
- Governors – the fit and proper persons testing is not aligned to the Governors however this will be considered if it is deemed appropriate.
- Non-compliance – an action plan will be development and to support with implementing actions to ensure the Trust are compliant.

Internal Audit Progress Report

The Committee congratulated the Trust on gaining substantial assurance from the Internal audit reports on; committee effectiveness review, key financial controls review, safe staffing review, data quality IPR review.

Internal Audit Workplan 2024/25

The Committee received the workplan for approval following consideration at the Executive Team Meeting on 16 January. A full plan will be presented to the Committee in April however, the Committee were content with the suggestions and approved in draft.

Internal Audit Q3 Recommendations Report

A total of 23 recommendations were reported as outstanding in October and therefore, the Trust developed a plan to ensure those actions have been embedded and evidence is provided to Internal Audit. It was confirmed 15 of the actions have been closed. The majority of the remaining actions are aligned to one review in relation to IT which will be signed off following a meeting between MIAA and the Trust's Digital Director. The Committee noted the progress and were assured with the revised process in place to address the implementation of recommendations.

Risk Management Report (including Board Assurance Framework and Corporate Risk Register)

Work is underway to review the Board Assurance Framework which will be tabled for discussion at the assurance committees throughout February to gain input into the current strategic risks for the organisation.

There are currently 17 corporate risk recorded on the risk register. It was noted that there are 10 risks aligned to the MSST service and will be discussed via the relevant reporting routes.

Concerns were raised in relation to the following risks:

- EPR implementation – the committee were reminded that all Apollo risks are recorded on the Apollo risk register and reported through the digital board and the EPR assurance meeting before DERIC Committee.
- BAF/CRR – the Trust confirmed that the link between the two registers will be strengthened as part of the creation of the new board assurance framework.
- Risk management training – the training compliance data to be presented via speciality/role to provide assurance that all cohorts of staff are completing the training.

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. Assurance was sought in relation to potential system breaches, the Trust confirmed an external company complete periodic checks on the systems including the NHS firewall. The details of this are presented through the DERIC committee via the security report.

Finance Governance Pack
The Committee were assured with the process and reporting in place for the finance governance paper.

GGI Action Plan
The Committee were assured with the action plan which reports the majority of the actions closed. The 2 outstanding actions are aligned to the clinical audit recommendations which have been aligned to the Quality and Safety Committee. The QS Committee will continue to gain oversight of the actions through business-as-usual items. It was agreed the GGI action plan could be closed and removed from the workplan.

Counter Fraud Progress Report
The Committee were informed that following a fraud protection check, counter fraud will continue to liaise with the IT security to support in blocking fraudulent correspondence. The Committee asked for the Trust to explore processes in relation to dismissed staff rejoining the Trust via agency.One new referral was reported since the last meeting which is currently under review. Overall, the Committee were assured with the progress report provided by Counter Fraud.

Counter Fraud Workplan
The Committee received and noted the workplan for 2024/25.

External Audit Progress Report
The deadline for completion of the accounts has been noted as 28 June. No issues were identified in relation to audit progress.

Annual Accounts
The paper presented outlined the annual report and annual accounts timetable for information.

Review of the Accounting Policies
The Committee considered and approved the updated accounting policies.

Risk Management Terms of Reference
The Committee considered and approved the term of reference for the Risk Management Group.

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)

Review of Standing Financial Instructions & Scheme of Delegation

Committee / Group / Meeting, Date

Board of Directors, 06 March 2024

Author:

Name: Diana Owen
Role/Title: Head of Financial Accounting

Report sign-off:

Name: Craig Macbeth
Role/Title: Chief Finance and Planning Officer
Committee: Audit & Risk Committee (6 February 2024)

Is the report suitable for publication?:

No – document requires approval first

Key issues and considerations:

The Standing Financial Instructions (SFIs) and Scheme of Delegation are required to be reviewed annually by the the Trust Board.

Both documents have been reviewed and proposed changes detailed below. These were reviewed by the Audit & Risk Committee at its meeting on 6 February 2024 and recommended for approval.

Scheme of Delegation

- Changes are proposed relating to approval limits for healthcare contracts. Currently all contracts require approval by the Chief Finance Officer or Chief Executive. It is proposed that lower value contracts can be approved by Directors. The changes are shown in Appendix A.
- References to the Finance Planning & Digital Committee have been replaced with Finance & Performance Committee.

SFIs

- References to the Finance Planning & Digital Committee have been replaced with Finance & Performance Committee.

Recommendations:

The Trust Board is asked to recognise the review of the SFIs and Scheme of Delegation and approve the proposed amendments.

Appendices:

Appendix A : Proposed Amendments re Approval of Healthcare Contracts

Review of Standing Financial Instructions & Scheme of Delegation

Current

6. Contracts & Tenders for Services Provided	
6.1 Healthcare Contracts	
a) Signing of contracts up to the value of £5m	Chief Finance Officer
b) Signing of contracts above the value of £5m	Chief Executive
c) Price of NHS contracts charges for activity not covered by PBR tariff	Chief Finance Officer
d) Private patients, overseas visitors, income generation and other patient related services	Chief Finance Officer
e) Reporting to the Trust Board where a negotiated contract does not comply with the terms of the NHS Contract or the Operating Framework	Chief Finance Officer
6.2 Tender Submissions	
Sign-off of tender submissions	Service Manager or Operational Delivery Lead / Service Lead

Proposed

6. Contracts & Tenders for Services Provided	
6.1 Healthcare Contracts *(includes all non-staff arrangements)*	
a) Signing of contracts up to the value of £125,000	Non-Board Director
b) Signing of contracts up to the value of £250,000	Executive Director
c) Signing of contracts up to the value of £5m	Chief Finance Officer
d) Signing of contracts above the value of £5m	Chief Executive
e) Reporting to the Trust Board where a negotiated contract does not comply with the terms of the NHS Contract or the Operating Framework	Chief Finance Officer
6.2 Pricing	
a) Price of NHS contracts charges for activity not covered by tariff	Chief Finance Officer
b) Private patients, overseas visitors, income generation and other patient related services	Chief Finance Officer
6.3 Tender Submissions	
Sign-off of tender submissions	Service Manager or Operational Delivery Lead / Service Lead

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

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

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

Designated Body Annual Board Report

Section 1 – General:

The executive management team – of *Robert Jones and Agnes Hunt NHS FT* can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: Dr Ruth Longfellow is the appointed Chief Medical Officer and undertakes the role of Responsible Officer.

   Comments: The Responsible Officer is supported in her role by the Medical Appraisal Lead (Mr Nilesh Makwana) and Sarah Thomas (Learning and Development Manager)

   Action for next year: No Further Action currently

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes/ [delete as applicable]

   Action from last year: The Trust has purchased a licence for the Medical Appraisal System, Premier IT. This was mandated by NHS England.

   Comments: A transition from Jo Bayliss (Appraisal Administrator) to Lorraine Fearne (Appraisal Administrator) occurred since March 2022. This has changed since September 2023 to Sarah Thomas

   Action for next year: Establish a resilient administrative team to support the RO in her role.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Action from last year: An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year. A Direct link between Premier IT and GMC has been established.

   Comments: The administrative process will be managed via the new medical appraisal software.

   Action for next year: Maintain accurate record using GMC connect.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Medical Director / RO ensures that the revalidation process adheres to the Trust policy and GMC guidelines already in place. Comments: Action for next year: Review and update process and policies in accordance with the Trusts policy framework and national guidance

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year. The Medial Appraisal Lead undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board. No issues have been identified. Comments: Action for next year: We have been approached by the CMO at ROH to undertake a peer review process. Follow this up this year.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development via the Study Leave for Consultant and Medical Staff policy and process and the appraisal and revalidation process which includes the provision of governance data and intelligence. Comments: Action for next year: Continue to ensure CPD opportunities for all locum and short-term placement doctors working in the organisation are supported in line with Trust policies.

Section 2a – Effective Appraisal

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

Action from last year: All doctors have been offered the opportunity to use Premier IT system which is GMC approved and mandated by the Trust. All doctors have now been transitioned to this system which meets all the requirements for effective appraisals.

Comments: Doctors have on the whole been positive and have made the transition to Premier IT with relative ease. The Appraisal 2022 MAG template has been integrated into the new system.

Action for next year: The new GMP GMC guidelines have been circulated and will be in effect from early 2024. This will be integrated into the new software and will include health and well-being questions.

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

Action from last year: March 2022 saw the introduction of Premier IT to the Trust, since May 2022 it has been mandatory for all Doctors to use the Trusts appraisal system Premier IT. Previous appraisals using the 2022 MAG form have been uploaded to the platform.

Comments: Doctors have in the whole been positive and have made the transition to Premier IT with relative ease.

Action for next year: Continue to support the doctors use of Premier IT through ongoing support and training.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Medical Appraisal policy in place following review and Board approval on 13/08/2020. Policy has been reviewed 13/8/2023 in accordance with Trust governance and policy process. Policy adheres to GMC Guidelines.

Comments:

Action for next year: Policy due for review by August 2026 in accordance with Trust Governance and policy framework.

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

Action from last year: The Trust has a total of 29 trained medical appraisers, with representatives from each of the different specialities, which ensures the Trust complies with the requirement that the same appraiser cannot appraise the same doctor for more than 3 consecutive years.

Comments: A number of doctors have expressed interest to take on the role of appraiser if replacements or an increase in appraisers is required.

Action for next year: No additional action required at this time.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Medical appraisers are encouraged to participate in ongoing performance review and network/development sessions which are organised quarterly. All appraisers agreed they would attend at least one network/development session per year and this attendance is monitored. These sessions are provided as an opportunity to discuss best practice and areas for improvement, review case studies and participate in workshops.

Comments: A number of invited speakers have presented at these development meetings. The recent coaching and mentoring skills presentation was especially well received.

Action for next year: Plan and arrange the programme content for the network/development sessions for 2024.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

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

Action from last year: The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead who audits all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England. An annual report of the findings is provided to the medical appraisers and submitted annually to the Board.

Comments: Audits of quality assurance have been completed and highlighted no concerns or issues

Action for next year: To continue to monitor.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	112
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	110
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	12
Total number of agreed exceptions	1

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Timely recommendations are made to the GMC about fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and Responsible Officer protocol.

Comments:

Action for next year: To continue monitoring and ensure all doctors have sufficient evidence in place in advance of their revalidation date.

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

Action from last year: Revalidation recommendations made to the GMC are confirmed with the doctor. Reasons for deferred recommendations are discussed with the doctor by the Chief Medical Officer and confirmed in writing prior to the revalidation date.

Comments: The Trust has a set of criteria which doctors are required to meet before a recommendation for revalidation is submitted. Failure to meet the set criteria will mean the revalidation recommendation will be deferred until it is met.

Action for next year: Continue to monitor and early engagement/ communication with doctor if deferment is likely outcome.

Section 4 – Medical governance

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

Action from last year: The organisation aims to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal process. The Trust also requires doctors to participate in those systems and processes put in place to protect and improve patient care.

Comments: GMC outreach due to talk on new GMP in March 2024

Action for next year: To continue to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal processes.

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

Action from last year: All doctors are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation, e.g. information about complaints, significant events and outlying clinical outcomes. This data is reviewed and discussed at their annual appraisal.

Comments: The Trust has a formal process to manage all complaints made to the Trust. All clinicians are provided with a copy of any complaints received regarding them or their practice or that of their registrars. This is reflected at their appraisals. Any concerns are escalated to the RO by the appraiser if required electronically through the platform.

Action for next year: Continue to monitor.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: The Trust has policies MHPS and Freedom to Speak Up where concerns can be raised and addressed confidentially.

Comments: Policies are reviewed regularly

Action for next year: Continue maintaining policies and updates.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: The new Medical Director/RO has put in place a Professional Standards Group to comply with the above requirements.

Comments: Numbers Of concerns escalated to People Services requiring investigation is presented to People and Culture committee

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

Action for next year: Ensure Professional Standards group continues to meet. Continue to report through People and Culture Committee

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: To create and agree a formal process regarding transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers in local hospitals where our doctors work.

Comments: NHS Resolution issue HPAN (healthcare professional alert notices) about doctors where there is a concern which is actions by the RO.

Action for next year: New Medical Appraisal coordinator to create formal process especially with SaTH and Alderhey and local Private Providers. Informal process is in place.

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

Action from last year: Any concerns are investigated locally by the Clinical Leads and Clinical Chairs supported by the Chief Medical Director/Responsible Officer, People Services Department. And Professional Standards Group

Comments:

Action for next year: Continue monitoring to ensure actions and policies are fair and free from bias or discrimination.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: The Trust has a comprehensive recruitment process in place which adheres with all legislation and NHS requirements for appropriate pre-employment checks to ensure all doctors including locum and short-term doctors have the qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments: Audits of the recruitment procedures are undertaken periodically by the Trust's official auditors.

Action for next year: Continue to work with recruitment team to monitor and factor in receipt of MPIT form and last appraisal.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**
- The Trust has purchased a licence for the Medical Appraisal System, Premier IT.
- The Trust has purchased a licence for Dr360 to provide an MSF replacing previous provider CFEP.
- An accurate record of all licensed medical practitioners with a prescribed connection to the designated body was fully maintained throughout the year.
- The Medical Director / RO ensures that the revalidation process adheres to the Trust policy and GMC guidelines already in place.
- The Medial Appraisal Lead undertakes an annual review of the medical appraisal process, data and feedback which is presented to the Board. No issues have been identified.
- All locum and short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development.
- All doctors have been transferred to the new Premier IT Appraisal system.
- The Trust has a total of 29 trained medical appraisers.
- Medical appraisers are encouraged to participate in ongoing performance review and network/development sessions which are organised quarterly.
- The appraisal system is quality assured on a continuous basis by the Medical Appraisal Lead who audits all submitted appraisals using the widely used Appraisal Summary and PDP Audit Tool (ASPAT), produced by NHS England.
- Timely recommendations are made to the GMC about fitness to practice of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and Responsible Officer protocol.
- Revalidation recommendations made to the GMC are confirmed with the doctor.

- The organisation aims to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal process. The Trust also requires doctors to participate in those systems and processes put in place to protect and improve patient care.
- All doctors are provided with all relevant information relating to the doctor's fitness to practice and which relates to their work carried out in the organisation and forms part of their annual appraisal review.
- The Medical Director/RO has put in place a Professional Standards Group to comply with the above requirements.
- Any concerns are investigated locally by the Clinical Leads and Clinical Chairs supported by the Chief Medical Officer/Responsible Officer, People Services Department, in addition to the Professional Standards Group
- Policy reviewed August 2023 in accordance with Trust Governance and policy framework.
- **Actions still outstanding**
- Review and update process and policies in accordance with Trust policy framework and national guidance.
- To create and agree a formal process regarding transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers in local hospitals where our doctors work.
- To continue to ensure all doctors practice in accordance with the principles and values set out in the Good Medical Practice and participate in the revalidation and appraisal processes.
- **Current Issues**
- • The Medical Appraisals administrative staff has experienced staff changes in 2023. The Administration is now supported by Sarah Thomas and Hayley Shepherd. New staff will require a period of time to familiarise themselves to the Medical Revalidation system and process. They are supported by the Medical Appraisal Lead and RO. This has affected the presentation of the AOA to the board.
- **New Actions:**
- To develop Premier IT software to meet the new GMC GMP guidelines.
- To continue communication, training and monitoring of Premier IT.
- Ensure doctors are confident to complete their appraisals in a timely manner.
- Link Premier IT with GMC record of all licensed medical practitioners with a prescribed connection to the Trust.
- Plan and arrange the content programme for the network/development sessions for 2024.

Overall conclusion:

- The appraisal data reported in this document demonstrate that the Trust continues to meet the requirements set out in the FQA for Responsible Officers and Revalidation and remain compliant with the standards/requirements for medical appraisers and revalidation.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of Robert Jonesa & Agnes Hunt NHS FT has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body.

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: RJAH NHS FT

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication reference: PR1844

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report 2023/24

Committee / Group / Meeting, Date

Board of Directors – Wednesday 7th February 2024

Author:

Name: Hannah Howells
Role/Title: Health and Safety Advisor

Contributors:

Mike Carr, Accountable Emergency Officer
Nick Huband, EPRR Lead

Report sign-off:

Mike Carr, Chief Operating Officer/Deputy CEO and Accountable Emergency Officer (AEO)
Quality and Safety Committee – Thursday 25th January 2024

Is the report suitable for publication?

Yes

Key issues and considerations:

This paper presents an update on the Trusts Emergency Preparedness, Resilience and Response (EPRR) function for Board scrutiny and assurance. The NHS England EPRR Framework, requires the Trusts EPRR service to report to Board annually on the state of its preparedness, detailing provision in several key areas.

This paper covers the 2023 calendar year and includes an update on our most recent NHS England EPRR Core Standards assurance process. There have been many positive changes over the calendar year with new plans and processes introduced.

- EPRR Working Group reestablished.
- In house training and exercising capability
- New EPRR policies/procedures in line with the Civil Contingencies Act 2024
- New business continuity programmes
- Loggist and Health EPRR training
- New Incident Control Room equipment procedures
- Greater partnership working and collaboration.
- Collaborative exercise planning

The Trust has an Accountable Emergency Officer (AEO), which is a statutory role providing overall responsibility and accountability for the service, however, EPRR is under resourced from a Trust and System perspective.

During 2023 various System solution discussions took place, but no resolution was agreed by the ICB. The ICB Board are meeting January 2024 to discuss a proposal which will benefit RJAH in terms of resourcing. The service at RJAH continues to be led by the Trust Health and Safety Advisor within their 0.5 WTE role.

Strategic objectives and associated risks:

The work of EPRR relates primarily to the Strategic objective: Delivery high quality clinical services.

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

- Risk 822 - Failure to comply with statutory legislation and guidance relating to EPRR.

Recommendations:

The Trust Board is asked to note the EPRR annual position.

Report development and engagement history:

Next steps:

The EPRR Working Group have developed a detailed work programme for the next twelve months, focusing on elements identified as requiring improvement by NHS England.

The EPRR Core standards are discussed with system partners, where leads meet to identify elements which may require a collaborative approach or workaround.

The Trust EPRR Working Group will report six monthly to Quality Safety and Committee forming part of the Health and Safety chair report.

Health and Safety Advisor to complete Diploma in Health Emergency Preparedness, Resilience and Response 2024/25.

Acronyms

EPRR	Emergency Preparedness, Resilience and Response
AEO	Accountable Emergency Officer
RJAH	Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
ICB	Integrated Care Board
CBRNe	Chemical Biological radiological nuclear and explosive
HAZMAT	Hazardous materials

Appendices

Appendix A	EPRR annual assurance 2023/24: Confirm and challenge summary
Appendix B	Annual EPRR Core Standards Assessment - consolidated system outcome report

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report 2023/24

1. Background / context

The Trust has an annual assurance process for Emergency Planning, Resilience and Response (EPRR). The NHS England EPRR Core Standards assurance framework is the benchmark for assurance of the Trusts resilience.

The Standards set out the requirements for EPRR teams to report annually to the Board on themes across the EPRR workplan to provide assurance of the Trusts' capability and preparedness.

During 2023, EPRR responsibility was transferred into the Estates and Facilities structure, with the annual workplan being facilitated by the Health and Safety Advisor. A new meeting structure was embedded to provide assurance to Board via Chair reports to Quality and Safety Committee.

The developments within the EPRR service include a more operationally focused EPRR provision, with more support mechanisms. Collaboration with health and multi-agency partners has been strengthened through joint planning and exercising.

Although new and of the required standard, many of the new processes are still in their infancy which did not always translate into fully compliant Core Standards assessments. Improvements will continue into the next calendar year and a detailed work programme is being monitored at the Trust EPRR Working group.

2. EPRR Annual assurance

2.1 Resources and Structure

The Trust has an Accountable Emergency Officer (AEO), which is a statutory role providing overall responsibility and accountability for the service.

The Trust Health and Safety Advisor works within the Estates and Facilities structure which aligns well to EPRR. Reporting to the Director of Estates and Facilities (EPRR Lead), this structure has worked well throughout the calendar year.

Governance structures have been amended, with EPRR updates being presented in the form of a chair report six monthly to the Quality and Safety Committee.

The Trust has a 24/7 On Call mechanism at both Strategic and Tactical levels. These have recently been bolstered with additional staff members.

The EPRR Core Standards require that the Board has assurance that the resources in place are sufficient to deliver the EPRR programme effectively.

2.2 Summary of Incidents and Business Continuity disruptions

1. Blick (internal pager) system 'voice over' failure – November 2023 - The Switchboard Business Continuity Plan was activated due to the volume of the voice over announcements being extremely low. A risk was identified that the Trust Emergency Medical Response Team would not hear accurate location/medical information when responding to a call. Blick system contractor attended site and repaired fault on system. Test exercises implemented thereafter and continue into 2024.

2. EPR Outage – November 2023 – EPR system outage out of hours. Concerns raised as failure not escalated or communicated to Executive or Senior Manager on Call. System came back online the next day, but post incident review meetings establish, and escalation process out of hours discussed and communicated Trust wide.

2.3 Training and Exercising

Historically the Trust has relied on partner agencies to deliver EPRR training. During 2023, in-house training and exercises were produced/undertaken by the Trust Health and Safety Advisor. In line with the EPRR framework the Trust must deliver up to five exercises within its programme: training delivered during the reporting period was:

- Loggist training – carried out by an external supplier. Completed by ten members of the Trust administration team.
- RSPH Level 4 Award in Health Emergency, preparedness, Resilience and response – completed by the Health and Safety Advisor.
- CBRNe/HAZMAT training – desktop exercise completed with Trust staff.
- Digital Cyber Security attack – desktop exercise completed with Trust Leads.
- Emergency scenario training – desktop exercises completed with various Estates and Facilities Leads/staff.
- External ICB cyber exercise
- System collaborative (SATH) Hospital evacuation exercise
- System collaborative exercise - Exercise Alport – Shropshire Community Health Trust hospital evacuation exercise

2.4 Business Continuity Planning

A key priority for 2023/24 was to embed learning from business continuity disruptions and to further develop business continuity planning and response plans, at organisational and service levels across the Trust. A key objective for next year will be to assess the maturity of the organisations business continuity management system against the International Standard (ISO 22301).

2.5 Resilience plans

Throughout the year, the EPRR working group developed and improved Trust wide resilience plans following learning from incidents, events and exercises:

- EPRR Policy
- Trust Corporate Business Continuity Policy
- CBRNe/HAZMAT Procedure
- Emergency and Critical incidents mutual aid standing operating procedure.
- Trust Evacuation and Shelter procedure.

2.6 EPRR Core Standards

As highlighted previously, the EPRR Core Standards is the Trusts annual self-assessment against the minimum standards. Standards are set out in 10 domains. A standard is rated compliant, partially compliant or non-compliant. Only compliant standards are counted towards the overall award. Awards are given as follows:

- Fully compliant – 100% compliant standards
- Substantially compliant – 88 – 99% compliant standards
- Partially compliant – 77 – 88% compliant standards
- Non-Compliant – less than 77% compliant standards

Post COVID and MEN Arena enquiry, the 2023 Core Standards were far tougher than previous years. To be compliant, every item of evidence must be demonstrated and have been reviewed within the current 12-month cycle.

The Trust achieved a non-compliant rating of 67%, however, did not receive any inadequate ratings on question sets.

Feedback received from NHS England that although significant progress had been made from the previous year, the Trust is to focus on resourcing the EPRR function fully to allow adequate and dedicated time to make substantial progress.

3. Proposed next steps

- The Trust EPRR Working Group will continue to monitor and manage the work programme aligned to the Core Standards.
- Further training to be cascaded across the Trust to comply with EPRR Framework.
- Health and Safety Advisor to continue to work with System Partners in producing collaborative system approach to EPRR Core standards.
- Trust wide business continuity plan review to be completed.
- A Live exercise to be devised and implemented Spring 2024.
- Resource EPRR appropriately going forward.

4. Recommendation

The Trust Board is asked to note the EPRR annual position.