Board of Directors (Public) 06.07.2022

MEETING
6 July 2022 09:30

PUBLISHED
5 July 2022

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	6/07/22		09:30

Item	Owner	Time
1. Welcome		09:30
1.1. Apologies	All	
1.2. Declarations of Interest	All	
1.3. Minutes from the previous meeting May 2022	Chair	
1.4. Matter Arising	All	
2. Presentations		
2.1. Patient Story - Mr. John Rigby	Chief Nurse and Patient Safety Officer	09:40
2.2. Green Plan - Simon Everett and Phil Davies	Chief Finance and Planning Officer	09:55
3. CEO Update	Chief Executive Officer	10:10
4. Integrated Performance Report	Chief Finance and Planning Officer	
5. Exceptional Items		
5.1. IPC Improvement Plan	Chief Nurse and Patient Safety Officer	10:15

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	6/07/22		09:30

Item	Owner	Time
6. Quality and Safety		10:25
6.1. IPR Exception Report (page 54 - 56)	Chief Nurse and Chief Medical Officer	
6.2. Chair Report from Quality and Safety Committee	Non Executive Director	
6.2.1. Safeguarding Annual Report	Chief Nurse and Patient Safety Officer	
6.2.2. Patient Experience Annual Report	Chief Nurse and Patient Safety Officer	
6.3. Chair Report from IPC Quality Assurance Committee	Non Executive Director	
BREAK		10:50
7. People and Workforce		11:05
7.1. IPR Exception Report (page 51 - 53)	Chief People Officer	
7.2. Chair Report from People Committee	Non Executive Director	
7.2.1. Freedom to Speak Update	Trust Secretary/Director of Governance	

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	6/07/22		09:30

Item	Owner	Time
8. Performance and Governance		11:20
8.1. IPR Exception Report (page 57 - 67)	Managing Director	
8.1.1. 104 week waiters (Presentation)	Managing Director	
8.2. Finance Performance Report (page 68 - 72)	Chief Finance and Planning Officer	
8.3. Chair Report from Finance, Planning and Digital Committee	Non Executive Director	
8.4. Operational Plan (Presentation)	Chief Finance and Planning Officer	
9. Items for approval:		
9.1. Research Strategy	Chief Medical Officer	11:50
9.2. Board Governance Pack	Trust Secretary/Director of Governance	11:55
10. Questions from the Governors	Chair	
11. Questions from the Public	Chair	
12. Risk Review	All	12:00
13. Overall Board Reflection and Comments	All	12:10
14. Any Other Business	All	12:20
14.1. STW Green Plan (for information only)		
14.2. Next Meeting: 7 September 2022 (Public)		

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Harry Turner ☎ 01691 404358
Chairman

BOARD OF DIRECTOR – PUBLIC MEETING
4 MAY 2022 AT 9.30AM AT THE WYNNSTAY HOTEL, OSWESTRY
MINUTES OF MEETING

Present:

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

In Attendance:

David Gilburt	Associate Non-Executive Director	DG
Sarah Sheppard	Chief People Officer	SS
Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
Mary Bardsley	Minute Secretary	MB
Colette Gribble	Governor	CG
Katrina Morphet	Governor	KM

MINUTE NO	TITLE
04/05 1.0	**APOLOGIES** Apologies were received from Kerry Robinson, Chief Performance, Improvement and OD Officer
04/05 1.1	**MINUTES FROM THE PREVIOUS MEETING** Subject to the two amendments listed below, the minutes were agreed as an accurate reflection of the meeting and therefore approved by the Board of Directors. • DG requested an update to page 2 of the minutes regarding the Childrens transfers to Alderhay Hospital and suggested the Quality and Safety Committee requested a review of the service. • Typing error on page 2 of the minutes – presentation to replace presenter
04/05 1.2	**MATTERS ARISING** None to note.
04/05 1.3	**DECLARATION OF INTERESTS** MN informed the Board of his interests which included, Director for The Shropshire Doctors Co-operative Limited, Warrington Housing Association and The Grange Trading Development Limited. MN is also a Trustee for the following, The Grange School Hartford Limited and The Eric Wright Charity.
PRESENTATIONS	
04/05 2.0	**STAFF STORY – CARRIE JENKINS** RL welcomed Carrie Jenkins, Deputy Chief Pharmacist to the Board meeting who joined to speak about Menopause. Through the Women's Network, the Trust has championed the creation of a menopause policy and has committed to raising awareness across the organisation. This is also supported by the system who have produced a menopause pack to support colleagues to speak about issues, concerns, and treatment options. Carrie's presentation highlighted the work that has been undertaken to manage issues that have arisen between the use of HRT and having Orthopaedic surgery along with promoting awareness.

	CB asked how the evidence based is used to inform the dispensary noting that all clinicians will have different preferences. Carrie explained that the evidence has been gathered from consensus documents following a UK trial of 80,000 women. CB also asked to what extend do the normal VTE measures that are undertaken for patients are mitigated against low doses of oestrogens? Carrie explained the risks with using HRT are relatively low and continued to explain the guidance of using the medication before surgery. The pharmacy support women in making their own choices before surgery. PK queried whether the Trust could measure the amount of surgery not being cancelled since the implementation of the policy. Carrie explained that there were 2 patients last year cancelled directly relating to HRT. The low numbers are due to the pharmacy's pro-active commitment in contacting patients ahead of surgery to discuss options which supports with rescheduling of patients and not cancelling. SK thanked Carrie for her presentation and noted the involvement within the women's network and encouraged a discussion with SS to support staff further. HT encouraged reflections from the Board on areas of improvement following the presentation: • Highlighted the importance of listening to patients and the impacts of surgery • Consistency within the implementation of the policy On behalf of the Board, HT thanked Carrie for joining the meeting to present the important topic and to enhance awareness further.
CEO UPDATE	
04/05 3.0	**CEO UPDATE** SK provided an updated in some of the noteworthy events and updates since the last Board Meeting, there included: ▪ RJAH staff supporting the system in response to Covid-19 ▪ Headley Court visits the new Centre and progress ▪ Congratulated the ICS in appointing the Chief nurse Officer and Non-Executive Directors ▪ Noted the Health and Care bill which will support the implementation of the ICS from 1 July 2022 ▪ Congratulations to the most recent Health Hero Award – Julie Cole from the metabolic Bone Team. Julie was nominated by her colleagues for stepping up and running the intra venous services independently, Julies hard work ensured no patients were cancelled. Well done Julie! The Board thanked SK for the update.
QUALITY AND SAFETY	
04/05 4.0	**CHAIR REPORT – QUALITY AND SAFETY COMMITTEE** CB presented the Chairs report to the Board, highlighting the following: ▪ Received the standard agenda items, SI and Never Event paper, Unit Report, Harms Presentation, and Performance Report aligned to the Committee ▪ Approved the Medical Devices Loan Policy ▪ Awaiting a presentation on Clinical Prioritisation, the harms review process will be adapted to support ▪ The reporting of falls to be adapted to report avoidable or unavoidable to support learning The Board noted the Chairs Report from the Quality and Safety Committee.
04/05 4.1	**LEARNING FROM DEATHS REPORT** RL informed the Board there has been a total of 6 deaths recorded through the reporting period of December 2021 – March 2022. Following the reviews, there have been no concerns identified. RL explained the Trust is liaising with SaTH to gain support from their Medical Examiner and Bereavement System as well as enhancing relationships within the ICS. The Board were assured by the information presented and thanked RL and team for the report.

04/05 4.2	**CHAIR REPORT – IPC QUALITY ASSURANCE COMMITTEE** CB presented the Chairs report to the Board, highlighting the following: ▪ Thank you to the Trust for presented the LM report which was noted to be informative and helpful. Noted that each recommendation had been added to the overarching IPC improvement plan and therefore content with the process in place to monitor the recommendations ▪ The Committee gained an understanding of the estates backlog including the reasons for the high levels of outstanding jobs and gained assurance on the process in place ▪ Further assurance is to be provided on the exit criteria that what is required to improve and progress out of the red rating. It was noted that the Trust has found this challenging without receiving the formal undertakings letter. ▪ A deep dive into all SSI's (not only hip, knee and spines) is to be presented The Board thanked the IPC Quality Assurance Committee for the assurance presented and noted the Chairs assurance report.
04/05 4.3	**IPC IMPROVEMENT PLAN** SEA presented the plan, highlighting in the following: ▪ One action from the immediate actions remains open (medical leadership) the remaining five have been closed and actions implemented ▪ 60 actions across 9 themes have been identified – all have clear timescales and leads aligned to support implementation ▪ 3 actions are behind plan with plans in place to progress ▪ 13 actions have been completed with 5 fully implemented ▪ 27 actions are currently in progress Following the Boards query, SEA confirmed the plan is reported to the following – IPC Working Group, IPC Committee, IPC Quality Assurance Committee before the Board of Directors. The Trust explained that the improvement plan will be developed to ensure the delivery of the exit criteria and aligned to the undertakings once received. SEA informed the Board that work to improve the culture and IPC strategy has commenced. HT highlighted the importance of ensuring the changes implemented are sustainable as well as the importance of supporting staff. SEA explained the Trust are using forums to relay the importance of IPC and being open about challenges faced, key successes are being commended to encourage good practice and MDT have joined the IPC working group and therefore engagement across the Trust has increased. SEA continued to explain, patient safety walkabouts have been reinstated along with buddy visits where staff are encouraged to reflect up on the journey. CB noted the lack of confidence staff have to challenge others within the Trust and encouraged the Trust to support staff to feel empowered to question. SN asked for consideration to be given on how the Trust can evidence staff being confident to challenge others. HT asked the Trust if there was any further support required before thanking Jacqueline and Lisa for their support so far. The Board discussed inviting the Chief Nurse of the ICS to an IPC Quality Assurance Committee meeting once the ICS was embedded. The Board discussed the housekeeper role which has been identified as a requirement to support the sustainability of the action's implemented. The approval process was explained to the Board which is to be followed. The Trust agreed to share further information in due course. The Board noted the progress within the improvement plan and thanked all staff for their continued hard work.
04/05 4.4	**OCKENDON REPORT – WIDER LEARNING** Following a review in to SaTH maternity services, there were a number of recommendation and themes presented within the report which can be translated across all aspects of healthcare and therefore are worthy of consideration to support wider learning and opportunities for improvement.

	HT thanked the Trust for the report and suggested a further paper is to be completed against the four pillars – safe staffing levels, a well training workforce, learning from incident, and listening to families. The Board asked for support from the Quality and Safety Committee in gain assurance. ACTION: A Trust review of the Ockendon report to be presented to the Quality and Safety Committee (July) to provide assurance against the four pillars. CB queried to what extent are families involved in serious incidents. The Trust explained that the patient liaison service is linked to serious incident reviews and offer to meet with families to support them throughout the process. SS reminder the Board that member of staff would have been directly affected by the report and highlighted the importance of supporting employees through a difficult period. SK agreed to raise awareness in the next managers briefing and communications to be shared to sign post staff to support systems. The Committee noted the report.
PERFORMANCE AND GOVERNANCE	
04/05 5.0	**CHAIR REPORT – FINANCE, PLANNING AND DIGITAL COMMITTEE** It was noted that the meeting was not quorate and therefore an Extraordinary FPD meeting was held to approve the operational and financial plan for 2022/23. Areas of concerns highlighted to the extra ordinary committee included: ▪ Identifying financial deficit ▪ Challenging recruitment plan ▪ Assumption of receiving the elective recovery funds ▪ Lack of assurance relating to mutual aid The Committee noted the chairs assurance report.
04/05 5.1	**PERFORMANCE REPORT** HT thanked the Trust for producing a flash report and following discussions the Trust agreed to add sickness rates, SSI, complaint and staff vacancies to the document. **CARING FOR STAFF** Sickness – reporting on Covid-19 continues to be monitored. There was a noted increase towards the end of March which is now decreasing. Voluntary Staff Turnover – noted a change in the rules relating to flexible retirements which were suspended during the pandemic. Reasons for leaving include retirement or relocation, work life balance or financial reasons. The trust commended the radiology recruitment. **CARING FOR PATIENTS** Serious Incident – one incident reported, PE following surgery WHO Documentation – three months off target. This is relating to step 4 of the process. The Trust has suggested benchmarking tolerance rate against similar organisations. 52 weeks – for month 12, English patient waiting over 52 weeks is 140 patients below planned trajectory and Welsh patients are 251 below planned trajectory – well done teams! **CARING FOR FINANCES** £2.7m favourable to plan – due to Covid framework and private patients Total elective activity – 74.09% of plan delivered Total outpatient activity – 82.51% of plan achieved CM explained that funding envelopes do not currently reflect the increases within the cost of living and covid. CB queried the Trusts reliance on OJP. CM explained that within the plan, the Trust are reducing the numbers of OJP to pre-pandemic baseline (2019/20) and highlighted the 400-session increase noted withing IJP. The Board noted the performance report.
04/05 5.2	**CHAIR REPORT – EXTRA ORDINARY FINANCE, PLANNING AND DIGITAL COMMITTEE** SN presented the chairs report which was predominantly relating to the system deficit and the submission of the operational plan for 2022/23. The plan was approved by the Committee noting the significant assumptions for the coming year. The Board highlighted

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	the challenging balance of patient quality and performance before thanking CM and Nia Jones for the continued hard work in preparing the plan. The Board noted the chairs assurance report.
04/05 5.3	**OPERATIONAL PAN 2022/23 (FINAL SUBMISSION)** Following approval (at FPD) and submission on 28 April 2022, the Operational Plan 2022/23 was presented to the Board for information only, highlighting the risks of delivery outlined within the presentation.
04/05 5.4	**FINANCIAL PLAN 2022/23 (FINAL SUBMISSION)** Following approval (at FPD) and submission on 28 April 2022, the Financial Plan 2022/23 was presented to the Board for information only, highlighting the risks of delivery outlined within the presentation.
04/05 5.5	**CORPORATE OBJECTIVES 2022/23** SR presented the suggested Corporate Objectives for consideration: ▪ Develop and maintain safe service ▪ Further develop the veterans' services to ensure it is established as a centre of excellence ▪ Support MSK integration across the system ▪ Optimise the potential of digital technologies to transform the care of patients are their outcomes ▪ Maintaining statuary and regulatory compliance SR noted that a footnote would be added to the final document to explain that all objectives will align to the ICS and support partnership working. The Trust highlighted that the implementation of digital will require a longer timeframe than 12months and therefore explained the objective is a starter point for implementation. The Board agreed the objectives and asked for the final version to be tabled for discussion at the Strategy Board Session in June.
04/05 5.6	**RISK APPETITE AND TOLERANCE** SR presented the paper to the Board noting it has previous been considered by the Audit and Risk Committee. SR explained there have been no amendments following a review and highlighted the requirement to revisit once the ICS has been implemented to which the Board agreed. The Board approved the Trusts Risk Appetite and Tolerance.
PERFORMANCE AND GOVERNANCE	
04/05 6.0	**QUESTIONS FROM THE GOVERNORS** There were no questions from the Governors.
04/05 6.1	**QUESTIONS FROM THE PUBLIC** There were no questions from the Public.
04/05 6.2	**ANY OTHER BUSINESS** There were no further items of business discussed.
04/05 6.3	**CLOSING REMARKS** HT thanked all those in attendance for their contribution in the meeting.
NEXT MEETING: PUBLIC MEETING – 6 JULY 2022	

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BOARD OF DIRECTOR – PUBLIC MEETING
4 MAY 2022
SUMMARY OF ACTIONS

REFERENCE/TITLE	LEAD	STATUS
Actions from the Previous Meeting – April 2022		
None outstanding.		
Actions from the Meeting – May 2022		
Ockenden Report A Trust review of the Ockendon report to be presented to the Quality and Safety Committee (July) to provide assurance against the four pillars.	Chief Nurse and Patient Safety Officer	Complete – added to the agenda for Julys QS meeting

Patient Story – Mr Rigby

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Mr John Rigby, Patient	Paper date:	6 July 2022
Senior Leader Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper written on:	4 July 2022
Paper Reviewed by:	Board of Directors	Paper Type:	Governance and Quality
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents the summary of a patient story by Mr John Rigby for information by the Board of Directors.

2. Executive Summary

2.1. Context

The Board of Directors requests patient stories to be presented throughout the year to provide the Board with insight and understanding into a patient's journey. The Board are then able to notice good practice and behaviours throughout the Trust but also to identify improvements which could be made within our services.

2.2. Summary

- Mr Rigby likes to be known as John, has several spinal issues and is under the care of Mr Balain.
- John has undergone several x-rays and outpatient appointments within RJAH.
- Experiences within x-ray department were positive.
- John has felt listened to at each appointment with Mr Balain.
- It is recognised staff have gone the extra mile and are always friendly and helpful.
- John compliments every member of staff who he has communicated with by email or over the phone – they were all friendly, professional, helpful, and considerate
- Improvements could be made with relocation of the physiotherapy department as it is a long walk from the main entrance.
- The Estates and Facilities Department have commented:
  "The Estates Strategy is actively reviewed with the priority of delivering outpatient services at the West end of the site, nearest to the main entrance and car park. Clearly this is a long-term plan, but we understand the importance it plays with patients. To mitigate in the meantime, we are opening entrances nearer points of care, something we are now able to do in line with infection prevention and control guidance, to allow for closer access for those with mobility difficulties.
  For those using the corridor we facilitate wheelchairs, as mentioned, and provide chairs at regular intervals, allowing all site users to rest and recuperate.
  We will consult with our Patient Led Assessment of the Care Environment (PLACE) team during their inspection for further constructive feedback and ideas, from the patient's perspective".

2.3. Conclusion

The Board of Directors is asked to note the patient story presented.

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Green Plan 2021-2024		
Unique Identifier:	POL226	Document Type:	Policy
Version Number:	1.0	Status:	Approved
Responsible Director:	Chief Finance Officer		
Author:	Simon Everett, Estates Manager – Compliance & Sustainability		
Scope:	Trust Wide		
Replaces:	Sustainable Development Management Plan		
To be Read in Conjunction with the Following Documents: (list related policies)	Green Travel Plan		
Keywords:	Sustainability, Sustainable Development, Carbon, Plastic, Single Use, Emissions, Pollution		

Considered By Executive Owner:	Chief Finance Officer	Date Considered:	24/08/2021
Endorsed By:	Sustainability Working Group	Date Endorsed:	24/08/2021
Approved By:	Finance, Planning and Digital Committee	Date Approved:	21/09/2021
Issue Date:	21/09/2021	Review Date:	21/09/2024
Security Level:	Open Access ✓	Restricted	Confidential

Green Plan
2021–2024

The Robert Jones *and* Agnes Hunt Orthopaedic Hospital

www.rjah.nhs.uk

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Welcome 2021

Without question, the negative impact of **human activity is being felt on our planet**.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has already reached significant milestones in taking responsibility for its activities and reducing its impact on the environment. In the summer of 2020, we completed our £1.2m energy savings scheme, aiming to remove carbon by 809 CO_2e tonnes each year from the installation of solar panels (pictured left) to many of our buildings, LED lights, insulation and the modification of our central steam boilers.

In October 2020, NHS England published 'Delivering a Net-Zero National Health Service', a report that details the scale of the environmental problems faced by the NHS and the country. This report sets ambitious targets requiring all NHS Organisations to become **Net zero by 2040** for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. This document is a milestone for NHS Organisations in that they now have key targets to achieve by the 2030s and 2040s.

The NHS aims to provide health and high-quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 brings, protecting patients, our staff and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

As an organisation we must therefore consider the resilience of the services we provide. By this, we mean sustainable development of such services, ensuring that both our growth and our activities do not have an adverse impact on the environment, and we protect against the adversities from the environment so that we can maintain our provision of world class patient care.

Introduction

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a **leading orthopaedic centre of excellence**.

A specialist hospital with a reputation for innovation, the Trust provides a comprehensive range of musculoskeletal (bone, joint and tissue) surgical, medical and rehabilitation services; locally, regionally and nationally.

RJAH is committed to embedding sustainability across the organisation as part of its ongoing aspiration to deliver world class patient care. We want our services to remain fit for purpose both now and in the future. The Trust recognises that if it does not address sustainability as an issue, it is contributing to climate change which is believed to have a detrimental effect on health and wellbeing.

The advent of Covid-19 has meant that as an organisation we had to adapt our plans to provide care to our patients and assist the wider care system under the most challenging conditions. Our staff rose to the challenge and clearly demonstrated that substantial adaptation is possible.

This Green Plan was written in response to both Covid-19 as an example of adversity as a result of human activity, and NHS England and Government guidelines. We anticipate bolder and more specific targets to come; for example, it is forecast that the Paris Climate Change Agreement targets may be improved upon at the forthcoming UN Climate Change Conference of the Parties (COP26) in Glasgow later this year.

By delivering this Green Plan, we expect to achieve significant CO_2 and financial savings between 2021 and 2024, creating a better environment for staff and visitors, and above all, deliver world class patient care.

Scope

This plan covers the entire organisation's activities, from the **world class development** and maintenance of our buildings, to the world class care we deliver to patients daily.

We are significantly influenced by NHS England's guidance and targets, so the plan aims to outline a strategy to care for our patients, care for our staff and care for our finances in a sustainable way, in line with recognised guidance.

In order to achieve this, we plan to:

Decarbonising our building and infrastructure – Significantly reduce our reliance on fossil fuels for energy for heat, power and transport

Journeys and Transport – Encouraging green travel to minimise the impact on environment and health

Food and Waste – Making our supply chain both ethical and resource efficient, whilst significantly reducing our use of products and materials that persist in nature, such as single use plastics.

A Culture of Aspiring to Deliver World Class Patient Care – Adapting our services to meet the needs of our patients and communities to provide care that is world-renowned.

Resilience to climate change - Improve our resilience from the effects of climate change for both our communities and physical infrastructure

Wellbeing – Responsibly care for the wellbeing of our workforce; for example our commitment to the cycle to work scheme.

Medicines – Reducing the amount of polluting medicines such as anaesthetic gases, and where this is not possible, capturing and destroying such gases so that they do not contribute to global warming

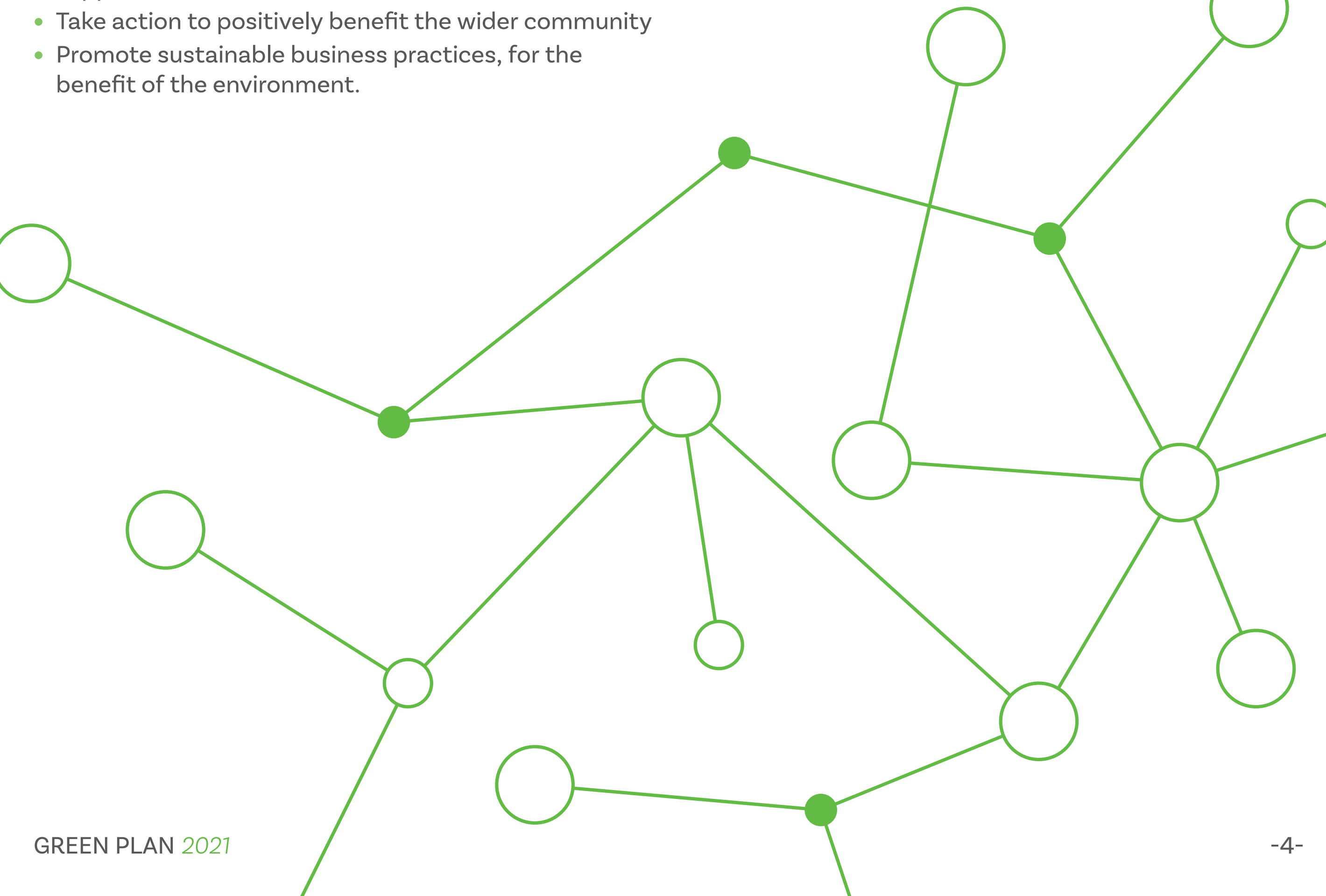
Procurement – Ensuring that the products and services we procure as a business are done so in a sustainable way, managing stock and waste responsibly and reducing indirect carbon emissions

Our **Corporate Responsibility**

We have a responsibility to ensure the way our organisation operates reflects the needs of our patients, our staff, our communities and the environment.

Our commitment to our Corporate Social Responsibility and Sustainable Development is underpinned by this Plan, and wherever possible, we will go beyond our statutory obligations to:

- Operate as a socially responsible employer
- Create equal opportunity and create an inclusive and supportive environment for our staff
- Take action to positively benefit the wider community
- Promote sustainable business practices, for the benefit of the environment.



Rationale *for* Net Zero, Rationale *for* *a* Green Plan

Why do we need to **develop sustainably,** and why do we need to reach net zero?

There is a credible business case for sustainable development. The earth's resources are finite, and so are becoming more costly to source or produce. Human activity has led to increased carbon in the atmosphere, proliferating global warming and encouraging acidification of our seas. Moreover, there are certain commitments required under the NHS Long Term Plan, the 2020 NHS Operational Planning and Contracting Guidance and the NHS Standards Contract. In order for us to World Class Patient Care, we should be leading on our journey to Net Zero.

Of the total carbon emitted by the NHS:

- Estates & Facilities account for 15%
- Travel accounts for 14%
- Medicines account for 25%

The remaining contributory factors include medical and non-medical equipment (18%), food and catering (6%), other procurement (18%) and commissioned healthcare services outside the NHS (4%).

A significant amount of waste persists in nature, so we need to avoid products that produce this waste where we can. Often, waste produces carbon (or the processing during manufacture) and therefore we need to avoid waste holistically. Plastics and waste management is a critical challenge alongside our carbon emission reduction.

Human activity is clearly influencing extreme weather events, so there are ethical implications to taking our responsibilities as both individuals and as an organisation seriously. We need to determine what our carbon footprint is in order to reduce it, and we need to build resilience to adverse weather events into our systems, service and infrastructure to ensure we continue to provide the very best level of care to our patients.

Understanding and guidance on what sustainability means should give more focus to delivering measurable changes and will enable us to nurture a culture of ethical and sustainable citizenship.

Having a dedicated Sustainability Lead is a necessity to co-ordinate the journey to Net Zero and validate our aspirations to truly deliver world class patient care.

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Decarbonising *our* **building** *and* **infrastructure**

Our **£1.2m investment in energy efficiencies** in 2020 has made some headway into reducing our demand on the national grid, with 440,000 kWh being generated per year by photovoltaic (PV) solar panels. That's compared to 3,380,000 kWh we imported from the national grid 2020-2021.

As we move to completely renewable resources to generate our energy for the site, we must act responsibly and consume fossil fuels with maximum efficiency. Because of the specialist decontamination systems, specialist ventilation systems and on-site catering services and the heating and domestic hot water systems that we deliver at the hospital, our legacy systems employ steam raising boilers which deliver superheated steam energy to equipment to ensure patient safety. We've been able to reduce our gas consumption by over 1.8 mWh per year; a significant reduction.

Our combined heating and power plant, equipment that we use that concurrently generates thermal and electrical energy has reduced the load on our heating system and therefore has increased our efficiencies when using fossil fuels. We now plan to explore methods of removing our reliance on fossil fuels to produce steam, heating and electricity.

In order to make significant headway into moving to net zero, we will:

- Determine the organisation's carbon footprint within the envelope of scopes 1,2 and 3 by 2022-23
- Explore other, greener, alternatives that could remove our demand on the national grid
- Consult on replacing our fossil fuel boilers with an alternative green energy source by 2032
- Increase our PV solar panel grid to further reduce our demand on the national grid
- Develop a metering plan to better inform our investments through the Estates' Strategy
- Commit to buy only green electricity from the national grid.

440,000 kWh

Journeys *and* Transport

Transport and travel accounts for around **14% of the NHS carbon footprint.**

The hospital is in a rural location in north Shropshire and therefore, we must look at maintaining public transport links, reducing patient journeys where possible and electrifying our vehicle fleet.

We plan to:

- Conduct staff surveys to engage with colleagues and measure data on commuting
- Change our fleet vehicles to EVs by 2024-2025
- Build on our relationships with local transport and authorities, improving transport links where possible
- Where there is no risk to patients, move consultations to online
- Work with our transport service providers to share their plans for removing combustion engine vehicles from their fleets
- Develop a strategy to Install EV charging points in line with government recommendation and rollout of wider, national programs
- Explore ways of incentivising car sharing (such as business travel rates) or use of public transport (such as season ticket subsidies)
- Incentivise ULEV car ownership
- Ensure close collaboration with our design and project teams, clinicians and Estates to ensure impact of travel is considered when developing new premises
- Develop a modernised Green Travel Plan.

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Resilience *to* climate change

Events as a direct result of climate change are diverse and increasing in frequency.

The organisation manages emerging risk through the Trust Risk Register at department level and consideration is also given at the Emergency Preparedness, Resilience and Response (EPRR) Forum.

To ensure we maintain business continuity and adapt to both direct and indirect extreme weather events we will:

- Design and construct new buildings in accordance with relevant guidance and legislation, for example; RIBA, BREEAM and the department of health document 'Resilience planning for NHS facilities (HBN 00-07)'
- Maintain and develop existing buildings and building services to provide resilience against adverse events and incidents as a result of climate change
- Provide relevant incident training to our workforce
- Maintain and bolster our contingency plans for emergencies, incidents and change in climate.

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Food *and* Waste

We have already signed up to the **single use plastic pledge**

We will:

- Explore ways in which we can avoid waste (such as re-use of unwanted furniture and office equipment)
- Divert 100% of our domestic, offensive and clinical waste from landfill
- Roll-out electronic patient ordering to avoid waste by 2022-23
- Improve our data collection on plate waste in the organisation by 2022-2023
- Plan our food waste minimisation through a formal strategy by 2023
- Expand our menus to include a wider range of plant based options by 2022-2023
- Reduce our meat-based menu options by 2025
- Replace outgoing/retired catering equipment with green-energy alternatives by 2025-2026.

The management of healthcare waste is an essential part of ensuring that healthcare activities do not pose a risk or potential risk of infection and are securely managed. UK wide legislation provides the Trust with a framework for best practice, which not only ensures, as a waste producer that the organisation meets legislative requirements but identifies and promotes opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.

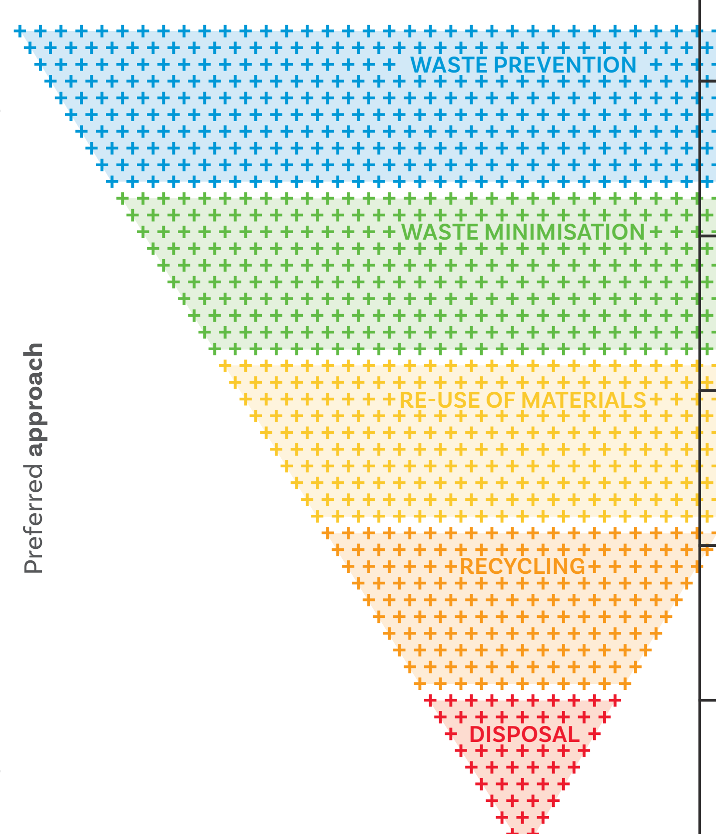
Divert 100% of our domestic, offensive and clinical waste from landfill

Our agenda focuses on applying controls identified in the waste hierarchy, across all waste streams – including clinical, domestic and food.

As a Trust identified as ‘Exemplar’ for its catering services, the organisation is committed to translating the recommendations identified in 2020’s NHS Food Review into practice.

This includes recognising our role as an anchor institution to promote a sustainable food culture, working with partners to enhance social value and environmental outcomes, and developing long term strategies to embed these changes into our operating model.

waste hierarchy diagram



Wellbeing

Wellbeing for our patients, staff and visitors is **paramount to our success** in delivering world class patient care.

Combating climate change early will have a positive outcome on burden of disease, thus improving lives and saving the NHS funding. Improving health and wellbeing through fitness and mental health support will also create an environment of prosperity and further reduce the burden on NHS services.

The wellbeing of our staff is critical to providing a consistently high level of care to our patients, so it's important that we continue to monitor staff wellbeing through 'Wellbeing Conversations', a supportive discussion to help staff process challenges they face both at work and outside of work, signpost to mental health support and ensure that a healthy work-life balance is maintained.

The Captain Sir Tom Moore Path of Positivity was built in 2021 an provides a safe area for patients and staff to exercise and find headspace when required. We also provide incentivised access to cycling equipment for our staff through the cycle to work scheme, and partner with mental health services to support our colleagues through crisis.

We will:

Introduce a flexible and agile working policy for all staff to reduce CO_2 emission from travelling to and from the hospital. This will also have a positive effect of rebalancing work and home life needs, with the results being a more productive and healthier (mentally and physically) NHS workforce.

The Captain Sir Tom Moore Path of Positivity was built in 2021

A Culture – Aspiring *to* Deliver World Class Patient Care

Our Hospital is **world-renowned** for the expertise and history of care we deliver to our patients.

The hospital's history is steeped in adapting to the needs of our patients and the needs of the NHS.

We will:

- Continue to be guided by our CCG on sustainable development
- Grow our culture to motivate and empower our people to deliver sustainable healthcare at a world class level
- Develop a culture of collaboration with our ICS and wider healthcare network to provide sustainable solutions for both for the Trust and local, regional and national organisations

We celebrate the amazing work our colleagues do daily, and have monthly 'health hero' awards and an annual Celebration of Achievement Awards where we come together to nominate and celebrate the successes shared over the year. We challenge poor practice and actively encourage colleagues to talk in confidence to nominated 'Freedom to Speak Up' guardians.

Medicines

Our current clinical practices do not include the most pollutant of anaesthetic gases, desflurane, but **we aim to seek alternatives** to the current gases

Pharmaceuticals are the second highest contributing factor towards the NHS carbon footprint. Here at RJAH we will aim to work with our Multidisciplinary teams and Integrated Care System to explore the following areas where we can make an impact and reduce environmental damage from pharmaceuticals.

- Alternative approved methods of anaesthetics that avoid utilising harmful gases
- Seek methods of engineering solutions where use of harmful gases cannot be avoided
- Work with the local system to ensure prescribing in environmentally friendly in the following ways:
  - **Labelling** – Where multiple options are available, ensure guidance is available on the possible impact on the environment the prescribing of a drug will have so that prescribers are educated and can use alternatives if appropriate. Explore and encourage future IT systems have this incorporated.
  - **Inhalers** – help reduce the impact of metered dose inhalers where clinically appropriate. A 50% cut in the carbon footprint of inhalers would save an amount approximate to 4% of the total carbon saving needed for the NHS to meet its 2030 carbon reduction target. Incorrect disposal of inhalers also has a negative environmental impact.
  - **Plastic bags** – Look to replace current plastic medicine bags with more environmentally friendly recyclable alternatives.
  - **Overprescribing waste** – Pharmaceutical wastage is a financial burden on the NHS and has a negative environmental impact. Discouraging stockpiling and regularly reviewing prescriptions can help to reduce waste and benefit patients by potentially reducing the number of medicines they take.
  - **Explore greener medicines deliveries** – work with local pharmaceutical delivery partners to develop environmentally friendly deliveries.
- **Look outside spread the message** – Pharmacists are respected healthcare professionals, and can use their scientific and clinical skills to communicate evidence on climate science and sustainability outside of the health service. Encouragement to communicate widely through being active on social media, sharing information and encouraging others to engage with a conversation about the NHS *'net zero'* change and how the health service can be more sustainable.
- Taking opportunities to speak externally to young people on how pharmacists can reduce the environmental impact of medicines.

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Procurement

NHS procurement services contribute to some of the other facets mentioned previously, but the remainder of 'other' procurement, for example physical items such as PPE, or contracted services such as out-sourced consultancy, **contributes around 18% of NHS emissions**.

There are opportunities to reduce consumption of goods and therefore avoid waste - and where we do procure, we should do so in such a way that minimises the impact socially and environmentally.

We will:

- Publish in partnership with Shropshire Healthcare Procurement Service (SHPS) an updated sustainable procurement strategy by Q4 2021-2022
- Procure, where reasonable practicable, from locally sourced businesses who are part of the frameworks recognised by SHPS.
- Ensure that we are procuring products that are ethically sourced and avoid where possible, products that persist in the environment, such as single-use plastics.
- Accelerate a paper-light campaign with the goal of paperless by 2040, by increasing digital usage in all areas resulting in secure, instantaneous transactions across the hospital.

Taking Action

We now have an opportunity to intervene; if we do so now, it will be easier for us to implement these plans, will be less costly and may avoid interruption of business continuity; thereby **positively impacting patient care, improve conditions for our staff and care for our finances.**

The action plan below identifies the roles responsible for delivering each measurable goal:

Action	Lead
Building and Infrastructure Lead: Nick Huband, *Director of Estates & Facilities*	
Determine the organisation's carbon footprint within the envelope of scopes 1,2 and 3 by 2022-23	Estates Manager – Compliance & Sustainability
Explore other, greener, alternatives that could remove our demand on the national grid	Estates Manager – Compliance & Sustainability
Consult on replacing our fossil fuel boilers with an alternative green energy source by 2032	Estates Manager – Compliance & Sustainability
Increase our PV solar panel grid to further reduce our demand on the national grid	Estates Manager – Compliance & Sustainability
Develop a metering plan to better inform our investments through the Estates' Strategy	Estates Manager – Compliance & Sustainability
Commit to buy only green electricity from the national grid	Head of Estates & Facilities

Action	Lead
Journeys & Transport **Lead: Nick Huband, *Director of Estates & Facilities***	
Change our fleet vehicles to EVs by 2024-2025	Facilities Compliance Manager
Build on our relationships with local transport and improve transport links where possible	Estates Manager – Compliance & Sustainability
Where there is no risk to patients, move consultations to online	Medical Director
Work with our transport service providers to share their plans for removing combustion engine vehicles from their fleets	Head of Estates & Facilities
Develop a strategy to Install EV charging points in line with government recommendation and rollout of wider, national programs	Estates Manager – Capital
Explore ways of incentivising car sharing (such as business travel rates) or use of public transport (such as season ticket subsidies)	Estates Manager – Compliance & Sustainability
Ensure close collaboration with our design and project teams, clinicians and Estates to ensure impact of travel is considered when developing new premises	Estates Manager - Capital
Conduct staff surveys to engage with colleagues and measure data on commuting	Estates Manager – Compliance & Sustainability
Develop a modernised Green Travel Plan	Estates Manager – Compliance & Sustainability
Incentivise ULEV car ownership	Head of Estates & Facilities
Resilience to Climate Change **Lead: Nicki Bellinger, *Assistant Chief Nurse and Trust EPRR Lead***	
Design and construct new buildings in accordance with relevant guidance and legislation, for example; RIBA, BREEAM and the department of health document 'Resilience planning for NHS facilities (HBN 00-07)'	Estates Manager – Capital
Maintain and develop existing buildings and building services to provide resilience against adverse events and incidents as a result of climate change	Head of Estates & Facilities
Provide relevant incident training for our workforce	EPRR Lead
Maintain and bolster our contingency plans for emergencies, incidents and change in climate	EPRR Lead

Action	Lead
Food and Waste **Lead: Nick Huband, *Director of Estates & Facilities***	
Divert 100% of our domestic, offensive and clinical waste from landfill	Facilities Compliance Manager
Improve our data collection on plate waste in the organisation by 2022-2023	Facilities Catering Manager
Explore ways in which we can avoid waste (such as re-use of unwanted furniture and office equipment)	Estates Manager – Compliance & Sustainability
Expand our menus to include a wider range of plant-based options by 2022-2023	Facilities Catering Manager
Reduce our meat-based menu options by 2025	Facilities Catering Manager
Plan our food waste minimisation through a formal strategy by 2023	Facilities Compliance Manager
Roll-out electronic patient ordering to avoid waste by 2022-23	Facilities Catering Manager
Replace outgoing/retired catering equipment with green-energy alternatives by 2025-2026	Facilities Catering Manager
Wellbeing **Lead: Kerry Robinson, *Director of Performance, Improvement and Organisational Development***	
Introduce a flexible and agile working policy for all staff to reduce CO_2 emission from travelling to and from the hospital	Improvement and Organisational Development Manager
Culture **Lead: Kerry Robinson, *Director of Performance, Improvement and Organisational Development***	
Continue to be guided by our CCG on sustainable development	Estates Manager – Compliance & Sustainability
Grow our culture to motivate and empower our people to deliver sustainable healthcare at a world class level	Improvement and Organisational Development Manager
Develop a culture of collaboration with our ICS and wider healthcare network to provide sustainable solutions for both for the Trust and local, regional and national organisations	Estates Manager – Compliance & Sustainability

Action	Lead
Medicines **Lead: Ruth Longfellow, *Medical Director***	
Explore alternative approved methods of anaesthetics that avoid utilising harmful gases	Nominated Anaesthetic Lead
Seek methods of engineering solutions where use of harmful gases cannot be avoided	Co-ordinating Authorised Person (Medical Gases)
Labelling – Where multiple options are available, ensure guidance is available on the possible impact on the environment the prescribing of a drug will have so that prescribers are educated and can use alternatives if appropriate.	Chief Pharmacist
Inhalers – help reduce the impact of metered dose inhalers where clinically appropriate.	Chief Pharmacist
Plastic bags – Look to replace current plastic medicine bags with more environmentally friendly recyclable alternatives.	Chief Pharmacist
Overprescribing waste – Discouraging stockpiling and regularly reviewing prescriptions can help to reduce waste and benefit patients by potentially reducing the number of medicines they take.	Chief Pharmacist
Explore greener medicines deliveries – work with local pharmaceutical delivery partners to develop environmentally friendly deliveries.	Chief Pharmacist
Look outside spread the message – Pharmacists are respected healthcare professionals, and can use their scientific and clinical skills to communicate evidence on climate science and sustainability outside of the health service.	Chief Pharmacist
Procurement **Lead: Craig Macbeth, *Chief Finance Officer***	
Publish in partnership with Shropshire Healthcare Procurement Service (SHPS) an updated sustainable procurement strategy by Q4 2021-2022	Senior Procurement Manager
Procure, where reasonable practicable, from locally sourced businesses who are part of the frameworks recognised by SHPS.	Senior Procurement Manager
Ensure that we are procuring products that are ethically sourced and avoid where possible, products that persist in the environment, such as single-use plastics.	Senior Procurement Manager

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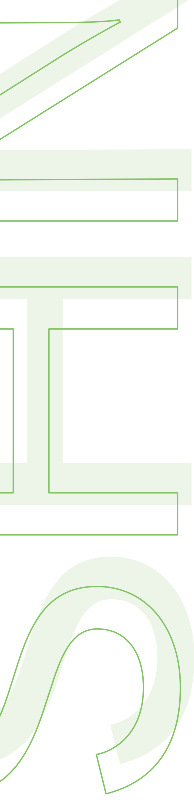
Acronyms

Acronym	Description
BREEAM	Building Research Establishment Environmental Assessment Method
CCG	Clinical Commissioning Group
COP26	UN Climate Change Conference of the Parties
CO_2	Carbon Dioxide
CO_2e	Carbon dioxide equivalent (where CO_2 is not emitted directly)
COVID-19	CoronaVirus Disease 19
EPRR	Emergency Preparedness, Resilience and Response (Forum)
EV	Electric Vehicle
HBN	Health Building Note
HTM	Health Technical Memorandum
ICS	Integrated Care System
kWh	Kilo Watt Hours
LEV	Low Emissions Vehicle
mWh	Mega Watt Hours
NHS	National Health Service
PV	PhotoVoltaic (solar panels)
Q4	Quarter 4
RIBA	Royal Institute of British Architects
RJAH	Robert Jones & Agnes Hunt Orthopaedic Hospital Foundation Trust
SHPS	Shropshire Healthcare Procurement Services
ULEV	Ultra Low Emissions Vehicle
UN	United Nations



CEO Update

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Stacey Keegan, Chief Executive Officer	Paper date:	6 July 2022
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	30 June 2022
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2. Conclusion

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

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

3. The Main Report

3.1. Integrated Care System

I want to start by acknowledging that our integrated care system for Shropshire, Telford and Wrekin has now officially become a statutory body as of the 1 July, which was on Friday last week.

RJAH as a member of the system are eager to play our full part in delivering the highest possible standards of health and care for everyone across all of our communities. We know that we have many challenges ahead of us, but I am confident that the partnership approach that we are embracing is the right one. I look forward to working with all our partners to deliver on our collective goals.

3.2. Patient Visitors

Board members will know that we re-opened the hospital to more patient visitors over the last couple of weeks, in line with changes happening at many hospitals around the country and in keeping with easing of the national guidance on infection prevention and control measures related to the coronavirus pandemic.

The halt we put on visiting earlier this year was the right thing to do to protect our patients and our staff. But we know that being in hospital can be a difficult time for people, and not being able to see any of their family or loved ones has made it even harder. We supported patients with technology to allow virtual contact, but nothing beats being able to talk to someone face-to-face.

We continue to monitor the situation very closely and are fully aware that covid prevalence in the community and our acute hospitals has risen over the past week. We will re-introduce covid restrictions if necessary.

3.3. Public Governor Vacancies

This past month, we have opened elections for four Public Governor vacancies. We are looking for nominations from candidates with a wide range of experiences and backgrounds to join the Council of Governors.

As a Foundation Trust, we have the flexibility to provide health services that our communities need, and our elected Governors play a crucial role in ensuring the views of the wider community are taken into account in providing and developing services.

More details can be found on our website.

3.4. Frank Collins - OBE

I'd like to offer my congratulations to Frank Collins – our former Chair – who has been named an OBE in the latest Honours list unveiled to mark the Queen's 70th Jubilee for his services to the NHS.

Frank was Chair of RJAH for seven years, taking the post on in February 2015 before stepping down earlier this year at the end of January.

Also, I'd like to congratulate Trevor McMillan, Non-Executive Director, STW ICS who was awarded an OBE for services to Higher Education.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

3.5. Pride Month

I was also delighted to see the hospital celebrating Pride Month throughout June, having the opportunity to see all the entries from local children and our patients from Alice Ward in our Pride T-shirt competition. The culmination of those celebrations came on Thursday last week, with the unveiling of our new Pride Progress flag outside our hospital, the progress flag recognises the diversity within LGBTQ+ communities. I hope it stands as a clear symbol of our commitment to inclusivity for all.

Celebrating Pride Month has given us a chance to pause and reflect, we have made progress but there is more we still need to do, as a health system and as a society, to make sure that everyone is valued for who they are.

3.6.Changing Places Facility

Next, I am delighted that our patients and visitors can now benefit from a state-of-the-art Changing Places facility – a dedicated space which supports the needs of those with learning and/or physical disabilities.

People with severe disabilities, such as muscular dystrophy, cerebral palsy and multiple sclerosis, and their carers say Changing Places facilities can be life changing and allow them to go out in public or attend hospital appointments without fear or stress.

Changing Places are larger accessible toilets and include equipment such as hoists, privacy screens, adult-sized changing benches, peninsula toilets and space for carers.

3.7. NHS Confederation

NHS Confederation, NHS England and Improvement joined forces to bring together two long standing conferences and create a new event – **NHS ConfedExpo**, which ran for two days in June that Harry Turner, colleagues and I attended.

The conference created a single point of focus for health and care leaders to come together at a time of transformation and recovery. NHS ConfedExpo fostered networking, spread learning and encouraged innovation.

The conference contained a mixture of high profile and influential plenary speakers, theatre sessions and a range of networking opportunities.

3.8. Telford and Wrekin Council

At the end of June, Telford and Wrekin Council won Local Authority of the year in the ‘Oscars’ of local government, the MJ Achievement Awards 2022.

The annual awards recognise the very best in council services across the UK.

Congratulations to Telford and Wrekin Council.

3.9. Messenger

On the 8th June 2022, General Sir Gordon Messenger and Dame Linda Pollard published their final report on the review of leadership and management in the health and social care sector, as commissioned by the Secretary of State for Health and Social Care in October 2021.

This review examined the state of leadership and management in the health and care sector, it recognised the change in environment that the NHS is now operating in, as more integrated care, collaboration, trust and relational leadership is required.

The report concludes with seven recommendations:

- Targeted interventions on collaborative leadership and organisational values
- Positive equality, diversity, and inclusion action
- Consistent management standards delivered through accredited training
- A simplified, standard appraisal system for the NHS
- A new career and talent management function for managers
- More effective recruitment and development of Non-Executive Directors
- Encouraging top talent into challenged parts of the system.

The Trust will be reviewing what is in place to meet the recommendations of the Messenger report and gaps that require us to take actions.

3.10. Health Hero Award

Finally, I will end as usual by announcing the latest recipients of our Health Hero Award - our winner for June is Mike Nowell, who works as part of the Digital Services Department, and who has been recognised for going above and beyond to support the Pharmacy Team who recently upgraded their computer systems.

He was nominated by Wendy Mayne, Pharmacy Technician Specialist, who said: “Mike is always there to support us and is happy to help. He is someone who keeps the hospital running and has so much knowledge but is always very humble and works so hard to support the clinical teams.”

Our Digital Services Team work so hard to ensure our systems are working correctly, and upgrading them when necessary, helping us to deliver safe patient care. I am delighted that Mike has been recognised for the key role he plays within this team.

Since we last met in public, we have also presented the May Health Hero Award. That went to Operating Department Practitioner Louise Jones for her innovation and ideas.

Louise, who works in Theatres in the anaesthetics department, has been recognised for her commitment to the environment and for setting a shining example for infection prevention and control (IPC) standards across the Trust. She was nominated by Dr Ruth Longfellow, our Chief Medical Officer and Consultant Anaesthetist.

Congratulations to both Mike and Louise.

4.0. Conclusion

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

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Month 2 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Senior information Analyst	Paper date:	6 July 2022
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	Paper Category:	Performance
Paper Reviewed by:	Senior Leader Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

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

The committee is asked to note the assurance provided on overall performance as presented in the month 2 (May) Integrated Performance Report, against all areas, and actions being taken to meet targets where missed, providing assurance on the process to meet the target.

2. Executive Summary

2.1. Context

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

The format of the IPR utilises Statistical Process Control (SPC) graphs and NHS EI recommended variation and assurance icons.

The reading guide within the IPR gives a full explanation on the interpretation of SPC graphs and the icons to support understanding.

2.2. Overview

The Board through this IPR should note the following;

The legacy of covid continues to impact delivery of our statutory targets and waiting times. Whilst a further revision to plan has been submitted in line with national guidance, this report measures our performance against the original plan. The revised plan will be reflected in our June IPR.

Patients continue to be booked in line with guidance regarding clinical priority as a primary rather than date order, with an additional focus on eliminating 104 week waiters.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Caring for Staff;

- Sickness Absence
  - Metric showing special cause variation of a concerning nature but back within control range
  - Both long term and short term sickness remain as special cause variation of concern
- Voluntary Staff Turnover – an exception at Trust level and specific Staff Groups are consistently off target
  - Additional Clinical
  - Administrative and Clerical
  - Estates and Ancillary
  - Nursing and Midwifery
- Vacancy Rate
  - Overall showing special cause variation of an improving nature

Caring for Patients;

- Number of Complaints
  - Off target for four consecutive months
- Unexpected deaths
  - One death reported
- WHO Documentation Audit - % Compliance
  - Five months off target
- 31 Days First Treatment
  - One patient breach; data quality issue to be rectified by Tumour Unit
- 18 Weeks RTT Open Pathways
  - Metric continues to fail the 92% target. As expected from covid impact, this will continue for a considerable time
- Patients Waiting Over 52 Weeks
  - Both English and Welsh showing special cause variation with increases reported this month
  - For month 2 our English patients waiting over 52 weeks is 80 patients above our planned trajectory
- Patients Waiting Over 78 Weeks
  - Both English and Welsh showing special cause variation with increases reported this month
  - For month 2 our English patients waiting over 78 weeks is 33 patients above our planned trajectory
- Patients Waiting Over 104 Weeks
  - English and Welsh individually showing special cause variation of concern
  - For month 2 our English patients waiting over 104 weeks is 14 patients above our planned trajectory
- 6 and 8 Week Wait for Diagnostics
  - Both English and Welsh standards showing as special cause variation and both consistently off target

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Caring for Finances;

- Bed Occupancy – All Wards – 2pm
    - Metric shown as special cause variation of an improving nature, although consistently failing target
- Financial Control Total
    - Adverse to plan
- Income
    - Adverse in month
- Cash Balance
    - Cash levels in month lower than plan

2.3. Conclusion

The Board is asked to **note** the assurances provided on overall performance as presented in the month 2 (May) Integrated Performance Report, against all areas and actions being taken to meet targets providing assurance on process to meet the target and where insufficient assurance is received seek additional assurance.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

	IPR Position		June 2022 Unvalidated Position	
Metric	**May-22**	**Snapshot Date**	**Snapshot Position**	**Supporting commentary**
Sickness Absence	4.89%	28/06/2022	4.80%	Sickness Absence % within Trust on snapshot date.
Vacancy Rate	4.97%	28/06/2022	5.59%	Unvalidated. Inclusive of May's payroll transactions. Subject to change.
Never Events	0	28/06/2022	0	
Serious Incidents	0	28/06/2022	0	
Surgical Site Infections	0	28/06/2022	1	One SSI confirmed in June; surgery took place in May
Patients Waiting Over 104 Weeks - English	113	26/06/2022	94	As per weekly submission made to NHS EI on snapshot date.
Private Patient Activity	65.57% (40 against a plan of 61)	29/06/2022	86.57% (58 against a plan of 67)	Snapshots include upcoming booked activity. Subject to change.
Total Elective Activity against Plan	102.31% (932 against a plan of 911)	29/06/2022	96.93% (852 against a plan of 879)	
Total Outpatient Activity against Plan	101.52% (14,186 against a plan of 13,974)	29/06/2022	95.28% (12,064 against a plan of 12,661)	

Integrated Performance Report
May 2022 – Month 2

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

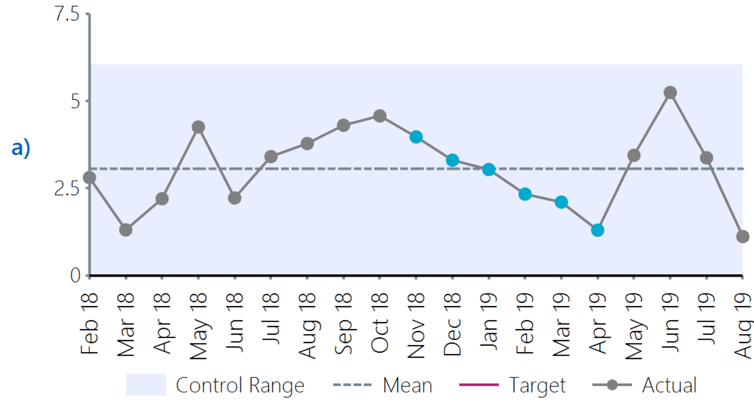
Some examples of these are shown in the images to the right:

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

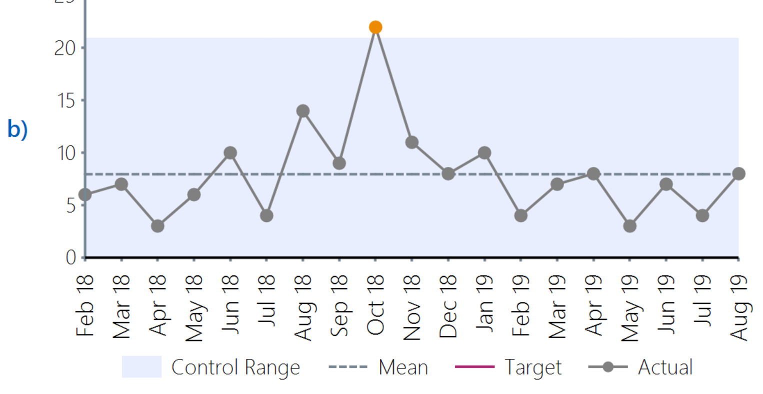
b) shows a point of concern sitting above the control range.

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

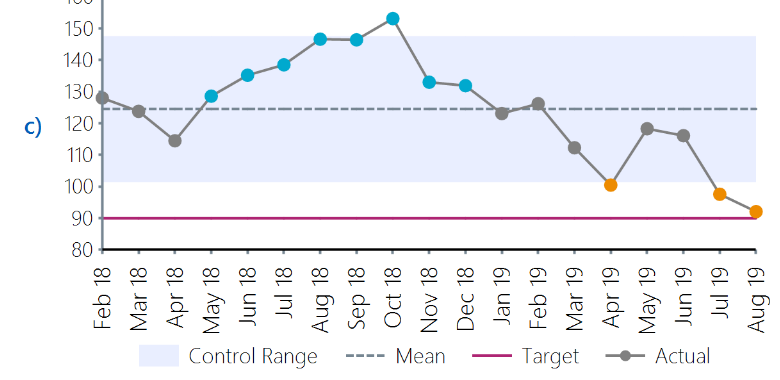
a)



b)



c)



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

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

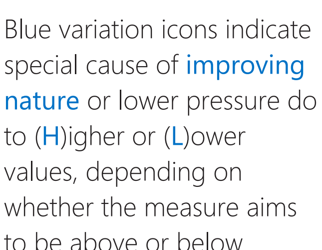
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually 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.

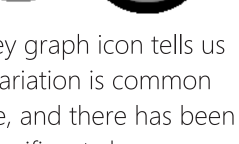
Variation Icons

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

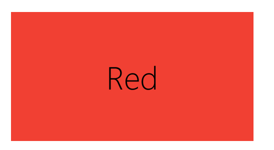
Blue

No improvement required to comply with the dimensions of data quality

Green

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.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan 22_23	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	4.89%		H	?	+	27/02/20
Voluntary Staff Turnover - Headcount	8.00%	9.86%		H	?	+	24/06/21
Vacancy Rate	8.00%	4.97%		L	P	+	14/03/19

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan 22_23	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	?		
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	11			?	+	
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	0		N/A to SPC	?		24/06/21
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?		

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan 22_23	Variation	Assurance	Exception	DQ Rating
Unexpected Deaths	0	1		N/A to SPC	?	+	16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P		
WHO Documentation Audit - % Compliance	100%	94%		N/A to SPC	F	+	
31 Days First Treatment (Tumour)*	96%	0%		L	?	+	24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85%	100%			?		
6 Week Wait for Diagnostics - English Patients	99.00%	61.54%		L	F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	59.22%		L	F	+	
18 Weeks RTT Open Pathways	92.00%	53.79%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	2,015	1,935	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	972		H	F	+	24/06/21

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan 22_23	Variation	Assurance	Exception	DQ Rating
Patients Waiting Over 78 Weeks - English	0	683	650	H	F	+	
Patients Waiting Over 78 Weeks – Welsh	0	331		H	F	+	
Patients Waiting Over 104 Weeks - English	0	113	99	H	F	+	
Patients Waiting Over 104 Weeks - Welsh	0	86		H	F	+	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Summary - Caring for Finances

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan 22_23	Variation	Assurance	Exception	DQ Rating
Total Elective against Plan	100%	102%			?		
Bed Occupancy – All Wards – 2pm	87.00%	83.03%		H	F	+	09/03/22
Total Outpatients against Plan	100.00%	106.92%		N/A to SPC	?		
Financial Control Total	-472	-633		N/A to SPC	Moving Target	+	
Income	9,778	9,554		N/A to SPC	Moving Target	+	
Expenditure	10,301	10,237		N/A to SPC	Moving Target		
Efficiency Delivered	138	149		N/A to SPC	Moving Target		
Big Ticket Item (BTI) Efficiency Delivered	0	0		N/A to SPC	?		
Cash Balance	23,735	23,218		H	Moving Target	+	
Capital Expenditure	838	243		N/A to SPC	Moving Target		

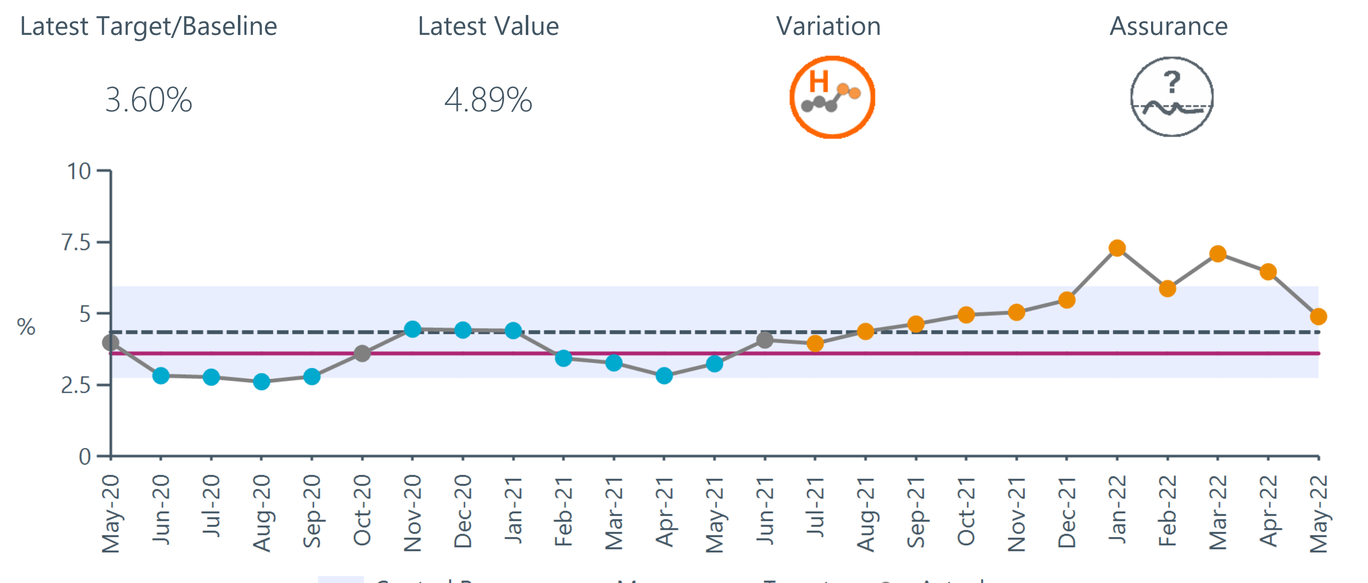
Sickness Absence

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

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
3.60%	4.89%		

Trajectory/Plan 22_23



What these graphs are telling us

Metric is experiencing special cause variation of a concerning 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 sickness absence reported for May is 4.89%. Sickness excluding 'infectious diseases' was 4.40%. The rate remains above target and is shown as special cause variation but is back within our control range. Unit level detail below for those areas that are above target:
* MSK Unit - 6.95% (6.02% excluding 'infectious diseases')
* Specialist Unit - 4.43% (4.33% excluding 'infectious diseases')
* CSU - 5.12% (4.42% excluding 'infectious diseases')

At Trust-level, the highest reason for absence was 'Anxiety/Stress/Depression'.

Staff groups with the highest levels of sickness absence were:
* Healthcare Assistants - 10.55%
* Registered Nursing Staff - 5.82%

Actions

Actions in relation to sickness include:
* Data Quality improvements where 'other known reasons' is recorded as absence reason; Workforce Information Team cross-checking against doctors' notes to update where possible
* People Services Business Partners continue to provide regular engagement and coaching to managers whilst targeting areas with highest levels of absence
* Emphasis on preventative actions to support staff to be in the workplace; this could include redeployment or agreement of flexible working
* Assess the wellbeing interventions that are available to staff; multiple sources of support available to staff but improvements in communication of these and appropriate signposting to be reviewed
* Analysis of staff survey with particular emphasis on those areas referred to in the Single Oversight Framework (although must be noted; there are limitations in the analysis as the results are not at department level)

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
3.24%	4.07%	3.95%	4.37%	4.63%	4.95%	5.04%	5.47%	7.29%	5.87%	7.09%	6.46%	4.89%

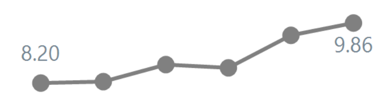
Voluntary Staff Turnover - Headcount

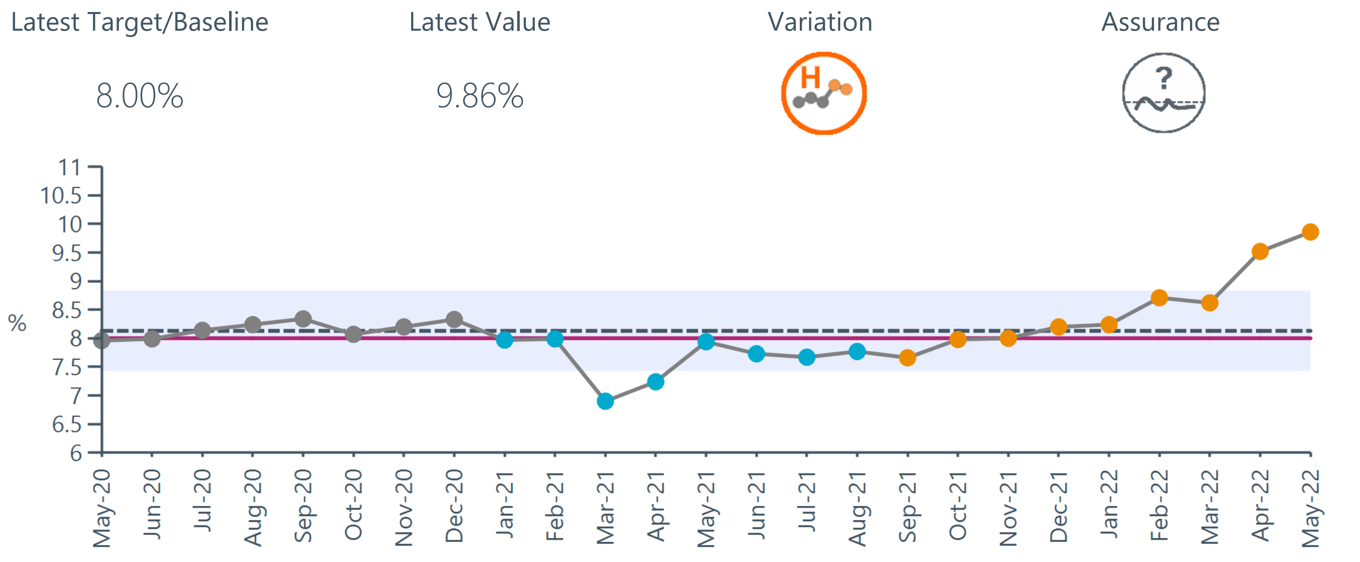
Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 217394

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
8.00%	9.86%		

Trajectory/Plan 22_23





What these graphs are telling us

Metric is experiencing special cause variation of a concerning 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

Voluntary Staff Turnover, at Trust level, has now exceeded the 8% target for six months, and is shown as special cause variation, remaining above the control range. In the latest twelve month period, June-21 to May-22, there have been 162 leavers throughout the Trust. This is in relation to a headcount in post of 1643, as at 31st May 2022.
The staff groups with turnover above target are; Nursing and Midwifery - 12.14%, Estates and Ancillary - 12.0%, Allied Health Professionals - 11.92%, Additional Clinic - 9.12%, Administrative and Clinical - 8.96%

The top three reasons for leaving (that accounts for 62.96%) at Trust level were:
* Retirement age 46 / 28.40%
* Voluntary Resignation - Other/Not Known - 35 / 21.60%
* Voluntary Resignation - Work Life Balance - 21 / 12.96%
This is based on the leaving reasons listed on termination form/ESR. There are three categories for Retirement - Age, ill health and flexi retirement. The total for these three categories was 55 leavers in the last twelve months. Of the 55 leaving due to retirement, 36 returned in some capacity (65%).

Actions

Actions in relation to voluntary staff turnover include:
* People Business Partners have carried out some initial analysis of data to analyse demographic view of the Trust workforce; there is a higher proportion of staff aged 50+ when compared to the NHS average and so correlates with the reasons for leaving. Within Specialist Unit some initial findings have been discussed with appropriate managers looking at skill mix and job descriptions to help with recruitment.
* In line with the 'Looking after our people' section in the Single Oversight Framework and NHS People Plan, need to consider the flexible working patterns being offered and taken up by staff; requirement to review the process to ensure there is accurate means of capturing this data for monitoring purposes. This can then be reviewed alongside turnover and retention data.
* Turnover in Therapies is a 'hot spot' at the moment; a review has been undertaken with a set of actions underway being supported with external expertise
* Two further 'hot spot' areas on two separate wards; reviews are currently underway that will help determine appropriate actions

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
7%	7%	7%	7%	7%	7%	8%	8%	8%	8%	8%	9%	9%

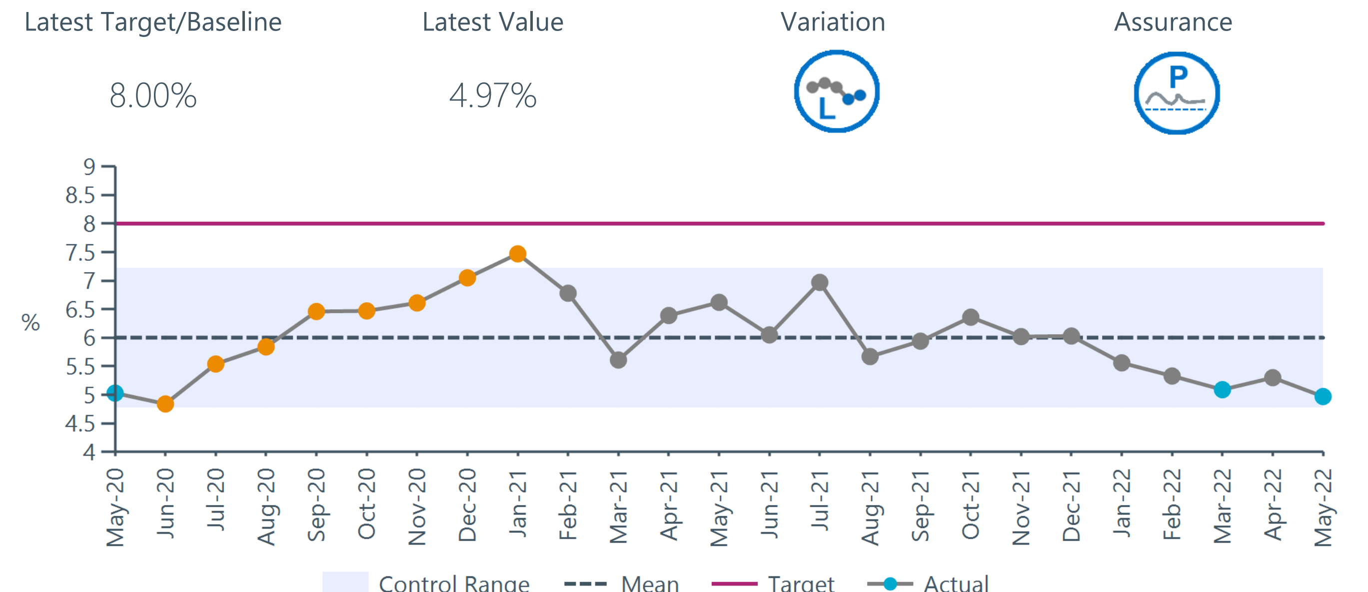
Vacancy Rate

% of posts vacant at month end 211183

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
8.00%	4.97%		

Trajectory/Plan 22_23



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. The assurance indicates that this is consistently passing (meeting) the target.

Narrative

The Trust-wide vacancy rate is reported at 4.97% at the end of May. This KPI is included as an exception as the SPC is indicating special cause variation of an improving nature. A breakdown by Unit is provided below identifying that not all areas of the Trust are below the 8% target. Units above target are:
* Specialist Unit - 8.95% equating to 30.02 WTE
* Assurance & Standard Team - 7.86% equating to 18.53 WTE
* MSK Unit - 6.01% equating to 29.96 WTE

Units below the 8% target are:
* Clinical Services Unit - 0.91%
* Support Services Unit - Over-recruited at -4.65%

Actions

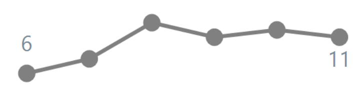
May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
6.62%	6.05%	6.97%	5.67%	5.94%	6.36%	6.02%	6.03%	5.56%	5.33%	5.09%	5.30%	4.97%

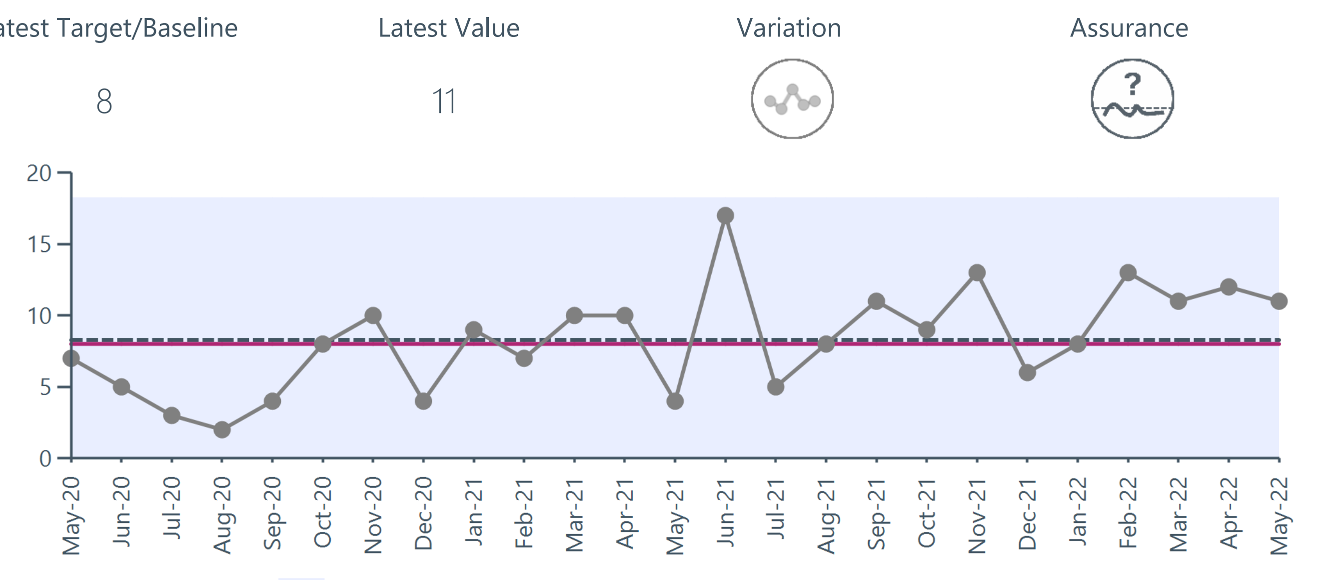
Number of Complaints

Number of complaints received in month 211105

Exec Lead:
Chief Nurse and Patient Safety Officer

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/Plan 22_23
8	11			





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

There were eleven complaints received in May; above the Trust's tolerance of eight. This KPI is included as an exception this month as it has been off target for four consecutive months. Seven complaints related to operational issues with reasons associated with delayed/cancelled surgery (2), care in radiology (1), lack of private beds (1), waiting time in clinic (1), staffing levels in therapies (1) and cancelled outpatient appointment (1). There were four further clinical complaints relating to outcome of clinic appointment (1), delays in patient discharge (1), outcome of surgery (1) and care on ward (1).

Actions

Actions in relation to complaints include:
* One of the Assistant Chief Nurses will be undertaking a review of the complaints received in the last twelve months, in particular, paying reference to those categorised as 'values and behaviour' to identify if appropriate training or actions are required in this area. The findings of this review will be reported to the Patient Experience Committee in August.
* Ludlow ward has now reopened so we do not anticipate any further complaints in relation to the ward used for private patients care.
* Establish if there is any benchmarking data available to understand if the increase in complaints is a national trend. If such data is available, determine if any actions or learning is available for us to access.
* The target for this KPI will be kept under regular review.

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
4	17	5	8	11	9	13	6	8	13	11	12	11

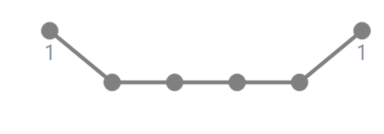
Unexpected Deaths

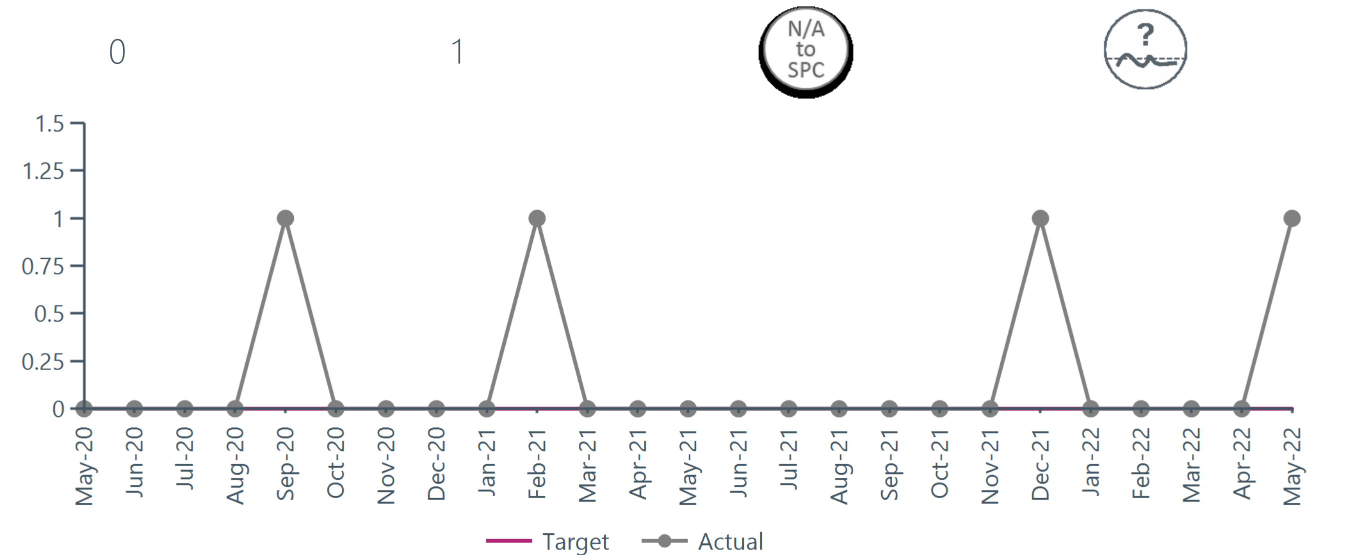
Number of Unexpected Deaths in Month 211182

Exec Lead:
Chief Medical Officer

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

Trajectory/Plan 22_23





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 unexpected death reported in May.

Actions

This will be reviewed in line with Trust Policy.

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

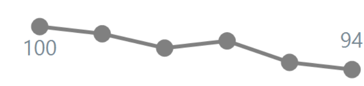
WHO Documentation Audit - % Compliance

% of sticker compliance for steps one to five of WHO documentation 217718

Exec Lead:
Chief Medical Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
100%	94%	N/A to SPC	F

Trajectory/Plan 22_23



Actual
Trajectory

What these graphs are telling us

This measure is not appropriate to display as SPC. The assurance indicates that this is consistently failing the target.

Narrative

The WHO Documentation Audit - % Compliance in April is reporting 94%.
A total of 40 paper documentation audits were undertaken by the Recovery team, where staff were checking for stickers evidencing adherence to each of the WHO five steps, results of which showed:
* Audit 1 - 100% compliant
* Audit 2 - 92% compliant – achieved 6/10 in sign-out
* Audit 3 - 94% compliant – achieved 9/10 in brief, sign-out and debrief
* Audit 4 - 90% compliant – achieved 9/10 in sign-in and time out, 7/10 in sign-out
The aim of the audit is to ascertain how well the team are recording compliance in patients' notes. A full and complete record of the background evidence of the audit is retained by Theatres and the outcomes of the audit are being reviewed for common themes and, where appropriate, actions to improve.

Actions

Documentation audit results and observations have been shared with the Matron, Assistant Chief Nurse and the Chief Medical Officer, and the detail behind the audit results and actions to improve compliance will be discussed at the fortnightly Theatre User Group meeting. A recommendation in relation to the 100% target compliance level will be brought to Patient Safety Committee by the Assistant Chief Nurse.

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
	94%	90%	95%	96%	93%	98%	100%	99%	97%	98%	95%	94%

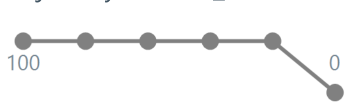
31 Days First Treatment (Tumour)*

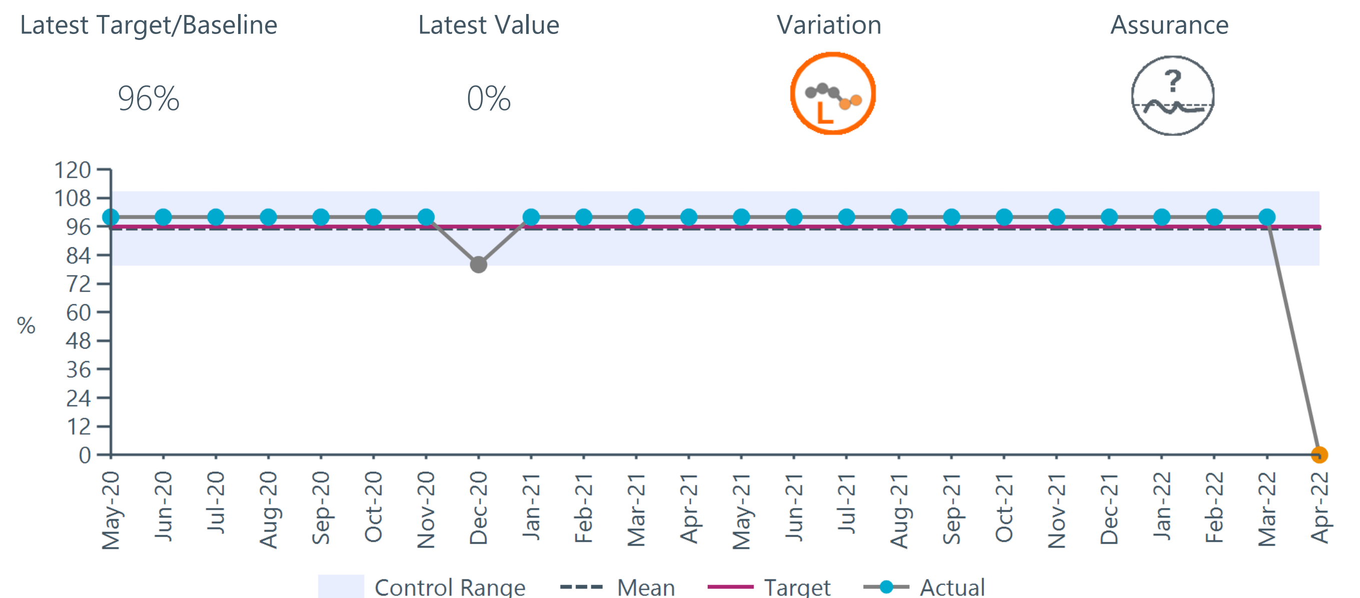
% of cancer patients treated within 31 days of decision to treat (*Reported one month in arrears) 211024

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
96%	0%		

Trajectory/Plan 22_23





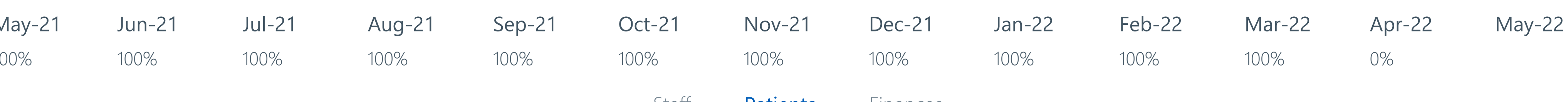
What these graphs are telling us

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

Narrative

The 31 Days First Treatment standard is reported at 0% in April; this measure is reported in arrears. This equates to one patient but a review of the pathway by the consultant and administrative staff has identified that this pathway was not recorded correctly in the data submitted to the national cancer waits system. This has now been updated and there will be no patients reported against this standard for April but the national reporting will not reflect this immediately as they hold two bi-annual revision periods with the first for April-September 22 in November.

Actions



May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	

6 Week Wait for Diagnostics - English Patients

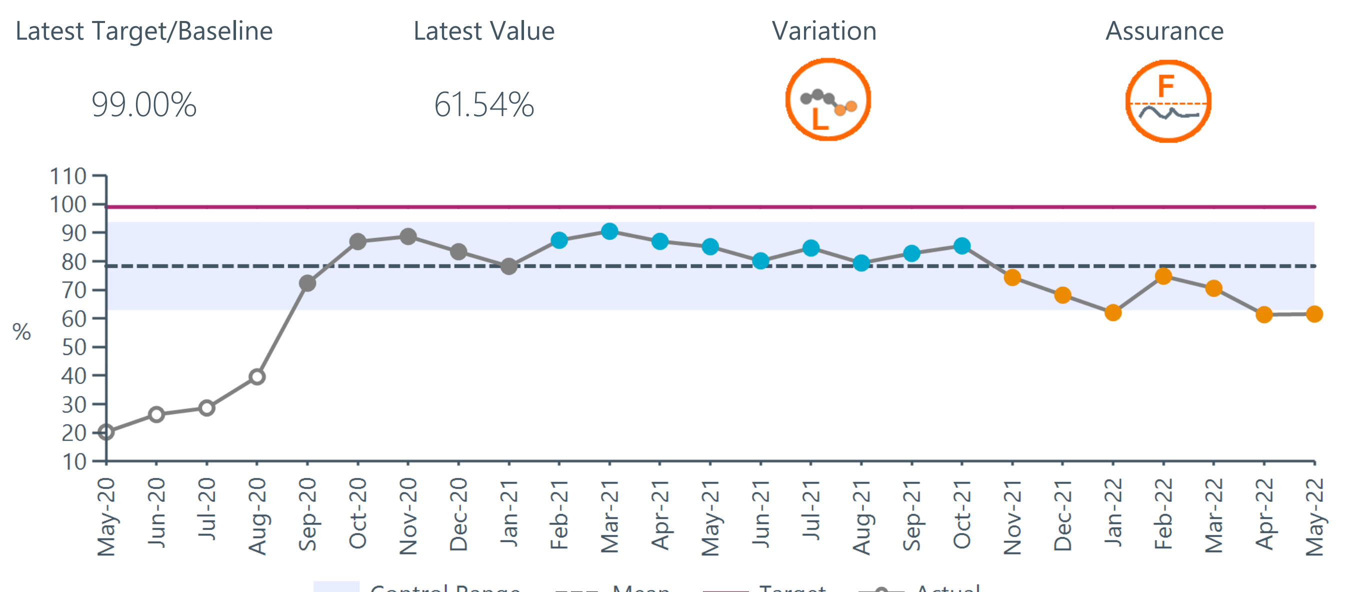
% of English patients currently waiting less than 6 weeks for diagnostics 211026

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	61.54%	L	F

Trajectory/Plan 22_23

68.16 … 61.54



What these graphs are telling us

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

Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 61.54%. This equates to 743 patients who waited beyond 6 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 52.14% - D2 (Urgent - 0-2 weeks) 4 dated, D3 (Routine - 4-6 weeks) - 3 dated, D4 (Routine - 6-12 weeks) - 643 with 281 dated
- CT - 86.81% - D4 (Routine - 6-12 weeks) - 19 with 7 dated
- Ultrasound - 82.13% - D4 (Routine - 6-12 weeks) - 74 with 71 dated
- DEXA Scans - 100%

Activity was lost in May due to the use of the mobile MRI scanner where throughput is lower, staff training on the new scanner and also a reduction in overtime provision from MRI staff as summer months approach. It also must be noted that the increased outpatient activity is resulting in increased referrals for MRI and Ultrasounds. Furthermore, the trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were changed from routine to urgent.
It must be noted that the trajectory for May for MRI was 50%.

Actions

Actions include:
- Extended weekend working to be implemented from October 2022, up until then staff to continue to work overtime at the weekends
- Currently reviewing skill mix within Diagnostics to train and then utilise established staff across multiple modalities where pressures arise
- Data supplied to system for Demand and Capacity Model to help with monitoring and forecasting within all modalities
- Currently developing a proposal for additional community services to increase community diagnostic services which will be taken through FPD Committee
- The Trust worked on proposal for additional ERF that would enable the mobile scanner to stay by this could not be prioritised by the system
It is anticipated that the actions above will help to improve the current performance although not meet the target. The national expectations are not for this target to be achieved throughout 22/23.

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
85.13%	80.17%	84.66%	79.43%	82.78%	85.42%	74.35%	68.16%	62.04%	74.81%	70.56%	61.33%	61.54%

8 Week Wait for Diagnostics - Welsh Patients

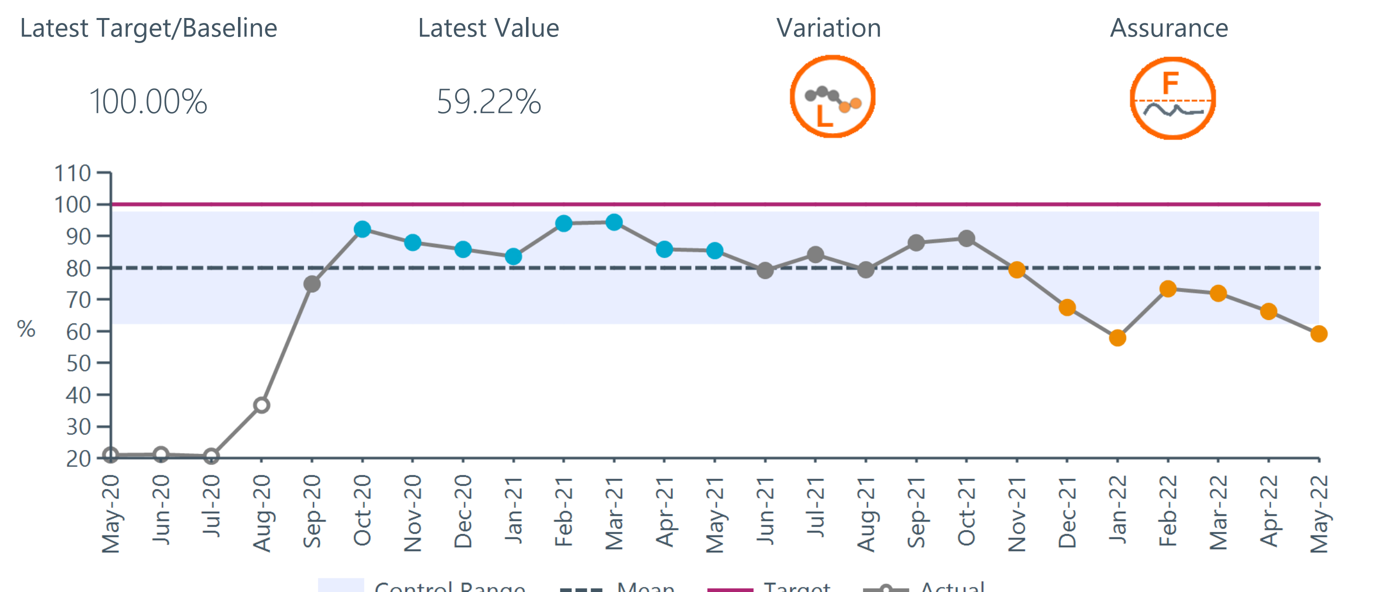
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	59.22%		

Trajectory/Plan 22_23

67.51 59.22



What these graphs are telling us

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

Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

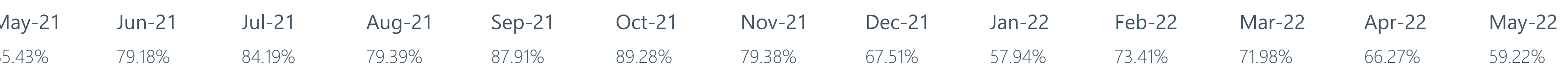
Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 59.22%. This equates to 343 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 54.24% - D3 (Routine - 4-6 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 328 with 128 dated
- CT - 83.78% - D4 (Routine - 6-12 weeks) - 6 with 2 dated
- Ultrasound - 90.24% - D4 (Routine - 6-12 weeks) - 8 with 7 dated
- DEXA Scans - 100%

Activity was lost in May due to the use of the mobile MRI scanner where throughput is lower, staff training on the new scanner and also a reduction in overtime provision from MRI staff as summer months approach. It also must be noted that the increased outpatient activity is resulting in increased referrals for MRI and Ultrasounds. Furthermore, the trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were changed from routine to urgent.

Actions

Actions include:
- Extended weekend working to be implemented from October 2022, up until then staff to continue to work overtime at the weekends
- Currently reviewing skill mix within Diagnostics to train and then utilise established staff across multiple modalities where pressures arise
- Data supplied to system for Demand and Capacity Model to help with monitoring and forecasting within all modalities
- Currently developing a proposal for additional community services to increase community diagnostic services which will be taken through FPD Committee
- The Trust worked on proposal for additional ERF that would enable the mobile scanner to stay by this could not be prioritised by the system
It is anticipated that the actions above will help to improve the current performance although not meet the target. The national expectations are not for this target to be achieved throughout 22/23.



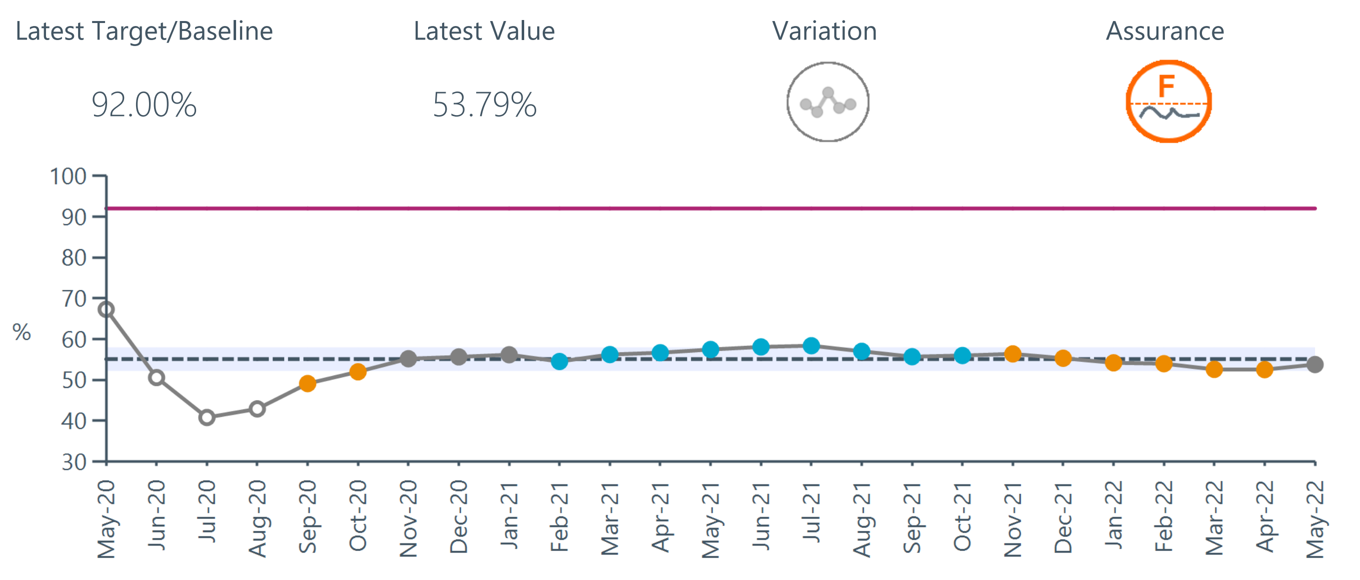
May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
85.43%	79.18%	84.19%	79.39%	87.91%	89.28%	79.38%	67.51%	57.94%	73.41%	71.98%	66.27%	59.22%

18 Weeks RTT Open Pathways

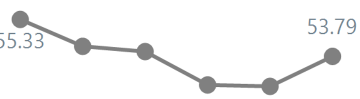
% of English patients on waiting list waiting 18 weeks or less 211021

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	53.79%		



Trajectory/Plan 22_23



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.
Following guidance from NHS EI we have updated the SPC graph to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. At present we are displaying our latest control range based on performance from September-20. We will continue to monitor the control range as we include further data points.

Narrative

Our May performance was 53.79% 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 - 7605 patients waiting of which 2076 are breaches
* MS2 - 1410 patients waiting of which 843 are breaches
* MS3 - 5061 patients waiting of which 3586 are breaches

Actions

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 - exceptions are patients choice/specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patients choice / specific specialties
* Develop plans to reduce 52 week waits with ambition to eliminate them by March 2025
We continue with the Trust's plans and actions to manage demand. These are inclusive of:
- Activity plans for Independent sector and mutual aid capacity
- Increasing available Theatre sessions - Theatres workforce plan and consultant recruitment
- Exploring options to increase Cases per Session (CPS): - CPS when compared with 2019/20 is being impacted by complexity of patients presenting as high priority
- More clock stops in non-admitted pathways - Capacity in delivery area (i.e. Radiology or MOPD) is continually assessed

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
57.46%	58.10%	58.40%	57.02%	55.71%	55.99%	56.39%	55.33%	54.21%	53.99%	52.60%	52.54%	53.79%

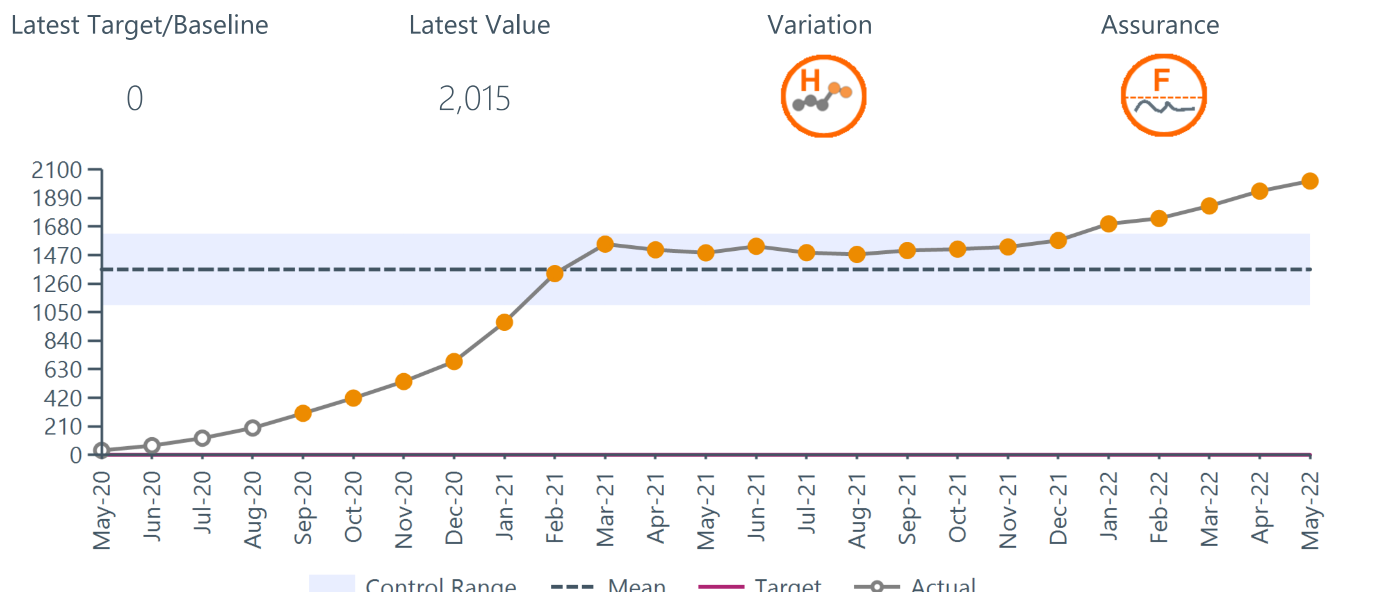
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Patients Waiting Over 52 Weeks – English

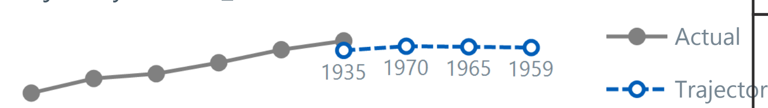
Number of English RTT patients waiting 52 weeks or more at month end 211139

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	2,015	H	F



Trajectory/Plan 22_23



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Narrative

At the end of May there were 2015 English patients waiting over 52 weeks; above our trajectory figure of 1935 by 80.

The patients are under the care of the following sub-specialities; Spinal Disorders (1050), Knee & Sports Injuries (336), Arthroplasty (208), Upper Limb (152), Foot & Ankle (94), Veterans (76), Spinal Injuries (53), Metabolic Medicine (18), Paediatric Orthopaedics (14), Tumour (6), Rheumatology (3), Neurology (3) and Orthotics (2).

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1332 patients
- >78 to <=95 weeks - 469 patients
- >95 to <=104 weeks - 101 patients
- >104 weeks - 113 patients

Actions

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 by July 2022 - exceptions are patients choice / specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patients choice / specific specialties
* Develop plans that support an overall reduction in 52-week waits where possible, in line with ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties

The submitted plans have been reflected in the trajectory line above.

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services.

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
1487	1535	1488	1475	1504	1514	1530	1578	1700	1740	1832	1941	2015

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

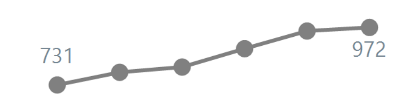
Patients Waiting Over 52 Weeks – Welsh

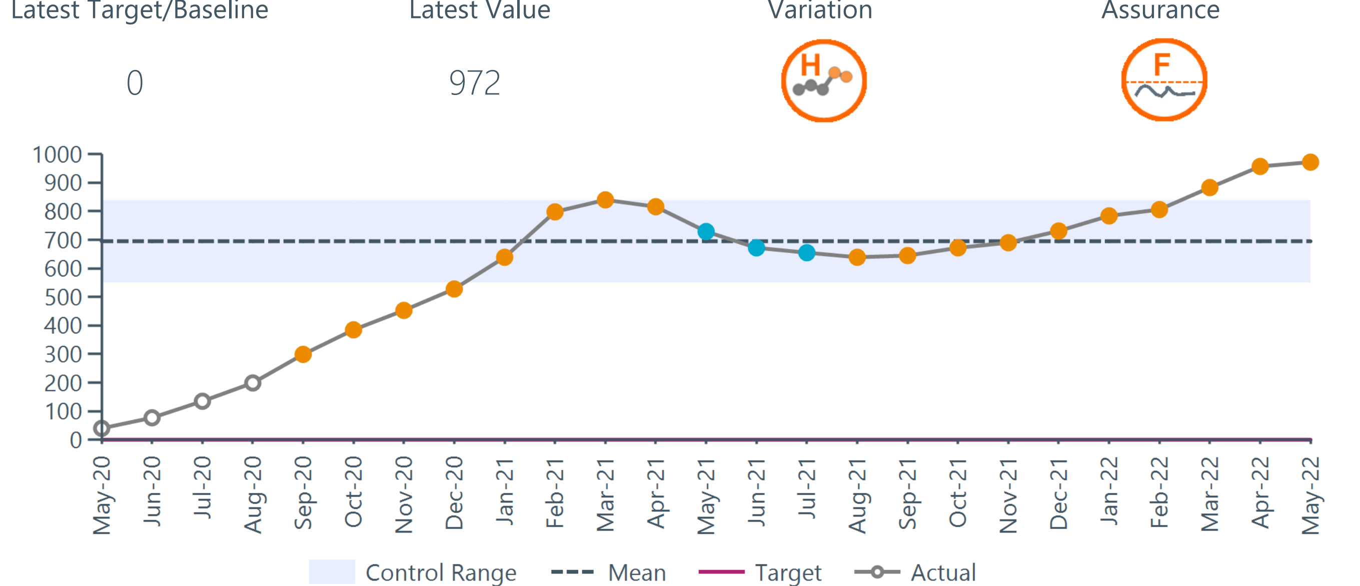
Number of RJAH Welsh RTT patients waiting 52 weeks or more at month end 211140

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	972	H	F

Trajectory/Plan 22_23





What these graphs are telling us

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Narrative

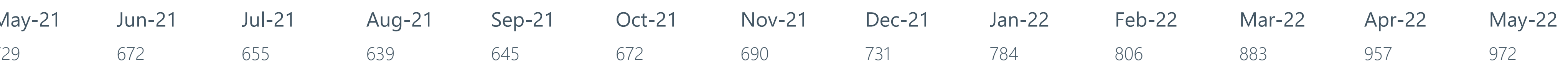
At the end of May there were 972 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (619), Arthroplasty (109), Knee & Sports Injuries (97), Upper Limb (66), Foot & Ankle (40), Spinal Injuries (10), Veterans (10), Paediatric Orthopaedics (8), Metabolic Medicine (7), Tumour (4), Neurology (1) and Rheumatology (1).

The patients are under the care of the following commissioners; BCU (513), Powys (445), Hywel Dda (10), Aneurin Bevan (1), Abertawe Bro (1) and Cardiff & Vale (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 640 patients
- >78 to <=95 weeks - 207 patients
- >95 to <=104 weeks - 38 patients
- >104 weeks - 86 patients

Actions

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

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services.



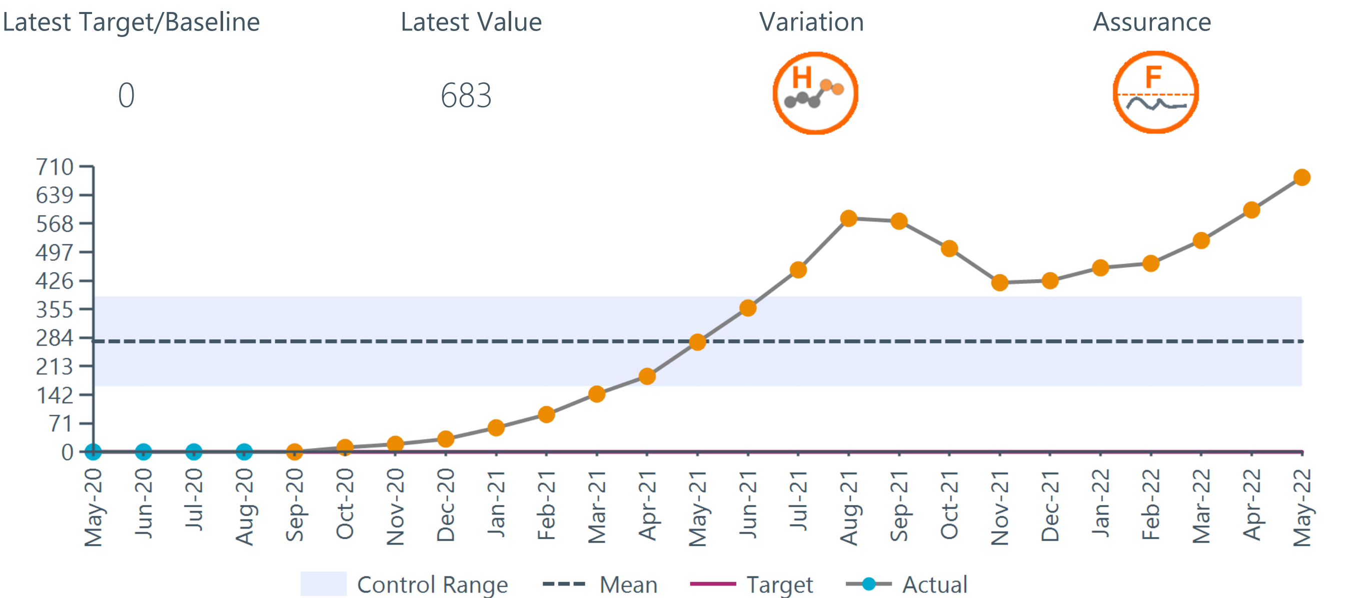
May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
729	672	655	639	645	672	690	731	784	806	883	957	972

Patients Waiting Over 78 Weeks - English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	683	H	F



Trajectory/Plan 22_23

What these graphs are telling us

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

Narrative

At the end of May there were 683 English patients waiting over 78 weeks; this was 33 patients above our trajectory.

The patients are under the care of the following sub-specialities; Spinal Disorders (476), Knee & Sports Injuries (98), Upper Limb (39), Arthroplasty (26), Spinal Injuries (24), Foot & Ankle (10), Veterans (6), Paediatric Orthopaedics (2), Metabolic Medicine (1) and Orthotics (1).

Actions

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 by July 2022 - exceptions are patients choice / specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patients choice / specific specialties
* Develop plans that support an overall reduction in 52-week waits where possible, in line with ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties
The submitted plans have been reflected in the trajectory line above.

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services.

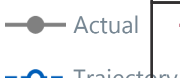
May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
273	358	453	581	574	506	421	426	458	469	526	602	683

Patients Waiting Over 78 Weeks – Welsh

Number of RJAH Welsh RTT patients waiting 78 weeks or more at month end 217775

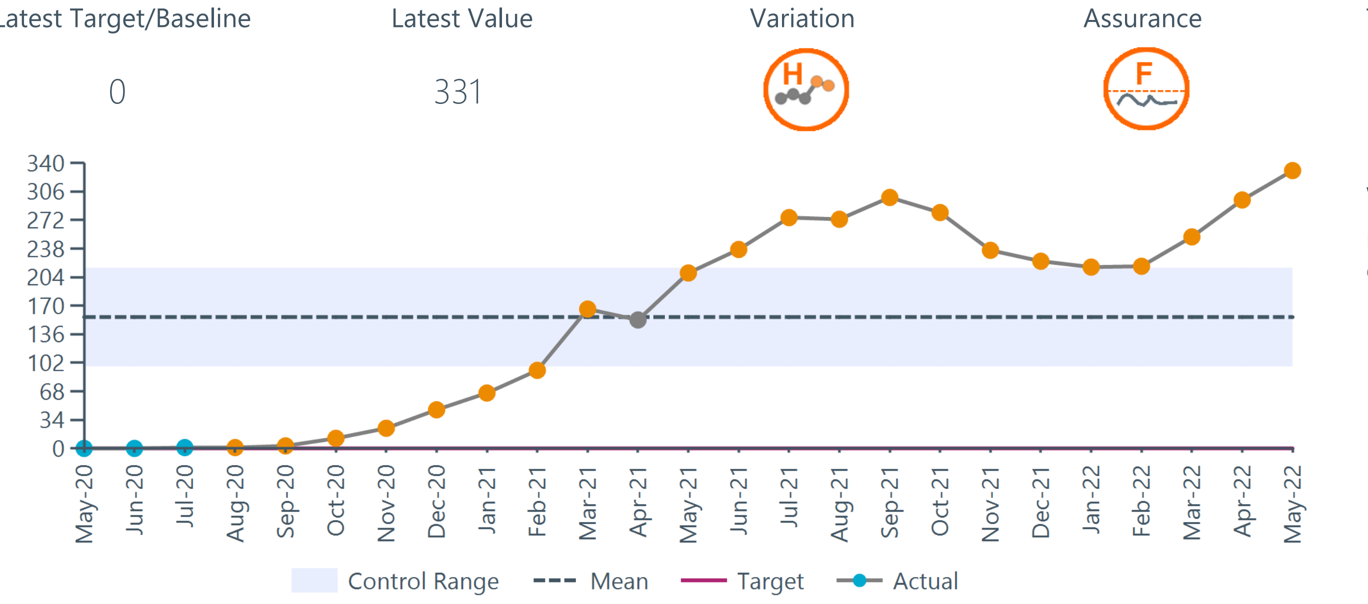
Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	331		



Trajectory/Plan 22_23

223
331
Actual
Trajectory



What these graphs are telling us

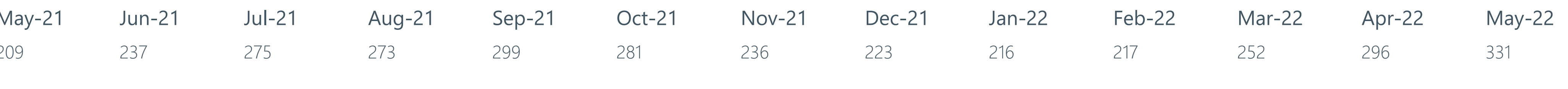
Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

At the end of May there were 331 Welsh patients waiting over 78 weeks. The patients are under the following sub-specialties; Spinal Disorders (268), Knee & Sports Injuries (34), Arthroplasty (12), Upper Limb (7), Foot & Ankle (4), Spinal Injuries (3), Veterans (2) and Tumour (1).

Actions

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services.



May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
209	237	275	273	299	281	236	223	216	217	252	296	331

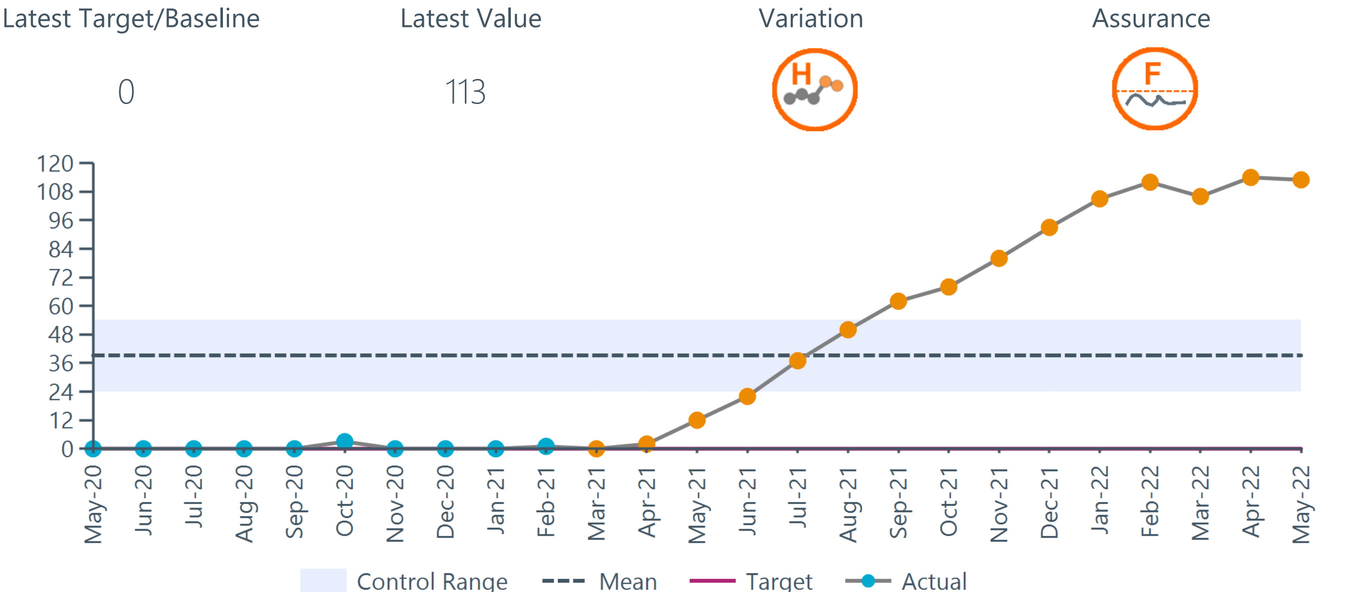
Patients Waiting Over 104 Weeks - English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	113	H	F

Trajectory/Plan 22_23



What these graphs are telling us

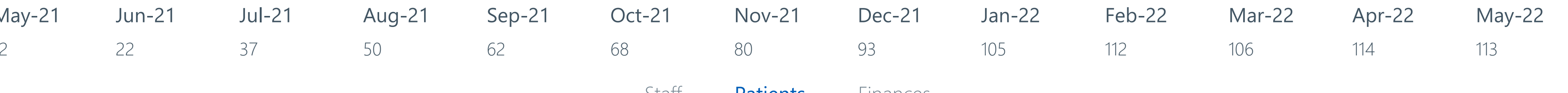
Metric is experiencing special cause variation of a concerning nature. Metric is consistently failing the target.

Narrative

At the end of May there were 113 English patients waiting over 104 weeks, above our trajectory figure of 99 by 14.
The patients are under the care of the following sub-specialities, with further details on the volume by priority;
- Spinal Disorders (94) - P2 (1), P3 (17), P4 (55), P6 (2), Not on Elective WL yet so no priority (19)
- Knee & Sports Injuries (10) - P3 (5), P4 (3), P6 (2)
- Spinal Injuries (4) - P4 (3), P6 (1)
- Arthroplasty (2 - P4)
- Orthotics (1 - Not on Elective WL yet so no priority)
- Veterans (1 - Not on Elective WL yet so no priority)
- Upper Limb (1 - P3)

Actions

2022/23 NHS England operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 - exceptions are patients choice/specific specialties
The Trust expects spinal disorders 104+ weeks to still be present. This is due to national pressures for this specialist service and continued demand. As acknowledged through the planning guidance, there may also be patients who choose to wait. This formed part of our 2022/23 planning submission and our submitted plans can be viewed in the trajectory line above. The Trust has taken actions to review the volume of patients who fall into the 'patient choice' category with improvements to the volumes now seen and reflected in revised trajectories.
Mutual aid support has been identified with the Royal Orthopaedic Hospital with ongoing discussions with the provider and patients being contacted where appropriate. Complexity remains a limiting factor for mutual aid support. Peer reviews of our complex patients has been requested through NHS EI. Other providers are also being explored.
Further actions include; Ongoing validation of these patients with a deep dive due for presentation at FPD.
Review and exploring the utilisation of emergency theatre lists.



May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
12	22	37	50	62	68	80	93	105	112	106	114	113

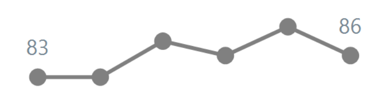
Patients Waiting Over 104 Weeks - Welsh

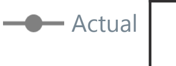
Number of RJAH Welsh RTT patients waiting 104 weeks or more at month end 217592

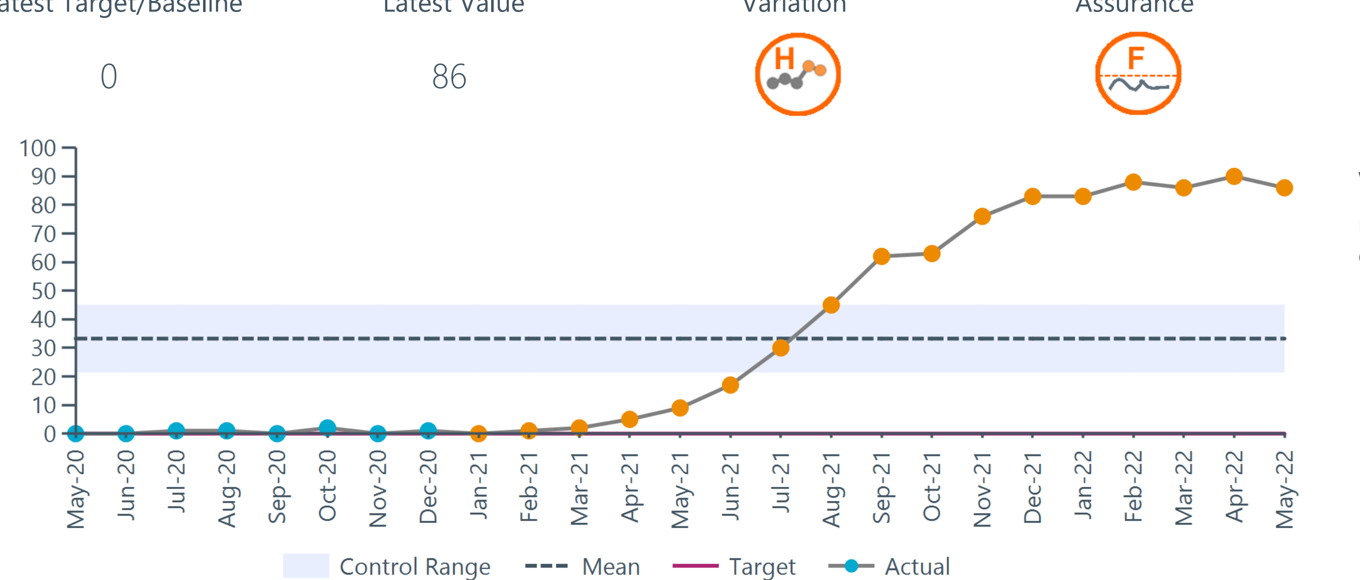
Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	86	H	F

Trajectory/Plan 22_23







What these graphs are telling us

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

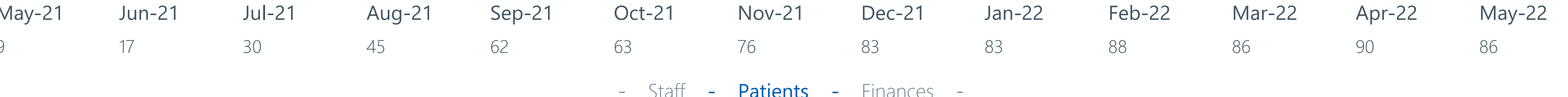
Narrative

At the end of May there were 86 Welsh patients waiting over 104 weeks. The patients are under the care of the following sub-specialities, with further details on the volume by priority;
- Spinal Disorders (85) - P2 (2), P3 (26), P4 (46), Not on Elective WL yet so no priority (11)
- Veterans (1 - P3)

Actions

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

The Trust's pressured service continues to be spinal disorders. This is due to national pressures for this specialist service and continued demand. As acknowledged through current clinical prioritisation, there may also be patients who choose to wait. This formed part of our 2022/23 planning submission, although plans were only required for English patients.



May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
9	17	30	45	62	63	76	83	83	88	86	90	86

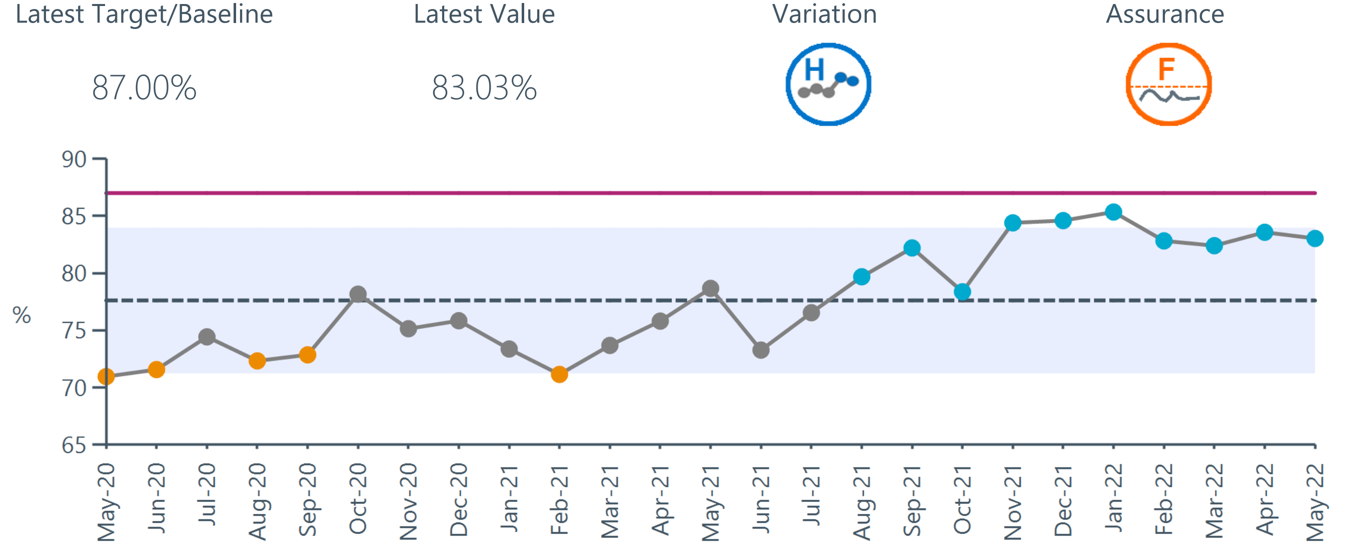
Bed Occupancy – All Wards – 2pm

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

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	83.03%	H	F

Trajectory/Plan 22_23



What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 83.03% for May and remains shown as special cause variation of an improving nature; now ten months above the mean. Breakdown provided below:
MSK Unit:
- Clwyd - 78.91% - compliment of 22 beds; ward closed for majority of the month
- Powys - 82.80% - compliment of 22 beds open throughout month
- Kenyon - 76.20% - compliment of 12 beds, increased to 22 beds for last 10 days of the month
- Ludlow - 77.56% - compliment of 16 beds; open from 6th May following ward closure

Specialist Unit:
- Alice - 40.68% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 79.26% - compliment of 10 beds open throughout month
- Gladstone - 92.88% - compliment of 29 beds open throughout month
- Wrekin - 95.27% - compliment of 15 beds open throughout month
- Sheldon - 89.52% - compliment of 20 beds open throughout month

Actions

With regular review, we continue to flex our bed base whenever possible to have sufficient beds open for the anticipated activity numbers based on the existing bed model. This includes assessing the variability of occupancy by weekday. Flexing has included ward and bed closures and redeployment of staff to other areas of the Trust. IPC guidance is reviewed as updates are issued. Consideration and assessment of length of stay and delayed transfers of care are considered when monitoring our occupancy.

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
78.67%	73.27%	76.54%	79.68%	82.21%	78.37%	84.40%	84.60%	85.35%	82.82%	82.40%	83.58%	83.03%

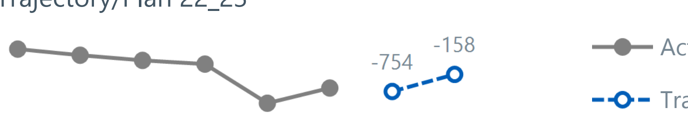
Financial Control Total

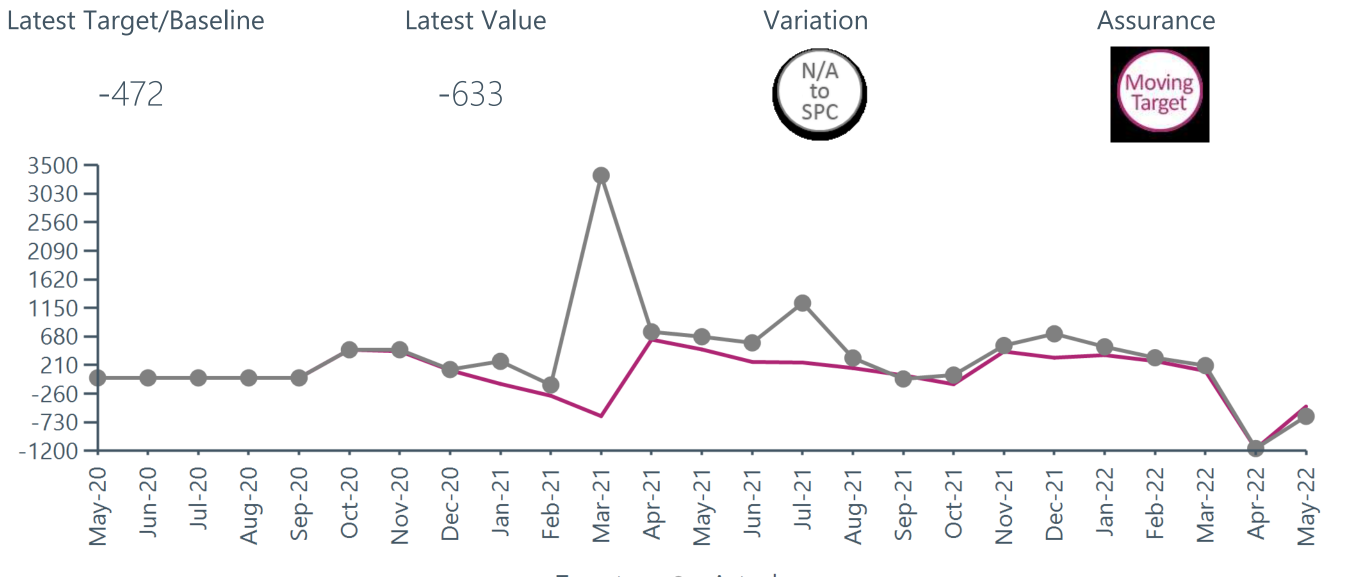
Surplus/deficit adjusted for donations 215290

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
-472	-633	N/A to SPC	Moving Target

Trajectory/Plan 22_23





What these graphs are telling us

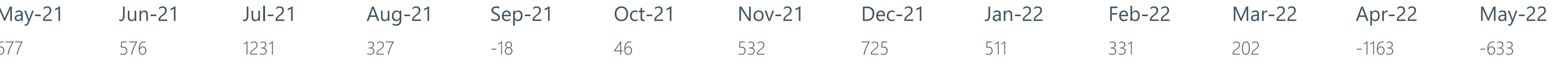
This measure is not appropriate to display as SPC. This measure has a moving target.

Narrative

Overall £663k deficit in month, £161k adverse to plan

YTD £1,797k deficit, £156k adverse to plan

Actions



May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
677	576	1231	327	-18	46	532	725	511	331	202	-1163	-633

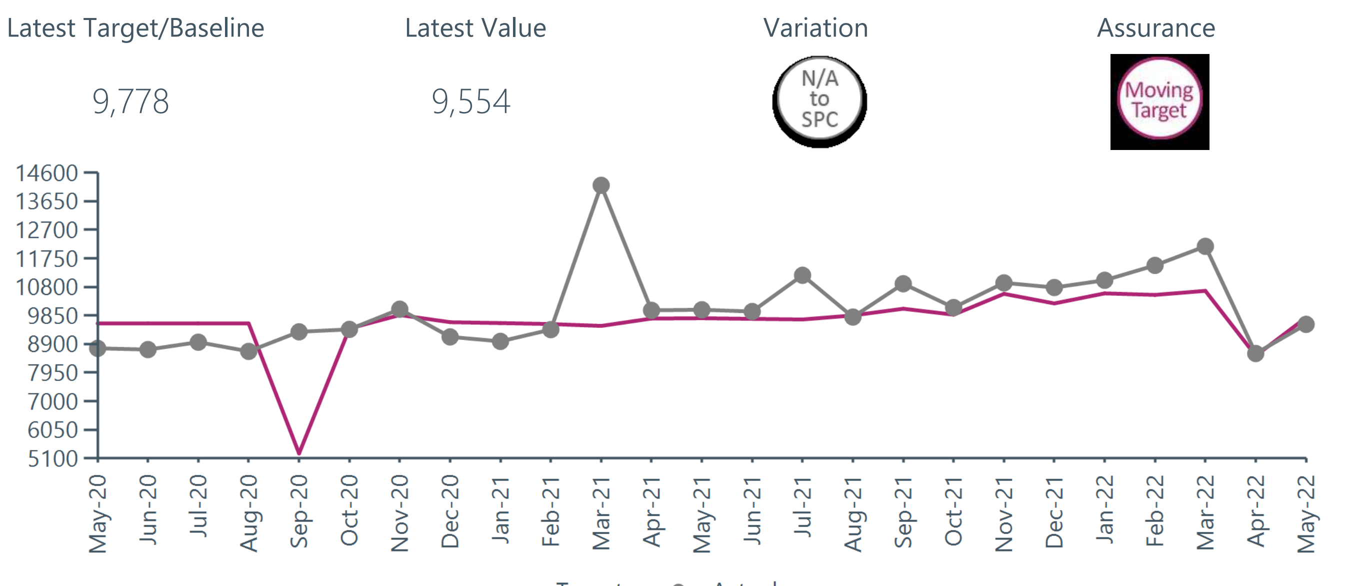
Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
9,778	9,554	N/A to SPC	Moving Target

Trajectory/Plan 22_23



What these graphs are telling us

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

Narrative

Income £225k adverse in month:

- Private Patient activity shortfall £150k
- Other income shortfall (Research, Car Parking & TSSU) £30k
- Pass through and ERF income adverse (offset expenditure)

Actions

May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
10039	9981	11188	9797	10905	10113	10935	10780	11021	11516	12150	8585	9554

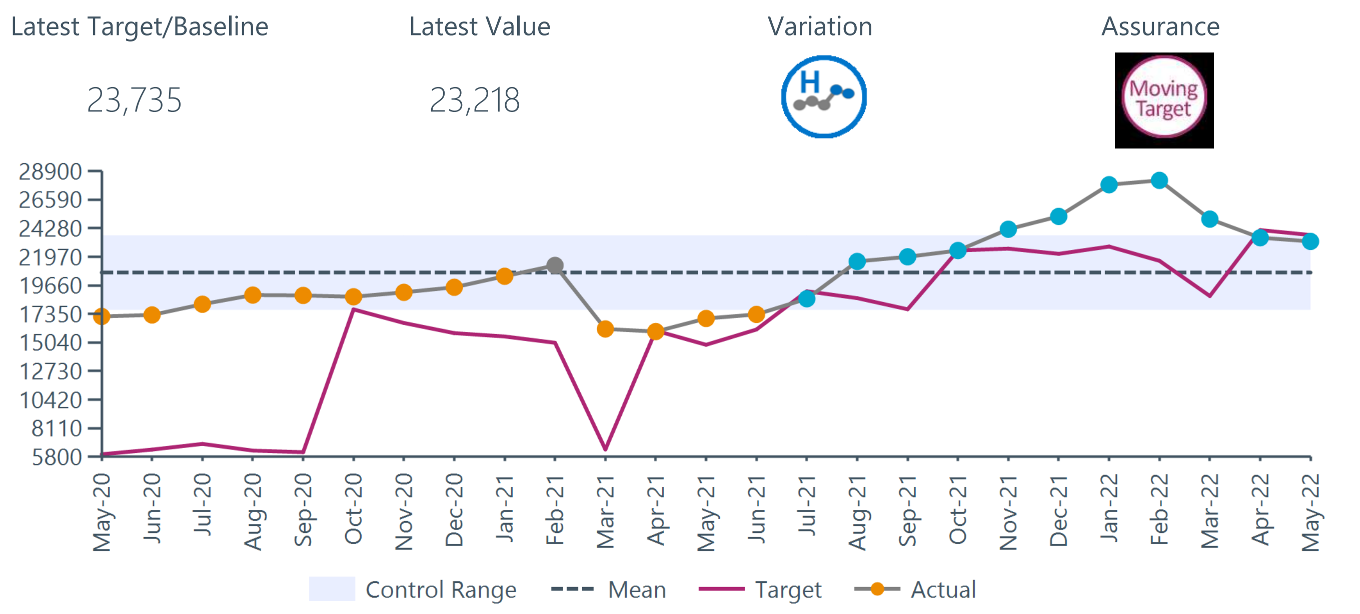
Cash Balance

Cash in bank 215300

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
23,735	23,218		Moving Target

Trajectory/Plan 22_23



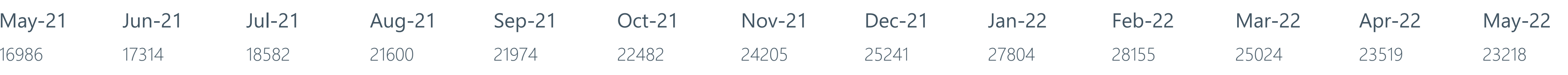
What these graphs are telling us

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

Narrative

Cash levels in month £0.5m lower than plan mainly due to inflationary uplifts not yet added to clinical income contracts

Actions



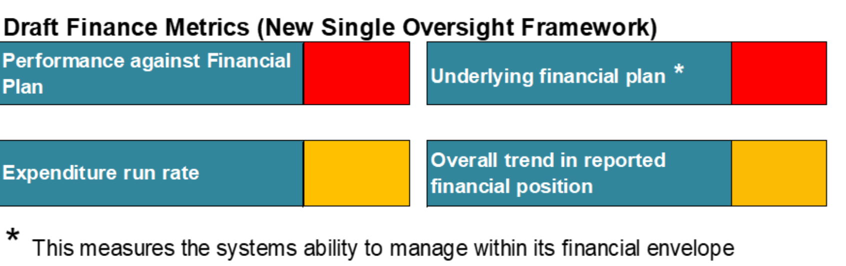
May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
16986	17314	18582	21600	21974	22482	24205	25241	27804	28155	25024	23519	23218

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st May 2022

Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			22/23 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	112,055	8,583	8,541	(42)	16,074	16,173	99
Covid-19 Funding	1,411	118	118	0	235	235	0
Private Patient income	5,868	525	332	(194)	881	602	(279)
Other income	6,653	552	563	11	1,100	1,129	29
Pay	(76,204)	(6,296)	(6,257)	39	(12,577)	(12,506)	71
Non-pay	(44,016)	(3,361)	(3,366)	(5)	(6,165)	(6,284)	(120)
EBITDA	5,768	122	(69)	(191)	(452)	(651)	(199)
Finance Costs	(7,995)	(644)	(615)	29	(1,288)	(1,246)	43
Capital Donations	3,300	493	250	(243)	986	585	(401)
Operational Surplus	1,073	(29)	(433)	(404)	(755)	(1,312)	(557)
Remove Capital Donations	(3,300)	(493)	(250)	243	(986)	(585)	401
Add Back Donated Dep'n	632	50	50	0	100	100	1
Control Total	(1,595)	(472)	(633)	(161)	(1,641)	(1,797)	(156)
EBITDA margin	4.6%	1.2%	-0.7%	-2.0%	-2.5%	-3.6%	-1.1%

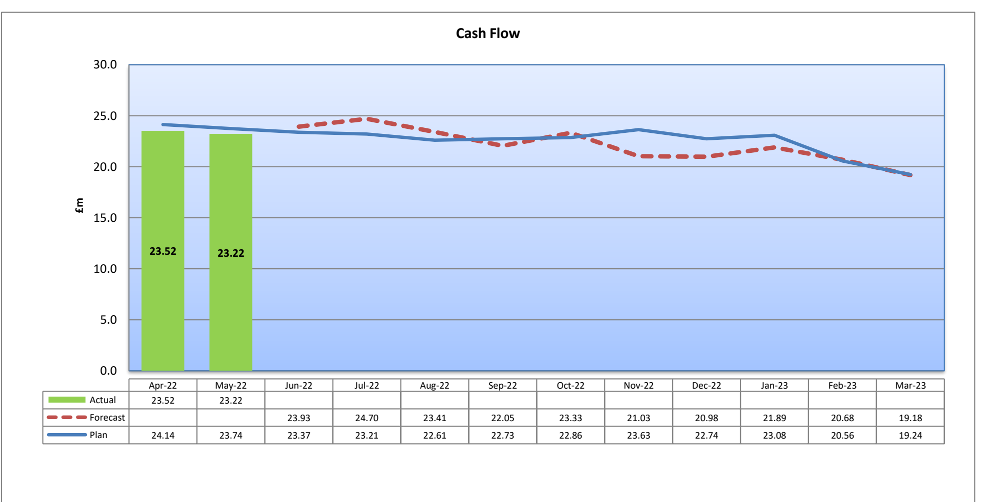
Statement of Financial Position £'000s				
Category	Apr	May 22	Movement	Drivers
Fixed Assets	88,023	89,983	1,960	IFRS16 finance lease assets new accounting method
Non current receivables	1,379	1,458	79	
Total Non Current Assets	89,402	91,441	2,039	
Inventories (Stocks)	1,301	1,303	2	
Receivables (Debtors)	5,269	5,990	721	Health Education England (HEE)
Cash at Bank and in hand	23,519	23,218	(301)	Deficit
Total Current Assets	30,089	30,511	422	
Payables (Creditors)	(17,580)	(18,507)	(927)	Invoiced creditors and HEE deferred income
Borrowings	(1,468)	(2,011)	(543)	Obligations under finance leases - rights of use
Current Provisions	(336)	(336)	0	
Total Current Liabilities (< 1 year)	(19,384)	(20,854)	(1,470)	
Total Assets less Current Liabilities	100,107	101,098	991	
Non Current Borrowings	(3,327)	(4,748)	(1,421)	Obligations under finance leases - rights of use
Non Current Provisions	(1,043)	(1,046)	(3)	
Non Current Liabilities (> 1 year)	(4,370)	(5,794)	(1,424)	
Total Assets Employed	95,737	95,304	(433)	
Public Dividend Capital	(36,354)	(36,354)	0	
Retained Earnings	(30,598)	(30,598)	0	
Revenue Position	879	1,312	433	In month deficit
Revaluation Reserve	(29,664)	(29,664)	0	
Total Taxpayers Equity	(95,737)	(95,304)	433	

Draft Finance Metrics (New Single Oversight Framework)



* This measures the systems ability to manage within its financial envelope

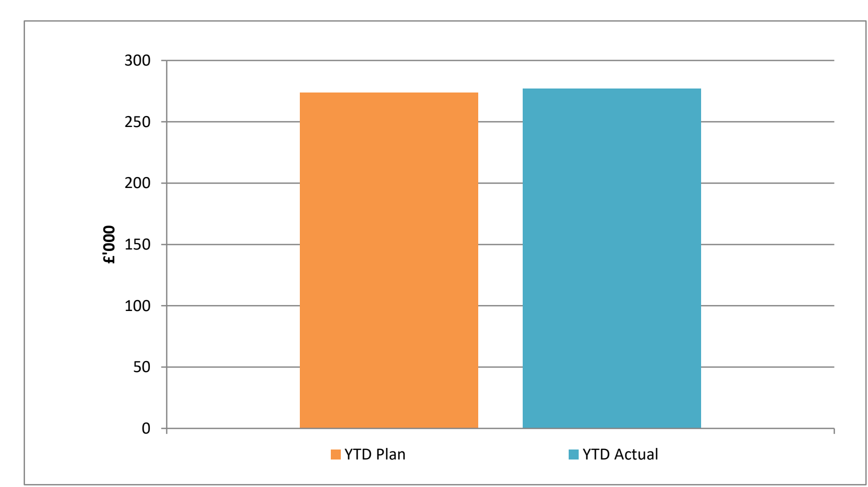
	YTD
Debtor Days	19
Creditor Days	56



Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st May 2022

Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's

AAS
SSU
SPEC
MSK
CSU
Units
0 20 40 60 80 100 120
£'000
YTD Plan
YTD Actual

Capital

Position as at	2223-02	Capital Programme 2022-23						
Project	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	350	15	-6	21	15	60	-45	350
I/T investment & replacement	300	0	0	0	0	0	-0	300
Capital project management	130	10	10	-0	20	21	-1	130
Equipment replacement	750	0	0	0	0	0	0	750
Diagnostic equipment replacement	920	270	0	270	390	83	307	920
IPC & safety compliance	360	50	0	50	50	0	50	360
EPR planning & implementation	4,500	0	0	0	0	0	0	4,500
Invest to save	200	0	0	0	0	0	0	200
Enhanced staff facilities	500	0	0	0	0	0	0	500
Additional theatres x 4 (replace barns)	3,000	0	0	0	0	0	0	3,000
Leases (IFRS16)	149	0	0	0	0	0	0	149
Veterans' facility	3,200	493	250	243	986	585	401	3,200
Donated medical equipment	100	0	0	0	0	0	0	100
Contingency	500	0	-12	12	0	-12	12	500
Total Capital Funding	14,959	838	243	595	1,461	738	723	14,959
Veterans' facility	-3,200	-493	-250	-243	-986	-585	-401	-3,200
Donated medical equipment	-100	0	0	0	0	0	0	-100
Capital Funding (NHS only)	11,659	345	-7	352	475	153	322	11,659

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

IPC Improvement Plan

0. Reference Information

Author:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	6th of July 2022
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	12th of June 2022 updated 30th of June 2022
Paper Reviewed by:	IPC Quality Assurance Committee	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

RJAH was escalated to Red on the NHSE/I IPC Matrix in August 2021. NHSE/I have continued to provide support to RJAH and the IPC team and alongside colleagues from partner organisations, have visited the site regularly. Following the last visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance. The Trust therefore remains red on the NHSE/I IPC matrix. The Trust has been moved into SOF 3 of the single oversight framework and issued with enforcement undertakings.

2.2. Summary

- Outlines progress with all immediate actions completed as outlined in NHSEI Letter
- 67 actions across 9 themes identified in IPC Improvement plan incorporating actions and recommendations from various sources.
- A further 6 actions have been added since last report to ensure all 7 exit criteria are aligned to the plan. At the 12th of June:
    - 2 actions behind plan
    - 32 actions complete (an increase of 9 since last report)
    - 26 actions in progress with clear action owners and timescales
    - 7 actions not started
- All actions have priority status assigned
- The revised business case for housekeepers and roaming deep clean approved at system investment panel however still no funding stream identified
- Exit criteria have been mapped to undertakings and monthly regional meetings scheduled
- Focus required on training compliance
- Overall positive NHSE/I inspection on 22nd of June with improvements noted

2.3. Conclusion

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

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

3. The Main Report

3.1. Introduction

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

NHSE/I have continued to provide support to RJAH and the IPC team and alongside colleagues from partner organisations have visited the site regularly. Following the last visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance. The Trust therefore remains red on the NHSE/I IPC matrix with immediate remedial action and improvement required.

The Trust has been moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. There are a total of 7 exit criteria that have been mapped to the undertakings.

3.2. Immediate Actions

The Chief Nurse received a letter on the 17th of February 2022 highlighting ongoing concerns around IPC and governance in line with the Code of Practice on the prevention and control of infections (Hygiene Code). There was concern raised that there had been a lack of progress against the previously agreed actions and a lack of evidence that the areas for improvement identified have been extrapolated across the Trust to reduce the risk of possible harm to others. A number of immediate actions were identified and outlined within the NHSE/I letter:

Table 1: Immediate Actions outlined in NHSE/I Letter

	Recommended Action	Progress update
1	Review of assurance and sign off processes for actions plans and a review of all actions plans that are currently marked as completed	This has been completed and all outstanding actions transferred to Tendable.
2	Complete the GAP analysis and action plan against the Code of Practice for the prevention of infection and related guidance (Hygeine Code) and ensure this has been presented to Trust Board within the next month.	GAP analysis completed in November 2021 with actions identified. Presented at IPCC and Q&S in March 22 and Trust Board April 22. Will report to Board quarterly.
3	IPC BAF needs to be updated and presented to the Trust Board within the next month.	Revised IPC BAF received Dec 2021. Presented at IPCC and Q&S in March 22 and Trust Board April 22. Will report to Board quarterly.
4	Development of recommendations of the One Together audit, presented to the Trust IPC Committee.	One Together Audit completed and circulated to key stakeholders in Dec 21. Presented at IPCC. Working group set up to progress actions with upward reporting to IPCC and subsequently Q&S via Chairs report.
5	Medical leadership intervention with medical colleagues compliance with IPC including hand hygiene, bare below the elbows and the use of theatre hats/caps.	Medical Director has written to all medical colleagues outlining expectations. Further actions oulined in Improvement Plan with review of uniform policy and re-launch of BBE campaign.
6	Review of the IPC team structure and the team capacity and priorities	Review and benchmarking undertaken in Dec 21. CCG supporting with review of IPC lead job plan. Case of need outlining re-structure and strengthening of the IPC team approved at SLG 22/03/2022. IPC Team development day completed 27/04/2022. Programme of works for 22/23 approved.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

3.2.1. IPC Improvement Plan

The IPC improvement plan has been developed to ensure actions are embedded trust wide and improvements are sustained. The plan has been developed to include all actions and recommendations from the following:

- NHSE/I Letter following February visit outlining immediate actions and recommendations
- Internal IPC Governance review recommendations
- Independent IPC review by Lisa Miruszenko
- CCG Assurance Visits
- Hygiene Code Gap Analysis self assessment
- Monthly NHSE/I IPC walkabouts

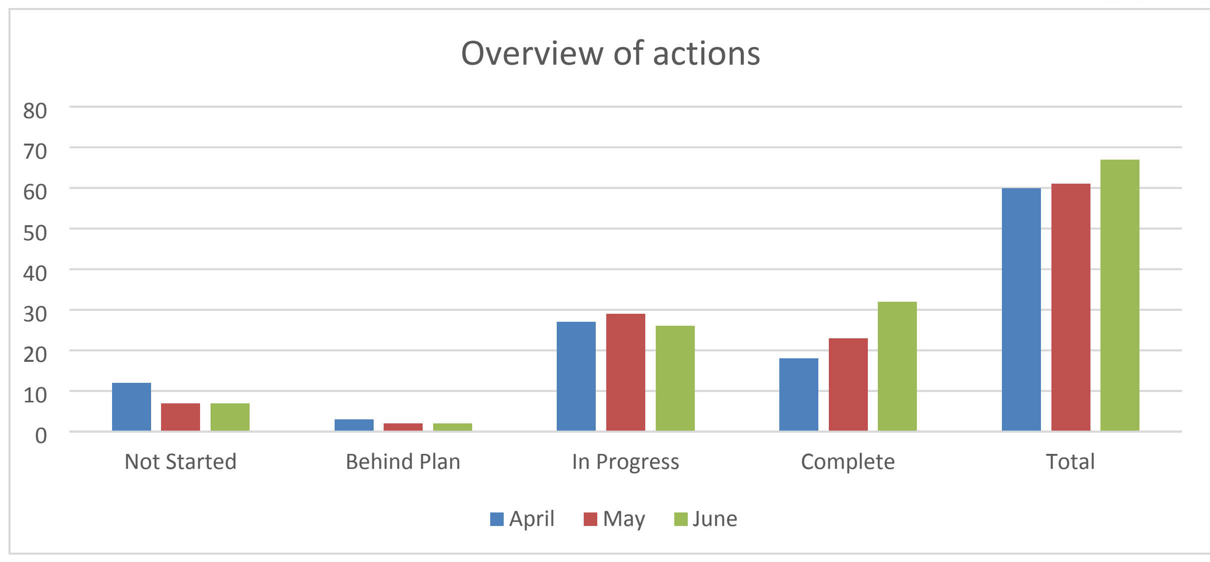
The IPC Covid-19 BAF released in December 2021 is due to be revised in line with the publication of the National infection prevention and control manual for England and therefore a further review of the updated BAF will be completed before any further actions are added to the IPC Improvement Plan.

A thematic review of all outbreaks over the last 12 months has been commissioned by the Chief Nurse and DIPC, any specific actions that have not already been considered will also be added to the IPC improvement plan following the review.

The IPC improvement plan has been split in to nine themes with a total of 67 actions. The themes and actions have been aligned to overarching seven objectives (exit criteria) and suggested evidence outlined in bold text beneath each objective.

Table 2: Overview of progress against actions IPC Improvement Plan on 12/06/2022

No.	Objective (Exit Criteria)	Not Started	Behind Plan	In Progress	Complete	Total
1.	Evidence of board assurance, senior leadership, and delivery of actions	2	0	2	1	**5**
2.	Trust staff have the necessary improvement skills to sustain improvement	0	0	3	9	**12**
3.	Trust IPC audits demonstrate improvement	0	1	14	9	**24**
4.	Trust reporting on HCAIs, outbreaks and SSIs	2	1	4	13	**20**
5/6.	Improvement in external IPC inspections	2	0	1	0	**3**
7.	Agreement between regulators, commissioners and the System that there is evidence of significant progress and confidence in the Trust leadership Team	1	0	2	0	**3**
	Total	**7**	**2**	**26**	**32**	**67**



The final two columns on the improvement plan describes the evidence required to close the action and methods of ongoing assurance.

A priority column has been added to determine the priority status of each action – this will be reviewed monthly at IPCC as priorities may be subject to change. Next steps are to include associated risk numbers for each of the high priority actions.

The two actions behind plan are:

No	Priority	Area for Improvement	Target completion date	Accountable Exec	Responsible Lead	RAG status
4.2	High	Escalate system cleanliness business case and consider other options for bed cleaning	30/05/2022	Director of Finance	Phil Davies	Red
3.4	Medium	Review Tendable IPC audit schedule and ward to Board reporting	30/05/2022	Chief Nurse	Ian Maclennan	Red

Action 4.2: Revised business case approved for Housekeeping and roaming deep clean team at RJAH SLG in May and supported at system investment panel on 1st of June 22. Funding streams still to be identified.

Action 3.4 Paper and draft reporting schedule for audits agreed at Patient Safety Committee on 3rd of May 2022. Reporting module for Tendable being built for regular committee and board reporting. This is linked with the development of a live dashboard where HH/BBE audits can be viewed in real time.

There have also been several actions where end dates have been extended/revised. The key high priority actions to note are outlined below:

No	Priority	Area for Improvement	Target completion date	Revised target completion date	Accountable Exec	Responsible Lead	RAG status 12th June	RAG status 30th June
9.5	High	Review of BBE posters and signage trust wide to align with policy	30/05/22	20/06/22	Chief Nurse	Med Illustration	Amber	Green
2.1	High	Review IPC nurses job plans and workload to ensure priority of works, allocating resource appropriately	30/05/22	30/06/22	Chief Nurse	Sara Ellis-Anderson	Amber	Green
3.12	High	Review IPC reports that go to Q&S and Board to ensure key issues and risks are escalated	30/05/22	30/06/22	Chief Nurse	Sara Ellis-Anderson	Amber	Amber
7.2	High	Update Uniform Policy to address non-compliance with HH/BBE /Uniform policy	13/05/22	23/06/22	Medical Director	Richard Potter	Amber	Green

Further progress has been made since the 12th of June with three out of the four actions now complete. **Action 3.12:** Improvement Director has shared various report formats. Quarter 1 report to be done in new format from July.

3.2.2. Key successes and achievements in May/June

- IPC newsletter from the Chief Nurse and Chief Medical Officer is published fortnightly to ensure key issues and good practice can be shared across the organisation.
- Clwyd flooring replacement complete and Powys refurbishment planned for August
- Stores management business case approved to allow logistics team to manage ward/department top up and stock rotation releasing nursing time
- Investment case for roaming deep clean team reviewed and SLG approved investment in Housekeepers and roaming deep clean team. This case was supported by the System Investment Panel on the 1st of June
- Weekly progress report on SSI PIRs continues – with zero PIRs outstanding at time of report. SOP for completing PIRs agreed with clear timescales agreed.
- Training Matrix review completed and to be mapped to ESR and ward areas.

3.2.3. Next Steps for July

- Approved Uniform policy to be disseminated trust wide with comms plan
- Revised reports for committee and Board for July (Quarter 1 report)
- BBE re-launch of campaign is live – embed and sustain improvements in compliance
- Development of live dashboard for IPC and cleanliness
- Targeted focus on IPC training and improvements required in compliance with hand hygiene assessments
- Re-assess Hygiene code gap analysis compliance

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

3.3. Associated Risks

- Risk 2859 – Environment Maintenance – Patient Safety.
- Risk 2864 – Non-Compliance with Hygiene Code
- Risk 1742 – Lack of autonomy to make organisational investments

3.4. Conclusion

The IPC improvement plan is being monitored weekly with good progress being made. Evidence for each action is completed is being collated. With the support of the Improvement Director the evidence will be reviewed and assessment made against undertakings. A monthly Improvement Review Meeting is in place to review assessment against undertakings.

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

The three month formal NHSE/I review was undertaken on the 22nd of June with overall positive improvements seen. There were clear plans in place and staff could articulate the further work required. The formal feedback letter is attached in appendix 1.

The Board is asked to ***note*** the actions taken and proposed improvement plan and seek additional assurance if required.

Appendix 1: Acronyms

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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

Classification: Official

Publication reference:

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

cc.
- Nina Morgan – Regional Chief Nurse
- Fran Steele – Director of S&T – Midlands
- Jacqueline Barnes – Improvement Director RJAH/NHSEI

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

5 July 2022

Dear Sara,

NHS England Visit 22 June 2022

I would like to thank you for organising the formal review visit of the Trust on 22 June 2022. The visit took place as scheduled, following the enforcement of legal undertakings by NHSE due to concerns raised for the prevention and control of infections within the Trust.

As this visit was part of the formal review process to assess the Trusts progress in meeting the undertakings, NHSE have taken the opportunity to review the Trust against the NHSE Midlands Infection Prevention and Control internal escalation matrix. Following the improvements that have been identified both in the areas that were visited and in the new governance processes that have been described, I can confirm that the Trust has moved from the RED RAG rating to **AMBER** on our matrix.

The day started with a detailed presentation from you and your team on the work that has been completed to date and the next actions that are in progress, which set the scene of the work that has taken place in the Trust. This included the improvement plan, the new processes for surgical site infection reviews, the strengthened IPC team capacity, and the new IPC vision for the Trust. Across the day we visited Ludlow ward, Outpatients department, Montgomery, Gladstone, Wrekin, Powys and Clwyd wards.

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

I would like to pass my thanks to the teams in these areas who were happy to show us around their areas, share the improvement works that have been undertaken and identified the areas that they are now working on, the engagement across the teams was evident throughout the day.

At the end of the visit, Trust level feedback was provided to the wider team of Executives and their staff, including yourself, the Trust Chief Executive, Medical Director and the Chief Nurse for Shropshire, Telford and Wrekin Integrated Care System. This demonstrates the level of ownership and commitment to the improvement journey within the Trust. The Chief Executive signalled the organisations desire to be world leading including in IPC and was aware of the journey required to get there.

Below is a summary of the key findings shared on the day. Generally, there was improvement noted across the organisation and within each ward and area that was visited throughout the day. Improvements were identified with the levels of engagement across the organisation and across the multidisciplinary team. There was evidence of a lot of work that had been completed within the Trust and staff were able to share the changes that they have been

Key areas of improvement identified:

- Estates work:
    - High quality work completed on Ludlow ward, notable improvements throughout the ward following completion of works.
    - Flooring has been completed on Gladstone and Wrekin wards,
    - Improvements in the laundry room, sluices and storeroom on Gladstone and Wrekin,
    - the kitchens on Gladstone and Wrekin have both been refurbished.
- The addition of the two new macerators in the sluice rooms on Gladstone and Wrekin has resulted in no pulp products being left in the sluice awaiting disposal.
- Improvement in the described governance process for IPC and oversight of actions and related processes.
- Increased focus on surgical site infection (SSIs) surveillance and the oversight and assurances related to this work, including the completion of the deep dive into mandatory reported SSIs.

- Improved oversight of the Estates work through the weekly IPC meetings, looking at the estates backlog and prioritising this work.

- Engagement across the multidisciplinary team in all areas that were visited during the day.

- Cleaning on Gladstone; the cleaners reported that they felt more engaged with the ward team and attend the safety huddles to ensure messaging is shared.

- We observed an improvement in bare below the elbows, there was one member of staff wearing a charity band, the same member of staff was observed later in the day and this had been removed.

- The glove use by the portering team has also improved. There was less inappropriate glove use observed in this group of staff which resulted in improved hand hygiene interventions being observed.

- There was a generalised improvement in Gladstone and Wrekin in relation to the storerooms and kitchens which

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

- We observed fewer staff wearing theatre hats and scrubs outside of the theatre areas, I am aware that work is ongoing to address this and the new uniform policy was due to be signed off the day after my visit.

- Estates work, there remains a number of estates actions that are required across the Trust, I am aware that there is a plan to continue to address these actions whilst maintaining service provision across the site and that this is actively monitored through the new governance processes. There are some locks on the toilet doors on Gladstone that require replacement, these were logged at the time of the visit.

- Improvements in bed cleaning in all but one of the areas visited was observed although attention to detail, especially around where catheter bags are attached is required.

- Shower room/temporary cleaning cupboard on Gladstone, I am aware there is a plan for this, and action is pending the completion of the works in the laundry room and cleaning cupboard.

- PPE use, specifically mask use given the changes that are being implemented. There was confusion observed around when masks should be worn and when they are not required. This was especially evident in outpatients, although I appreciate that the changes had only occurred the previous day. We also observed a couple of instances of inappropriate PPE use, this included a staff member not doffing PPE at the correct time and another member of staff not donning the appropriate PPE when it was indicated. In addition, we observed a small number of staff who were wearing their masks under their chin, masks should either be on or off, if they are removed we would recommend a new mask is donned.

Key themes where improvement is still required:

- Attention to detail when cleaning, including underneath chairs, high levels and moving items for cleaning. This included down the side of desks in the clinic rooms on Montgomery, high level dusting on curtain rails in Montgomery, moving items to support cleaning on ward areas.

- Attention to detail when cleaning patient equipment, including the inside surfaces, although this has improved since the previous visit.

- Storage of single use and single patient use items, including toiletries. We recommend a review of how patients on Midlands Centre for Spinal Injuries (MCSI) are provided with the lubricant to complete their bowel care rather than stocks being kept next to the toilet.

- A review of sluice/dirty utility rooms to ensure that there are PPE dispensers (danicentres) are in place so staff have access to PPE in locations where it is required.

- A review of storage areas, such as therapy cupboards on wards and the work to continue in the main storeroom on MCSI.

- Consideration for a Trust wide review of the “sepsis box” as out of date items were found within the box as they are not frequently in use.

- There were a number of “new” shower chairs that had been purchased in the last six months that have already started to rust, it is recommended that there is a discussion with the manufacturer.

- We identified a continued concern with the “leg troughs” which are becoming stained inside the covers despite cleaning. These have been purchased recently

and strikethrough is evident on the newly purchased ones as well. We would recommend a review of the use of these and a discussion with the manufacturer.

Next Steps

Due to lack of time on the day, we have agreed a further date in July to complete the review of theatres. I would recommend that this also includes Baschurch and HDU.

Thank you for sharing your revised SSI process and post infection review documentation from your team. I will review these and provide feedback directly to you within the next two weeks.

The next full review will be completed at the end of September 2022 and will assess against the NHSE IPC escalation matrix and the exit criteria for the undertakings. This will include a full documentation review, with documents to be shared at least two weeks prior to the visit.

We have discussed delivering the “matrons masterclass” for IPC to the clinical directors, given the observed levels of engagement across the multidisciplinary teams this would be a logical next step of that engagement process and could include the therapy staff as well. Please let me know if this is something that you would like me to deliver this and we can arrange a suitable date.

On the day we discussed the opportunity to write up the MRSA outbreak on MCSI for publication and consideration for presentation at conferences to showcase the work that has been done and the changes within the organisation as a result of this work. I am happy to support you and the team with the publication process and the submission of abstracts and posters for conference.

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

I note that the ICS IPC lead has provided ongoing support for your IPC team. I would recommend that if the ICS IPC lead is conducting visits, that the ICS IPC lead agrees these with you directly with time set aside for direct feedback prior to leaving the Trust.

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

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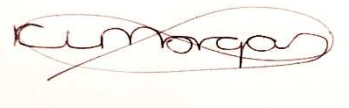
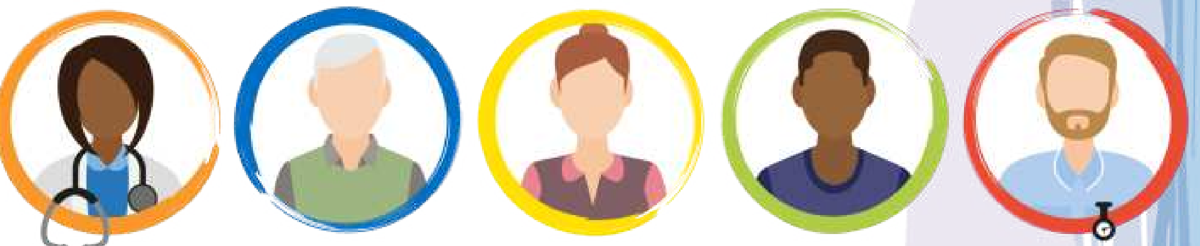
Yours sincerely,



Kirsty Morgan
Assistant Director of IPC – Midlands

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

RJAH IPC Improvement Plan Progress Update



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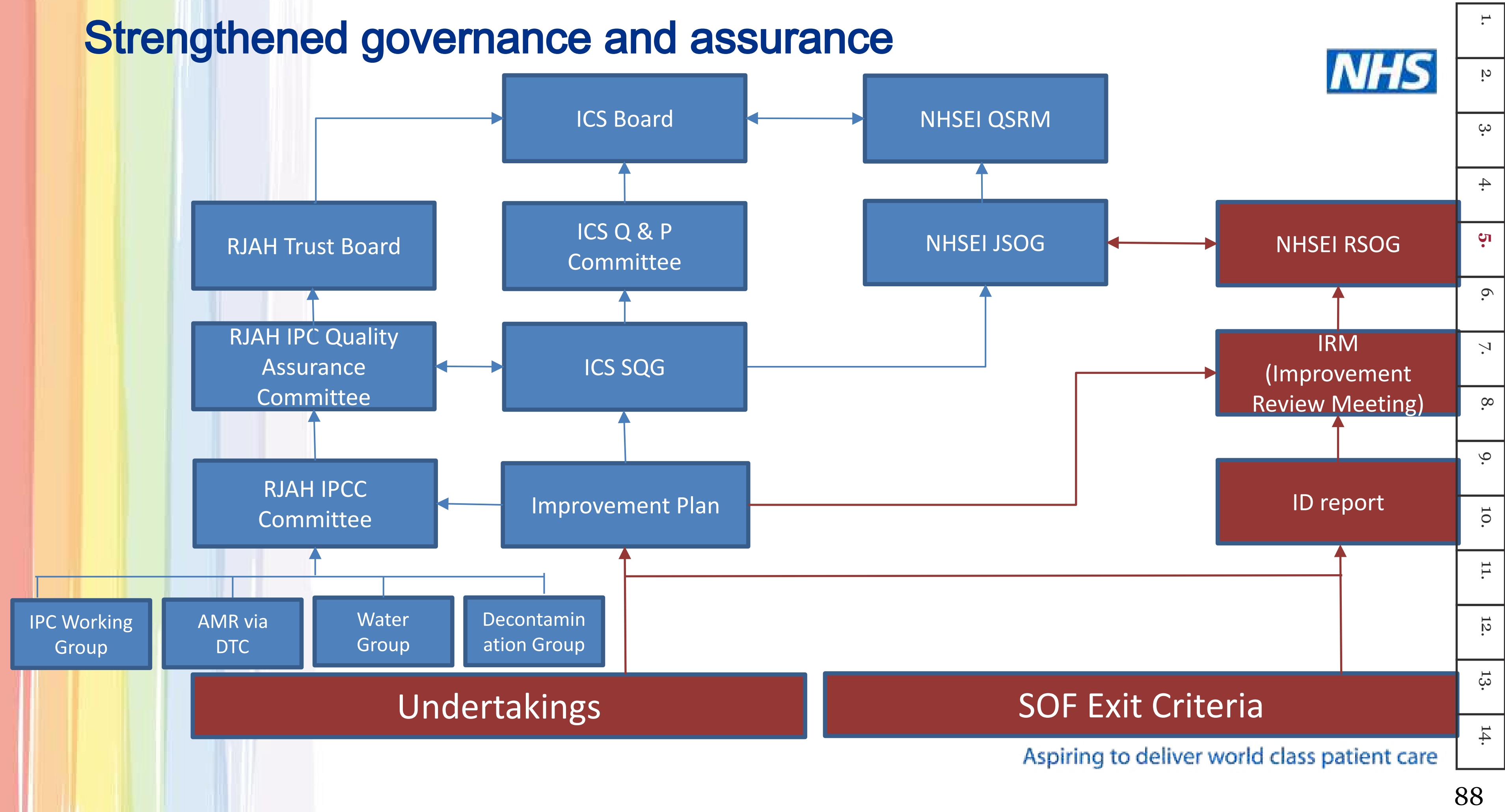
Trust Board Actions

- *Briefing provided to both the ICB and CCG – included within Boards*
- *Stakeholder briefings – CEO to CEO*
- *Good Governance Institute – Clinical Governance review commissioned*
- *Breach of licence and undertakings scheduled for RJAH July Board*
- *Governors briefed and standing agenda item at Council of Governors*
- *Monthly report and Improvement plan reported monthly at Board*
- *Strengthened Board oversight/governance - IPC Assurance Sub Committee, chaired by NeD*
- *Twice weekly escalation meeting chaired by the CEO*
- *Board Patient Safety Walkabouts re-established*
- *IPC incorporated as a standing agenda item within regular CEO - staff briefings*


Strengthened governance and assurance
NHS
ICS Board
NHSEI QSRM
RJAH Trust Board
ICS Q & P Committee
NHSEI JSOG
NHSEI RSOG
RJAH IPC Quality Assurance Committee
ICS SQG
IRM (Improvement Review Meeting)
RJAH IPCC Committee
Improvement Plan
ID report
IPC Working Group
AMR via DTC
Water Group
Decontamination Group
Undertakings
SOF Exit Criteria
Aspiring to deliver world class patient care
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IPC Improvement Plan

No	Priority Level	Area for Improvement	Target completion Date	Revised target completion Date	Accountable Exec	Responsible Lead	RAG Status	Progress Update
Objective 1: Evidence of board assurance, senior leadership and delivery of actions - Monthly Board report with progress against IPC Improvement Plan - IPC QAC minutes and action logs - Board minutes - Patient Safety walkabouts - Quarterly paper to QhS Committee - Increased compliance in Hygiene Code GAP analysis - % compliance								
1. Leadership and Culture								
1.1	High	Leadership development programme to be considered for the IPC Team	28/06/2022		Chief Nurse	Kirsty Forde	Amber	Series of IPC team away days (x3); first away day completed 27/04/2022
1.1.1		IPC Summit to be scheduled	28/06/2022		Chief Nurse	Kirsty Forde	Amber	
1.1.2		IPC Strategy to be launched	28/06/2022		Chief Nurse	Sara Young	NS	
1.2	Medium	Development plan for senior nurses to ensure succession planning for corporate roles	28/06/2022		Chief Nurse	Kirsty Forde	Green	Clinical Leadership programme starting April 22. Roles and Responsibilities [illegible]
1.3	Low	Consider an IPC pledge from each of the senior leader team to re-enforce the standards expected	28/07/2022		Chief Nurse	Sara Ellis-A	NS	To link in with re-launch of IPC strategy
1.4	Low	Dedicated campaign regarding reporting cleanliness or IPC concerns to further improve awareness	28/07/2022		Chief Nurse	FTSU Guard	NS	To link in with re-launch of IPC strategy. FTSU now aligned with Head of Clinical Governance and Quality [illegible]
1.5	High	Strengthened engagement from medical workforce	09/06/2022		Medical Director	Clinical lead	Amber	
Objective 2: Trust staff have the necessary improvement skills - IPC training monthly report (% improvement) - IPC champion role job description re-launch - Review of audit of SI/outbreak actions (implemented actions)								
2. IPC Team and Capacity								
2.1	High	Review IPC nurses job plans and workload to ensure priority of works, allocating resource appropriately	28/05/2022	30/06/2022	Chief Nurse	Sara Ellis-A	Amber	Programme of works for 22/23 agreed at IPCC on 28/5/22. Date revised to ensure input from incoming deputy DIPC
2.2	High	Review of microbiology provision and update of current SLA with SATH	28/07/2022		Chief Nurse	Dave Forde	Amber	Current SLA renewed for further 6 months
2.3	Medium	Add additional levels of IPC observation in clinical areas to add independent level of assurance	28/04/2022		Chief Nurse	Sara Ellis-A	Green	Reinstate sit and see audits. Patient Safety walkabouts have been reintroduced from April 22
2.4	Medium	Review annual IPC audit schedule and align with IPC policies	13/05/2022		Chief Nurse	Kirsty Forde	Green	To align with policies and Hygiene code gap analysis. Audit frequency updated and circulated to wards and departments [illegible]
2.5	Medium	Re-launch of IPC champions (link roles)	28/05/2022	30/06/2022	Chief Nurse	IPC/Matrons	Amber	To link in with re-launch of IPC strategy
2.6	Medium	Consideration of whether it is appropriate for IPC to sit within an operational unit	18/05/2022		Chief Nurse	Sara Ellis-A	Blue	Reviewed and agreed reporting lines for IPC team to sit within Assurance and Standards Team
2.7	High	IPC Structure Review to address capacity of IPC team	28/05/2022		Chief Nurse	Sara Ellis-A	Green	IPC to sit with A&S team reporting to Head of Clinical Governance as interim measure - Complete. New lead IPC joint post with ShropCom [illegible]
3. Training								
3.1	High	IPC training report to include details on HH/ANTT/Donning and Doffing per discipline	15/04/2022	30/06/2022	Chief Nurse	Kirsty Forde	Green	IPC training to be updated with regular reporting through IPCC. Report due at IPCC in April. Training needs analysis to be undertaken by the T[illegible]
3.2	Medium	IPC week focussing on IPC skills stations promoting education and development on all elements of IPC for staff	28/04/2022		Chief Nurse	Lisa Newson	Green	IPC Fayre successfully delivered w/c 19/04/22
3.3	High	IPC training role to be developed to offer practical PPE/HH training for all disciplines on a rolling programme	28/05/2022		Chief Nurse	Sian Sayles	Blue	Funding identified for post. Post Approval complete, JD developed and post advertised on [illegible]/2022. Trainee ODP being temporarily [illegible]
3.4	Medium	Antimicrobial training for doctors induction from April 22	28/04/2022		Chief Nurse	Antimicrobial	Green	IPC induction for junior doctors amended to 1 hour from April 22 to include antimicrobial stewardship training
3.5	High	IPC training needs analysis to be undertaken	28/05/2022		Chief Nurse	Kirsty Forde	Green	To support action 3.1. Email sent to training team 18.05.22 to prioritise for completion. IPC have completed a further review of training require[illegible]
Objective 3: Trust IPC audits demonstrate improvement - Hand Hygiene/Bare Below the Elbows audits (quarterly IPC report, monthly IPC unit report, IPC IPR dashboard) - Trust general IPC inspection audits (quarterly IPC report, monthly IPC unit report, IPC IPR dashboard) - NHSE/I Letters following informal visits - NHSE/I Letters following 3 and 6 month reviews								
4. Cleanliness								
4.1	High	Case of need for stores management/housekeeper role as part of ward team	12/04/2022	05/05/2022	Director of Finance	Phil Davies	Green	Stores case of need approved and can be funded internally. Housekeeper case of need - original business case options re-reviewed and agre[illegible]
4.2	High	Escalate system cleanliness business case and consider other options for bed cleaning	28/05/2022		Director of Finance	Phil Davies	Red	Revised business case approved for Housekeeping and roaming deep clean team at RJAH-ISLG and supported at system investment panel [illegible]
4.3	Medium	Clear roles and responsibilities defined for cleaning aligned with implementation of National Standards for Cleanliness	18/03/2022		Chief Nurse	Sian Langford	Green	Meeting to review and agree responsibilities occurred on 10/03/22. Update presented at SNAHP 29/03/22. Quarterly review required
4.4	Low	Standardised bed cleaning checklist for all wards for daily checks	18/03/2022		Chief Nurse	Kirsty Ditcher	Green	Email sent to all ward managers for standardised bed cleaning checklist to be in use from 09/03/2022
4.5	Low	Trust process required for the cleaning of water coolers - to be included in action 4.3 roles and responsibilities	18/03/2022		Director of Finance	Sian Langford	Blue	Contractor completed Trust wide descale/deep clean w/c 7th March. Pall [illegible] identified re-lamenting ongoing provision of monthly descale [illegible]
4.6	Low	Standardised template for patient equipment cleaning checklist for all wards/departments	28/05/2022	15/06/2022	Chief Nurse	Matrons	Amber	Matrons to develop a standardised ward/departmental cleaning checklist. Date extended to reflect staff absence and shortages within the Ma[illegible]
5. Estates								
5.1	High	Prioritisation matrix for estates works to be developed to ensure estates improvements are IPC risk assessed	28/03/2022	28/06/2022	Director of Finance	Phil Davies	Green	IPC priorities agreed at working group, applied retrospectively to outstanding tasks and being applied to all new tasks
5.2	High	Trust programme of ward/department closure to address flooring replacement to be agreed for 22/23	12/04/2022	30/06/2022	Director of Finance	Phil Davies	Amber	Meeting with RJAH/RFPD scheduled for 28.05.22
5.3	Medium	Policy for PPM (Helpdesk Tasks) to be written	28/05/2022		Director of Finance	Phil Davies	Amber	Estates Policy written - due to go to IPC WG for review and escalated for approval
5.4	High	Adequate provision of hand wash basins on Ludlow Ward	28/07/2022		Chief Nurse	Phil Davies	Amber	Safe process agreed at IPC WG - basins due to be installed in Ludlow corridor before end of May

IPC Improvement Plan | Pivot tables

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Immediate Actions outlined

	Recommended Action	Progress update
1	Review of assurance and sign off processes for actions plans and a review of all actions plans that are currently marked as completed	This has been completed and all outstanding actions transferred to Tendable.
2	Complete the GAP analysis and action plan against the Code of Practice for the prevention of infection and related guidance (Hygeine Code) and ensure this has been presented to Trust Board within the next month.	GAP analysis completed in November 2021 with actions identified. Presented at IPCC and Q&S in March 22 and Trust Board April 22. Will report to Board quarterly.
3	IPC BAF needs to be updated and presented to the Trust Board within the next month.	Revised IPC BAF received Dec 2021. Presented at IPCC and Q&S in March 22 and Trust Board April 22. Will report to Board quarterly.
4	Development of recommendations of the One Together audit, presented to the Trust IPC Committee.	One Together Audit completed and circulated to key stakeholders in Dec 21. Presented at IPCC. Working group set up to progress actions with upward reporting to IPCC and subsequently Q&S via Chairs report.
5	Medical leadership intervention with medical colleagues compliance with IPC including hand hygiene, bare below the elbows and the use of theatre hats/caps.	Medical Director has written to all medical colleagues outlining expectations. Further actions oulined in Improvement Plan with review of unifrom policy and re-launch of BBE campaign.
6	Review of the IPC team structure and the team capacity and priorities	Review and benchmarking undertaken in Dec 21. CCG supporting with review of IPC lead job plan. Case of need outlining re-structure and strengthening of the IPC team approved at SLG 22/03/2022. IPC Team development day completed 27/04/2022.

Strengthened IPC team

Proposed Structure

DIPC

Band 8C IPC Associate/Deputy DIPC
0.5 WTE

SLA Consultant Microbiologist

B7 Lead IPC Nurse
1.0 WTE

B6 IPCN
1.0 WTE

B6 Governance Lead
1.0 WTE

B5 SSI Nurse
1.43 WTE

B3 IPC Assistant
12 months fixed term 1.0 WTE

B2 Admin
1.0 WTE

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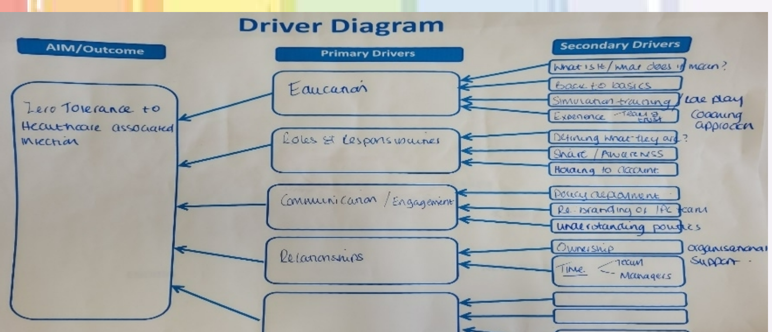
Development of IPC Strategy



Next steps…. IPC Summit

Minimise the risk of acquiring Nosocomial Infections to patients and aspire to prevent all avoidable infections.

Develop innovative methods of educating staff in the delivery of high-quality infection prevention and control

Building relationships to ensure that effective communication and engagement to support the message that 'Infection Control is everyone's responsibility

Explore and update surveillance mechanisms and reporting to facilitate embedding of best practice.

Continue to comply with statutory requirements related to the Code of Practice, to maintain a safe environment.

Enhance patient and public involvement in infection prevention to improve patient experience

Continue to work as an ICS approach with local providers.

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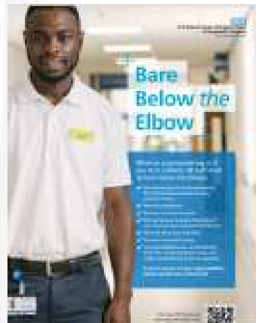
Key achievements to date



April - June 22

- Surgical Site Infection Prevention Working Group developed
- Monthly IPC training data report.
- PIR process for all Surgical Site Infections
- IPC Annual Audit plan. Full mattress audit completed
- Utilisation of Tendable for all IPC audits and action plans.
- Redesigned IPC Intranet page.
- Re-launch of BBE campaign #rollyoursleevesup
- IPC Fair – promoting awareness and education
- Updated Uniform Policy
- Introduction of fortnightly IPC bulletin from CNO and CMO
- Launch of National Standards of Healthcare Cleanliness

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Cultural Improvement Journey

NHS

Communication

IPC Team

- Set the IPC vision
- Define the parameters of IPC
- Start, stop, carry on
- Roles & responsibilities
- Skills matrix / development
- Learning site visits
- Policy deployment
- Processes
- Measurement

Roles & Responsibilities / Standards of Practice

- Guidelines
- Collective ownership
- Trust wide roles & responsibilities
- Decision trees
- Sit & see

Productive Series

- Launch improvement framework
- IPC collaborative
- Wards, outpatients & theatres
- 6S
- Huddles
- Visual management
- Quality Control Boards / Process

Leadership Development

- Nurse leadership programme
- IPC champions mentoring programme
- Mentoring faculty

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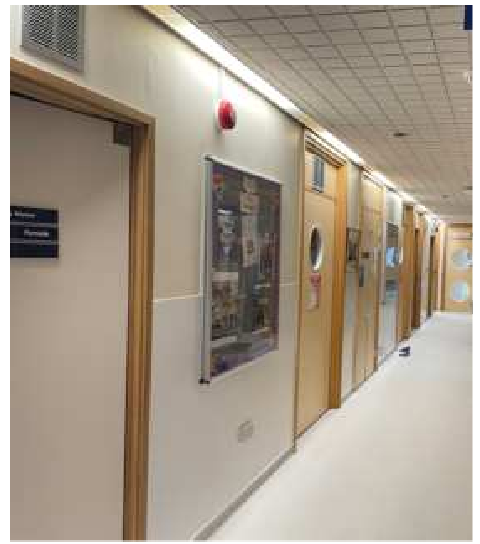
Environmental Improvements

- *Wrekin/Gladstone ward improvements completed March 22*
- *Ludlow ward refurbishment completed April 22*
- *OPD Plaster room refurbished*

Environmental Improvements

- *Clwyd ward flooring replaced*
- *Theatre improvements*



NHS

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Investments to Support IPC Improvements

- Estate and equipment improvements :
  - Invested c£900k in improvements to ward environments, patient facing areas and replacing equipment during 21/22.
  - Further investment planned for remaining ward areas with £360k included in Trust plans for 22/23.

- IPC team structure – made permanent changes to strengthen IPC team £94k per annum (funded through internal re-allocation of resources).

- Further improvement requirement identified in respect of cleaning resource across wards and wider Trust. Business case developed requiring £440k investment for 15.2 WTE housekeepers and deep cleaning team.
  - Due to system financial position of the STW ICS a triple lock process has been introduced to stabilise the financial position. Any new investment must be signed off by organisation, ICB and regulator.
  - Case submitted to Investment Prioritisation Panel and ranked as one of top priorities for system but with ongoing financial pressures approval has not been possible for c9 months – no local latitude for an organisation to self fund.
  - The risks of non investment have become consequences with increased SSI's and legal undertakings.
  - Seeking solution through ICB to move forward without destabilising financial position of system further.

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Risks, Challenges and Focus for Next Three Months

- *Cleanliness resource business case approval and implementation*
- *Embedding and sustaining improvements trust wide*
  - Developing ownership at every level throughout the organisation
  - Encouraging staff to 'spot' the issues and act
  - Empowering staff and patients to positively challenge
  - Developing identified IPC champions
  - Themes and learning routinely
- *Digital solution for recording SSIs, outbreaks and other infections*
- *Sustainability of the governance oversight (including any actions and improvements identified through the GGI review*

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Any Questions ?

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Classification: Official

Publication reference:

To: Mr Harry Turner, Chair
The Robert Jones and Agnes Hunt
Orthopaedic Hospital NHS Foundation
Trust
Gobowen
Oswestry
SY10 7AG

NHS England
Cardinal Square
10 Nottingham Road
Derby
DE1 3QT

5 July 2022

Dear Mr Turner,

R.e.: Robert Jones Agnes Hunt NHS Foundation Trust Improvement Review Meeting held 30 June 2022

Further to the enforcement undertakings applied to your Trust under section 106 of the Health and Social Care Act 2012, a monthly Improvement Review Meeting (IRM) has been established as the combined formal oversight by NHS England and the Shropshire Telford and Wrekin Integrated Care System in relation to Infection Prevention and control concerns raised within the Trust.

Meetings will take place monthly until the end of September, when the necessity and frequency going forward will be reviewed. Following each meeting, we will formally write to you to summarise the discussions and actions agreed, our expectation is that you will share these formal feedback letters with your Trust Board. An action log will be produced and shared with all IRM members for management within the meeting, we will escalate any actions not completed and any concerns within our formal feedback letter to you.

The first IRM took place on 30 June 2022. As co-Chairs of the meeting, we write to share the discussions held and any actions agreed as the formal record of the meeting.

1. Overview and purpose

It was explained that the Trust has been placed into level 3 of the System Oversight Framework and the IRM will be the formal mechanism used to review progress against the undertakings in relation to the IPC concerns.

2. Terms of Reference

Draft terms of reference were circulated as part of the meeting papers and agreed, subject to one addition: formal feedback letters from the meetings to be sent to you as the Chair of the NHS Foundation Trust.

The revised terms of reference are enclosed for you information.

3. Undertakings and Exit Criteria

Copies of the exit criteria and legal enforcements were formally shared as part of the meeting papers. It was noted that the exit criteria have been mapped to the undertakings and that this process has ensured that there are no gaps. In the files shared with members, the mapping was detailed along with the list of example evidence required to meet each exit criteria. However, this should not be seen as an exhaustive list but as a minimum guide.

4. Delivery Update

The Trust Executives provided a detailed and comprehensive presentation, which gave an update on:

- Trust Board actions with strengthened governance and assurance arrangements;
- The Trusts IPC Improvement Plan and progress against immediate identified actions;
- The strengthened IPC team, IPC strategy and the upcoming IPC summit;
- The cultural improvement journey within the wider organisation;
- Environmental improvements to date (including the Wrekin/Gladstone ward improvements in March; the Ludlow ward refurbishment in April, the OPD plaster room refurbishment and the Clywd ward flooring replacement);
- Investments to support the IPC improvements; and
- Risks, challenges and focus for the next three months.

The business case for additional housekeepers / deep cleaning team, as one of the remaining risks, was discussed. Whilst we noted this isn't a new requirement, having first been presented nine months ago, and also noted that funding in-house via invest to save plans during 2022/23 is an option, we understood that approval for the expenditure is required by system partners as part of the triple lock process as a result of the system financial position. It is understood that high priority has been placed on the business case from a system perspective, which is reassuring with the IPC concerns.

5. Feedback from Formal NHSEI Visit – 22nd June 2022

Kirsty Morgan, Assistant Director, IPC – Midlands, fed back on her formal three-month inspection of the Trust on 22nd June. This was a planned inspection, as detailed within the enforcement undertakings.

It was encouraging to hear how positive this visited had been, with significant noticeable improvements reported and interest/involvement across all teams and staff disciplines during the visit. The Ludlow ward refurbishment and the OPD plaster room refurbishment were cited as examples of where hard work has taken place to address the IPC concerns; along with continued improvements on the Gladstone and Wrekin wards.

Kirsty reported that she noted a few areas for improvement as part of her visit, including attention to detail on cleaning, but stated that there was nothing identified that the Trust were not already aware of and that didn't appear on their action list. The regular review by the IPC working group to help prioritise estates work was seen as positive.

6. Support for Identified Actions

It was noted that Jacqueline Barnes, Improvement Director, is supporting the Trust to implement IC Net, a digital platform recommended to support the surveillance and

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reporting of infections. Jacqueline has linked your Trust with regional colleagues and local NHS Trusts who are familiar with this software. As Chairs of the meeting, we stated our support for this identified action.

7. Assessment Against Undertakings

The comprehensiveness of the Trust's presentation and the positive feedback from the NHSE led IPC inspection, indicate that the Trust is demonstrating good progress to address the enforcement undertakings.
It was agreed to look at the undertakings in more detail in future meetings to support a formal monthly assessment to be agreed.

ACTION: A self-assessment by the Trust of progress against the undertakings to be sent ahead of each meeting. Jacqueline Barnes, Improvement Director will support your Executive leads in completing this.

Overall, this was a positive first meeting and we look forward to seeing continued progress in the coming months.

Yours sincerely,

[Sender's e-signature]

Fran Steele
Director of Strategic Transformation
North Midlands

Alison Bussey
Chief Nurse
STW Integrated Care System

Enc: Terms of Reference V2 FINAL

Cc: Members of the IRM
Nina Morgan, Chief Nurse, NHSE

Chair's Assurance Report
Quality and Safety Committee 23 June 2022

0. Reference Information

Author:	Olivia Evans, Executive Assistant	Paper date:	6 July 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	Paper written on:	4 July 2022
Paper Reviewed by:	N/A	Paper Category:	Governance and Assurance
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality and Safety Committee meeting held on 23 June 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The Committee was quorate.
- The Committee received the standard agenda items which included the SI and Never Events paper, a Unit quality report, the Harms presentation, and the performance report.
- The Committee approved the IRMER procedures, VTE policy and Research Transparency policy.
- Areas to highlight to the Board include:
    - Introduction of new way to report deaths including “sudden but not unexpected” in line with national reporting.
    - A Serious Incident Thematic Review was presented which provides recommendations which will be assigned leads and workstreams.
    - Complexity work continues to progress; however resource of Information team remains an issue.
    - Safeguarding annual report approved by Committee.
    - NHSEI visited Trust as part of 3 monthly IPC reviews with positive feedback.

2.3. Conclusion

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

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3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 23 June 2022. The meeting was quorate with 2 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Penny Venables	Non-Executive Director
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow	Chief Medical Officer
In Attendance:	
Martin Newsholme	Non-Executive Director
Jenny O'Connor	Shropshire, Telford and Wrekin CCG
Stacey Keegan	Chief Executive
Jo Wales	Deputy Research Manager
Louise Arnold	Radiology Quality Lead
Dawn Forrest	Managing Director for Specialist Unit
Kirsty Foskett	Head of Clinical Governance and Quality
Lisa Newton	Assistant Chief Nurse for Specialist Unit
Liv Evans	Minute Secretary
Apologies:	
Apologies were received from Shelley Ramtuhul, Paul Kingston and Tracey Slater	

3.2 Actions from the Previous Meeting

The Committee discussed the action plan in detail and an update was provided for each action. There were 5 actions noted as outstanding a forwarded on to the next meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There was no declaration of interest shared	N/A	
2. Performance Report		
Number of complaints continues to not achieve target for forth month.	No	Deep dive to be undertaken into complaint due to the

Complaints rate per 1000 WTE continues to not achieve target for forth month. Standard complaints response rate within 25 days has not met target for 7 months. Delayed discharges have achieved target for the first time since April 2021. One unexpected death reported in month.		continuation of not meeting the target. .
3. Support Unit Quality Report		
Sustained improvement in Datix management and appraisals. New PAS due to be implemented within 18 months. Work ongoing to decrease WNB (was not bought) rates within Paediatrics. 17 ongoing projects within PMO. Time to recruit KPI at 92 days against target of 40 days.	Partial N	Campaign delayed due to covid but being implemented shortly. Work with People Services to understand delays.
4. MSK Quality Report		
Incident reporting levels remain consistent with top themes patient delays, patient transfer, tissue viability, medication incidents and patient falls. High compliance of hand hygiene throughout Unit. 0 surgical site infection within month. 12 clinical audits overdue in addition to 10 overdue actions. 19 complaints in month driven by reduced private patient surgery due to lack of theatre availability.	Partial	Concerns raised relating to the number of overdue clinical audits being reported. Work ongoing within Unit to drive forward actions. To be added to the workplan to increase oversight.
5. Serious Incidents and Never Events		
Thematic review of SIs identified potential recommendations: - Development of a Conflict of Clinical Opinion Policy - A review of communication processes and policies within Pre-Op. - To improve awareness of the paediatric requirements. - To ensure autonomous practitioners have the relevant level of clinical supervision which is outside of their yearly appraisal process. - Opportunities to further understand the job demands on individuals.	Yes	

- RCA investigators need to ensure statements are factual and not subject to bias.		
6. Complexity Work Update		
Verbal update provided stating identification of certain factors which define a patient as orthopaedically complex is phase one – which is currently in progress.	Yes	
7. Harms Presentation		
Cohort 1 – 2264 patients. 29 initially listed as moderate harm: - 21 patients moved to low harm post clinic review. - 7 patients awaiting clinic appointment outcome. - 1 RCA and duty of candour completed for spinal patient as suspected loss of neurology in fingers. Cohort 2 – 2839 patients. 31 initially listed as moderate harm: - 9 patients moved to low harm post clinic review. - 27 patients awaiting clinic appointment outcome. - 2 RCAs and duty of candours completed for 2 spinal patients who developed urosepsis.	Partial	MD working with team to ensure clinic appointments are made priority.
Discussion was held around process of harms review and confirming other factors such as mental health and job loss does not impact priority on waiting list.	No	RL looking to work with system to prioritise on other factors within P2, P3 and P4 waiting lists.
8. Safeguarding Annual Report		
Report notes: - Increase in deprivation of liberty safeguards (DoLS). - Level 3 training needs further focus. - Increase in domestic abuse incidents. The Committee *approved* the annual report.	Yes	
9. Patient Experience Chair Report		
The Committee *noted* the Patient Experience Committee chair report.	Yes	
10. Safeguarding Chair Report		
The Committee *noted* the Safeguarding Committee chair report.	Yes	
11. Patient Safety Committee Chair Report		
To highlight: - Patient safety culture questionnaire finds have led to cultural workstreams of focus. - Monthly training report not reported for second month. PV raised concerns with the training team as seems to be a theme throughout the Committee. SEA believes there are resource issues within the team which is on their risk register.	Yes	
12. Research Committee Chair Report		

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Main risk to highlight is continued gap between project forecast and planned income.	Partial	Confident projects will increase however cannot be defined as of yet.
13. Trust Performance and Operational Improvement Board Chair Report		
To highlight: - Overdue follow ups remaining high with a trajectory for clearance asked to be presented at the next Board. - 104 week waiting patients continues to be a priority.	Partial	Work ongoing with Units to create trajectory to eliminate 104 week waits by July 2022.
14. Review of the Work Plan		
The Committee noted the workplan for 2022/23 and will continue to reflect upon the document throughout the year.	N/A	
15. Attendance Matrix		
The Committee noted the attendance matrix which is shared for information.	N/A	

3.4 Approvals

Approval Sought	Outcome
IRMER Procedures	Approved
VTE Policy	Approved
Research Transparency Policy	Approved

3.5 Risks to be Escalated

During its business the Committee confirmed there are no risks to be escalated to the Board.

4. Conclusion

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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0. Reference Information

Author:	Anne Worrall Adult Safeguarding Practitioner and Suzanne Marsden Named Nurse for Children	Paper date:	6th of July 2022
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer and named nurse for Adult Safeguarding	Paper Category:	Annual Report
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an annual review of Children and Young People and Adult Safeguarding within the Trust for 2021/22. The Board is asked to note the paper.

The annual safeguarding report provides an overview of the work which has been undertaken and performance during 2021/22 in relation to children and young people and adult safeguarding and outlines key priorities for 2022/23. This report should be read in conjunction with the Shropshire Safeguarding Community Partnership (SSCP) annual reports. A link to these documents will be available on the safeguarding web page.

2. Executive Summary

2.1 Context

The annual safeguarding report provides an overview of the work which has been undertaken and performance during 2021/22 in relation to children and young people and adult safeguarding, working in conjunction with the Shropshire Safeguarding Community Partnership.

2.2. Summary

- Summary of children and adult safeguarding referrals noting an increase in domestic abuse cases
- Increase in DoLs referrals following increased education
- Summary of training with level 3 safeguarding in children and adults remaining an area of focus
- Summarises objectives that have been fully and partially achieved for 21/23
- Outlines key priorities for 22/23

2.3 Conclusion

The Trust Board are asked to review the content of the report and make any recommendations and approve as appropriate.

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3. The Main Report

3.1 Introduction

The Robert Jones & Agnes Hunt Orthopaedic Hospital (RJAH) NHS Foundation Trust is an organisation which has a culture that prioritises quality of care having strong leadership and focus, and good partnership working to promote the well-being, security and safety of children and young people and adults (adults with care and support needs) who are under our care. For the purpose of this document we define children and young people as those who have not yet reached their 18th birthday.

Part of the organisation's commitment is to work alongside both the Shropshire Safeguarding Community Partnership (SSCP) and other partner agencies, to ensure there are effective systems in place to safeguard children and young people and adults with care and support needs.

RJAH is committed to meeting the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (Aug 2019) and provides evidence on how the trust meets the requirements. An action plan to demonstrate compliance against the standards has been developed. This is monitored by the safeguarding team reporting on the actions and continual improvements.

The Trust is required to meet the Care Quality Commission (CQC) fundamental standards which is the independent regulator to ensure health and social care services are safe, effective, compassionate and of high-quality care. CQC Regulation 13: Safeguarding service users from abuse and improper treatment is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

3.2 Our Vision

Children and young people

Nothing is more important than children's welfare. Children who need help and protection deserve high quality and effective support as soon as a need is identified. Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, we must ensure our staff put the needs of children first when determining what action to take.

This child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.
We need to ensure all practitioners follow the principles of the Children Acts (1989 and 2004) that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary. Working Together Document (DOH 2019).

Adults with care and support needs

Adults with care and support needs have the right to live in safety, free from abuse and neglect (Care Act, 2014)

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All practitioners need to work together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action ensuring we are making safeguarding personal.

Safeguarding as core business

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is committed to safeguarding children and young people and adults with care and support needs, to ensure their welfare needs remain paramount whilst in our care, making safeguarding everybody's responsibility. We achieve this by;

- Ensuring the Trust is compliant with statutory responsibilities, national and local guidance, CQC registration and standards. Evidence of compliance is reported quarterly and annually to the Clinical Commissioning Group (CCG).
- Ensuring the Trust provides evidence on how the organisation meets the requirements of the Safeguarding Accountability and Assurance Framework (Aug 2019).
- Having clear lines of accountability in place, which are accessible and promoted to all staff.
- Ensuring all staff receive safeguarding training to the level appropriate to their role and responsibilities.
- Having safeguarding children and young people and adult policies and procedures in place that are aligned with national and local guidance including safe recruitment policies and procedures.
- Ensuring there are processes in place for the management of allegations against staff.
- Encouraging staff to raise concerns.
- Reviewing and monitoring incidents and complaints to identify trends or patterns.
- Ensuring that we are aligned to and committed to delivering the SSCP annual objectives and contributing to the SSCP annual report.

4. Shropshire Safeguarding Partnership Priorities

Shropshire Safeguarding Community Partnership (SSCP) Priorities 2020-2023

- Joint priorities include:
  - Domestic abuse,
  - Exploitation and
  - Transitional safeguarding (the period of moving from Children's Services into adulthood)
- The Adult priority is Self-Neglect
- The Children's priority is Neglect
- The Community Safety priorities are preventing offering and Drug and Alcohol Misuse

The priorities identified by the partnership over the next three years will be monitored through the completion of the business plans by each multi-agency group.

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
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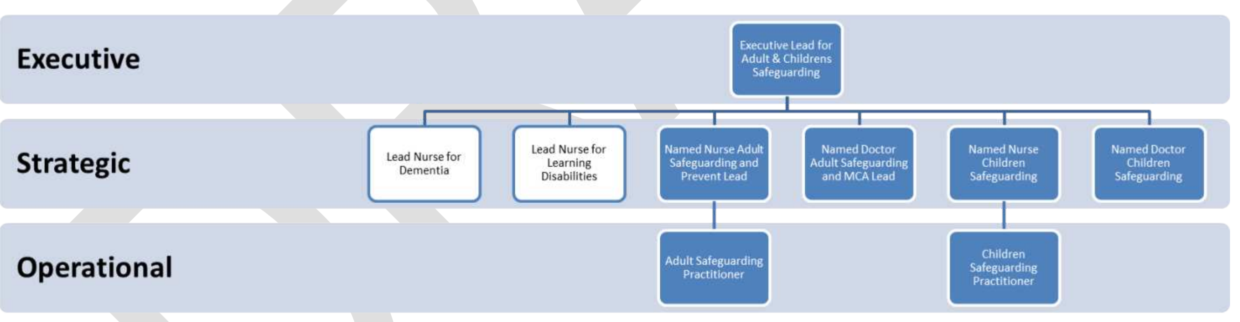
5. Safeguarding accountability structure across the RJAH



Executive Lead for Safeguarding Children and Adults	Stacey Keegan, interim CEO Sara Ellis-Anderson, interim Chief Nurse and Patient Safety Officer (from Aug 21)
Non-Executive lead for Safeguarding Children and Adults	Paul Kingston
Named Doctor for safeguarding children and young people	Dr Richa Kulshrestha, Consultant Paediatrician allocated 1PA per week protected time, to undertake this role. Supported and supervised as necessary from the County wide Designated Doctor – Dr Ganesh.

Named Nurse for safeguarding children and young people	Suzanne Marsden - is the Children's Unit Manager and has 7.5 hrs per week allocated time to undertake this role as a band 8a Supported and supervised quarterly by Audrey Scott Ryan Designated Nurse for Safeguarding Children Telford CCG
Children's Safeguarding Practitioner	Vicki Jones Alice Ward Sister who has completed her safeguarding train the trainer course last year as well as a range of safeguarding level 3 modules to facilitate this role.
Named Doctor for adults	Mr Srinivasa Budithi has 1 PA per week allocated and works alongside the lead nurse for adult safeguarding monitoring of referrals/cases and providing support and expert advice to staff.
Named Nurse for adults	Sara Ellis-Anderson, Interim Chief Nurse. Supported and supervised quarterly by Sarah Dempsy, Deputy Designated Safeguarding Lead Nurse at NHS Redditch and Bromsgrove CCG
Adult Safeguarding Practitioners – 1.2 FTE job share by Anne Worrall (commenced in post April 20) and Katie Harris (commenced in post March 21-April 22)	Safeguarding practitioners are responsible for safeguarding training; monitoring of referrals/cases and advice/support to staff. Promotion of good professional practice within the organisation and a culture that all staff are aware of their personal responsibility to report concerns. Safeguarding practitioners and link nurses are responsible for embedding policy, training and education and supporting/advising staff.
Lead Nurse for Dementia	Ward Manager Lorna Edwards leads on Dementia care alongside her ward manager role supported by the Named Nurse for Adult Safeguarding and Assistant Chief Nurse Nicki Bellinger
Lead Nurse for Learning Disabilities	Adult safeguarding practitioner - Katie Harris started to develop this role in the absence of a senior lead for Learning Disabilities. Assistant Chief Nurse Nicki Bellinger will continue with this work in 22/23.
Lead Nurse for Mental health (new for 22/23)	The Trust has seen an increase in patients contacting the hospital with significant mental health concerns and these have been managed by the Adult safeguarding practitioners. The plan is to recruit a senior manager to lead on this role in 22/23.

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6. Meetings

Interagency children's meetings attendance:

- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Chief Nurse. The Named and County Designated Professionals, Matrons Adult Safeguarding Practitioners and Learning and Development Manager attend this meeting.
- Regional Named Nurse meeting children – this is held twice a year and normally has level 4 training incorporated into the afternoon session of the meeting. This meeting has been opened up to adult colleagues this year. Unfortunately due to COVID restrictions the level 4 training element has not been included again this year.

- SSCP Training pool Meetings attended by the Named Nurse children, these meeting remain on Teams.
- SSCP Learning and Development systems Group

Information from the county meetings is cascaded through the Paediatric Forum, Children's unit meetings as well as the Trust Safeguarding committee.

Interagency adult's meetings attendance:

- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Chief Nursing Officer. The Named and County Designated Professionals, Matrons Adult Safeguarding Practitioners and Learning and Development manager attend this meeting.
- SSCP learning and development sub-group attended by Adults & Children's Named Nurse
- SSCP MCA and DOLS sub-group attended by Adults Named Nurse
- SSCP Assurance and Improvement System group attended by Named Nurse
- SSCP Domestic Abuse Priority Group attended by Adults and Children's Named Nurse
- SSCP Self Neglect Strategic Priority Group attended by Adults Named Nurse
- SOCJAC – minutes received by Named Nurse
- STING - Shropshire and Telford Implementation Network Group "STING" for Mental Capacity Amendment Act including - Liberty Protection Safeguards attended by Adult Safeguarding Practitioner
- Responsible Bodies group for LPS attended by Adult Safeguarding Practitioner

Information from the interagency meetings is cascaded through Link meetings chaired quarterly by Adult Safeguarding Practitioners as well as the bimonthly Trust Safeguarding Committee.

The Trust intranet safeguarding pages are regularly updated and have links to the SSCP website. The Safeguarding team also produces a bi-monthly Safeguarding bulletin to disseminate key messages and information.

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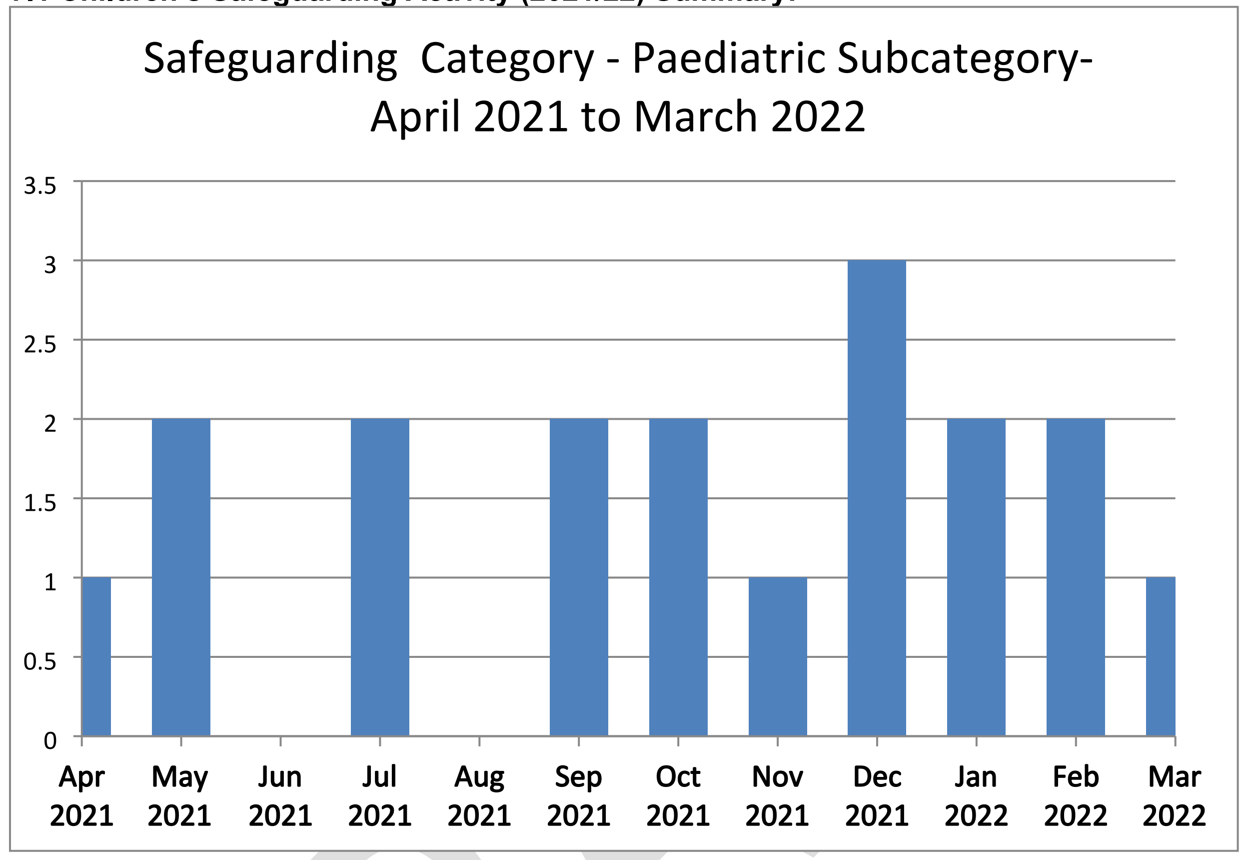
7. Referrals and incidents

7.1 Children's Safeguarding Activity (2021/22) Summary:



There have been a total of 18 Children and Young People safeguarding incidents reported in 2021/22 an increase of 5 from last year. (N.B one Datix was recorded twice by separate staff)

10 incidents resulted in referral to the patient's local authority for early help, targeted support and 1 for CAMHS; 2 of these incidents related to children who were frequently not brought to appointments; 1 incident was a referral - targeted help was not meeting the needs of the family and the children was then accepted by the children with disability team.
6 incidents related to attendance to conference / core group or professional meetings. (4 for the same patient and one Datix was submitted twice by two different staff members)
2 incidents related to unaccompanied children under 16yrs in the Trust.

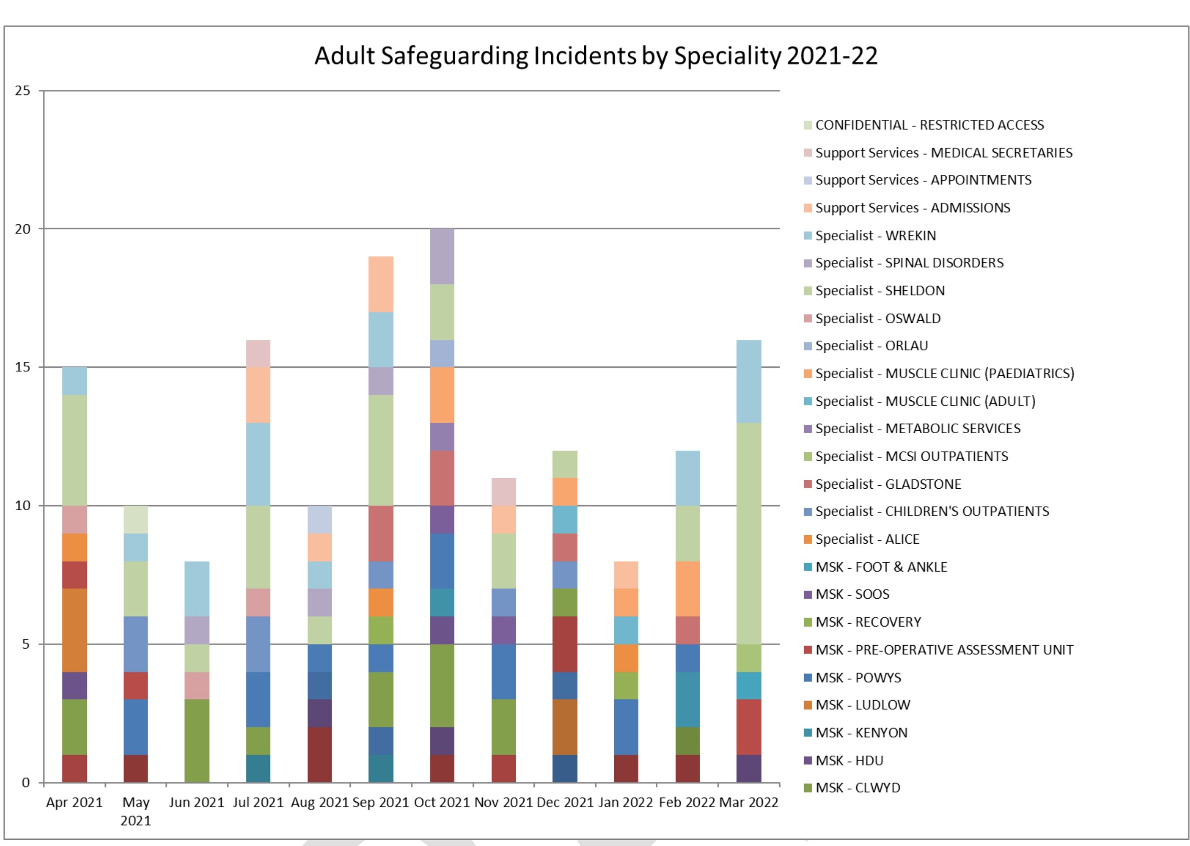
There were no clear themes; however mental health and anxiety issue were seen in many of these incidents, either experienced by the child or the parent and could possibly be linked to the effects of COVID restrictions, isolation, and anxieties associated with the COVID pandemic.

One Datix highlighted a learning opportunity, and a learning review was completed and shared with the Team.

Location of patients:

	Shropshire	Telford & Wrekin	Wirral	Flintshire	Walsall	Staffordshire
Q1	1	1		1		
Q2	2					
Q3	4	2	1		1	
Q4	2	1	1			1

7.2 Adult Safeguarding Activity (2021/22)



Summary:

There has been a total of 143 Adult Safeguarding Datix incidents including a subcategory of Deprivation of Liberty safeguards (DoLs) and adult safeguarding near miss and mental health issues reported in 2021/22. Out of the 143 Datix there has been a total of 61 Deprivation of Liberty safeguards (DoLs).

Out of the remaining 82 Datix under the category of adult safeguarding, near miss and mental health issues there has been 16 formal adult safeguarding referrals to various local authorities, and 2 referrals to the Multiagency Risk Assessment Conference (MARAC).

	Shropshire	Telford & Wrekin	Hereford	Flintshire	Surrey	Powys
Q1	2	1	0	0	0	0
Q2	2	1	1	1	1	0
Q3	2	0	0	0	0	1
Q4	0	0	0	0	0	0

	Gwynedd	Denbighshire	Birmingham	London
Q1	1	0	0	0
Q2	0	0	0	0
Q3	0	1	1	0
Q4	0	0	0	1

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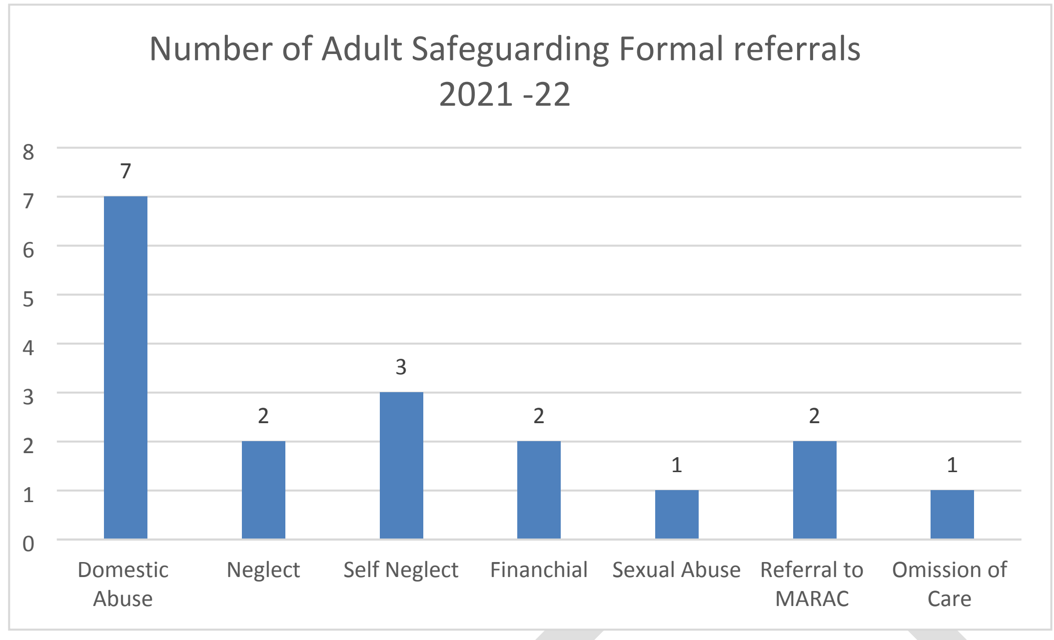
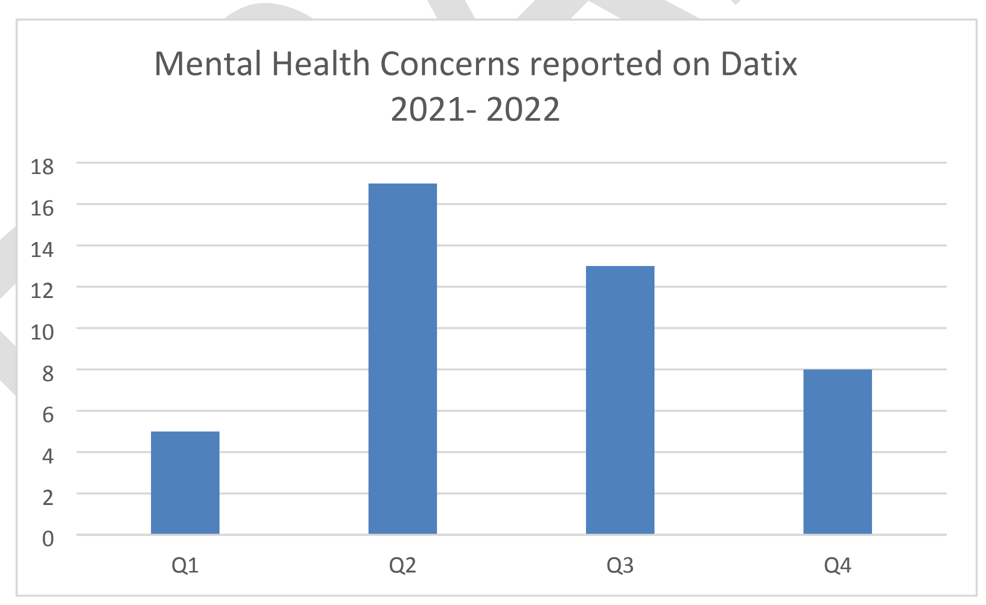


The category/types for abuse for safeguarding referrals have been varied throughout the year. However, the highest number has been the category of domestic abuse where many of the signs of abuse has been a combination of verbal abuse, physical and control and coercion. In addition to this there has been 2 formal referrals following the DASH risk assessment to MARAC Multiagency Risk Assessment Conference.



A total of 43 incidents recorded that did not meet threshold for referral to the local authority the predominant theme was deterioration in mental health resulting in signposting or onward referral to supporting services. There has been an increase in patient contacts to PALS and the Access team that is thought to be a direct correlation to increased waiting lists. A quarterly report is being overseen at Quality and Safety committee to monitor number of contacts and a standard operating procedure (SOP) with associated training has been developed for administrative staff to follow in the event of a contact from a patient in crisis.

The Trust has also seen a significant increase in the number of patients being admitted with complex mental health issues. This is something which as an organisation we have not been well equipped with, and many staff have not been regularly exposed to patients with mental health diagnoses working within an elective orthopaedic hospital.

Having identified a gap, and recognising the impact of this, a Mental Health Task and Finish group was set up to look at how we manage patients with mental health disorders, which involved reviewing the necessary support and training for staff, including policies and procedures, and signposting to other resources and agencies.

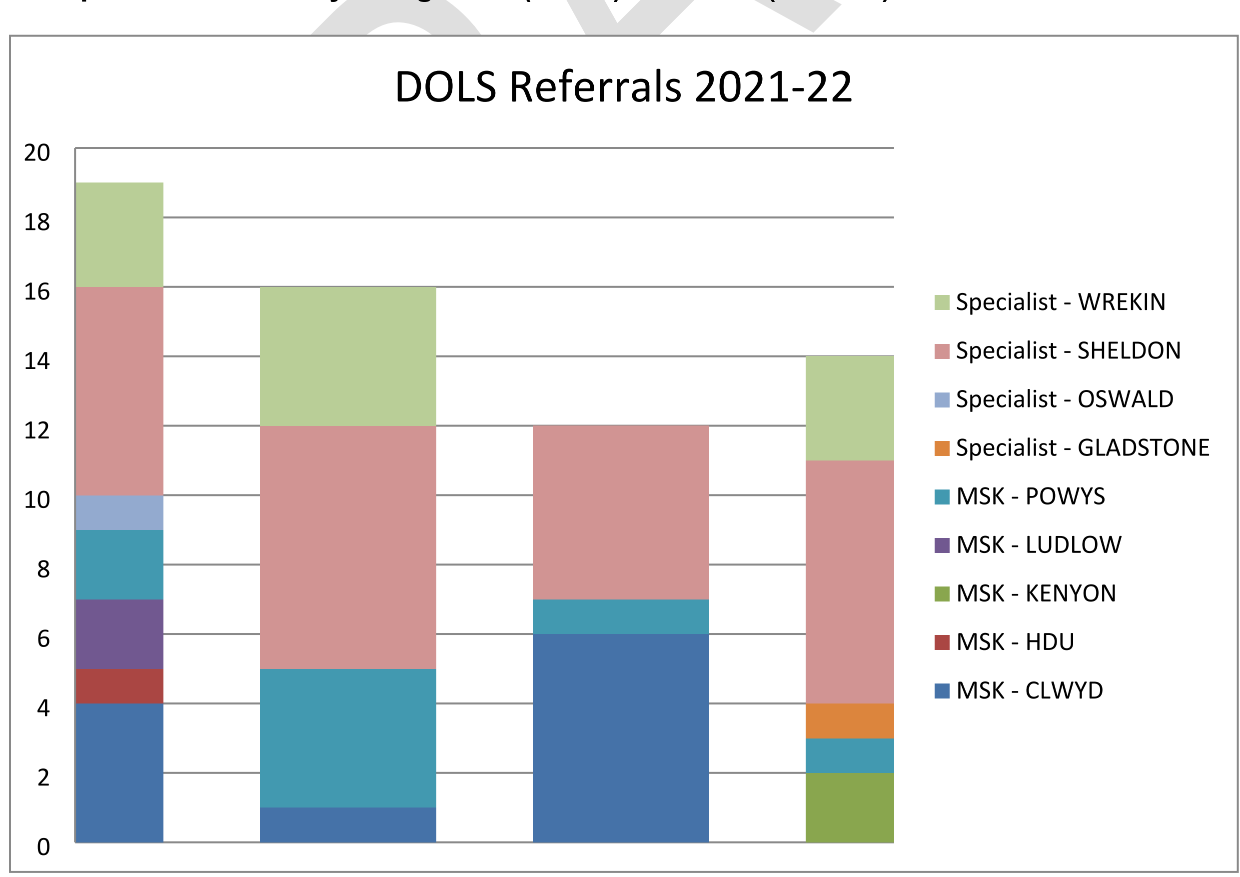
The group identified a range of actions to be undertaken to support staff due to the increase in patients experiencing mental health concerns in the trust.

Key actions undertaken and detailed in the action plan:

- Tier 1 eLearning training package has been designed and developed by members of the task and finish group. This is now a requirement for all staff to complete every three years.
- Tier 2 face to face bespoke mental health training programme has been set up for clinical staff to attend. This programme is being delivered by the Liaison Mental Health Team based at Shrewsbury Hospital.

- A review of the Service Level Agreement between the Robert Jones and Agnes Hunt Orthopaedic Hospital and Midland Partnership NHS Foundation Trust (MPFT) has been undertaken. This is to ensure there is ongoing support and a service from the relevant specialist professionals offered to patients which includes staff training.
- Review of policies and procedures in relation to Mental Health. T
- Review of Mental Health First aider's role and how this fits into supporting staff within the organisation.

8. Deprivation of Liberty Safeguards (DOLS) Referrals (2021/22)



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Summary:

There has been a consistent level of reported DoLs between 13 and 19 referrals per quarter. This is a significant rise in numbers of approximately 50 % overall in comparison to DoLs reported in 2020 -21. There has been a continuing increase in staff awareness of what constitutes a DoLs through staff education, and training, and training compliance has continued to be consistent.

To create more staff awareness patients who are subjected to a DoLs are discussed at the daily safe care huddles coordinated by the Clinical Site Manager with Ward Managers and Matrons. This is when patient's acuity and dependency requirements are discussed so to ensure the correct level of nursing care level is allocated.

Following the recommendations of the Mental Capacity Audit conducted during 2020 there has been a continual focus on mental capacity and DoLs which has led to review the training package delivered by the external provider. To assist and improve this session additional recommended resources has been added to help staff prepare before the training session. The resources included is a video of how to conduct a mental capacity assessment, and the completed example Mental Capacity Assessment (MCA) form is also distributed for staff to refer to.

The Liberty Protection Safeguards (LPS) was introduced by the Mental Capacity (Amendment) Act 2019 to replace the DoLS as the system that authorises arrangements amounting to a deprivation of liberty to provide care or treatment to an individual who lacks the relevant mental capacity, in England and Wales. The new system is designed to be more streamlined and will put the person at the centre of the decision-making process.

The core principles of the MCA are at the heart of the proposed design for LPS. This will help further align mental capacity awareness and practice across different settings and professionals.

NHS bodies will now have a role in arranging assessments and authorising and will take a proactive role in ensuring readiness in line with regulations, the code and the additional government guidance.

In readiness for the implementation of LPS the trust is a member of the STING Shropshire and Telford Implementation Group. The Trust has continued to participate as a member of the group working with key stakeholders and is in the process of reviewing the new updated version of the code of practice which is currently going through the consultation period. The trust is also preparing in readiness for LPS by undertaking the following actions:

- Monitoring number of DOLS quarterly through Datix system and quarterly report to Safeguarding Committee. This includes assessing the number of objections which is documented.
- Board briefing to SLG delivered July 2021 using national briefing documents.
- Regular agenda item at Safeguarding Committee
- Safeguarding team are signed up to Department of Health and Social Care (DHSC) newsletter
- Staff safeguarding webpage has a section on DOLS and LPS
- Staff safeguarding bulletin focussed on the MCA

The introduction of the new legislation Liberty Protection Safeguards, the responsibility for Mental Capacity Assessments and their implications will fall on Trusts as the Responsible Body rather than Local Authority. This means that Trust self-governs the assessments and decision-making process.

In preparation for this during quarter 4 the Adult Safeguarding Practitioners have undertaken a MCA Documentation Peer Review Audit. The aim of the audit is the review quality of documentation when staff complete a mental capacity assessment form, demonstrating how staff are supporting decision-making. Through the audit process it determines staff compliance of using Assessing Patient's Mental Capacity Policy and provides evidence through completion of the capacity assessments using the

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correct tools, interventions, and approaches. It is therefore more important than ever to ensure that the documentation around MCAs is robust, thorough, and detailed.

9. Prevent Referrals (2021/22)

There have been zero prevent referrals for 2021/22. The Named Nurse for adults safeguarding attended Channel Panel multi-agency training and the annual Prevent self-assessment was completed. Quarterly returns are sent to NHSE to monitor training levels and incidents reported.

10. Safeguarding complaints (2021/22)

There have been no complaints recorded in 2021/22 that have resulted in a safeguarding referral being made.

11. Managing allegations / Local Authority Designated Officer (LADO)

There have had no LADO referrals this year. There have been no referrals to the Nominated Safeguarding Senior Officer (NSSO).

12. Training

12.1 Child safeguarding training

Training compliance continues to be monitored against the Trusts targets of 92%. Training figures for March 2022 were:

Level	Compliance
Level 1	**96.3%**
Level 2	**95.8%**
Level 3	**72.6%**
Level 4	**100%**

Please see appendix one for further detail

The Named Nurse coordinates and delivers level-one training for staff working in the Trust and provides all staff groups across the Trust with expert advice and support regarding safeguarding children issues. Clinical staff, undertake level-two training as an e-learning module and the vast majority of level three training is accessed via the Shropshire Safeguarding Children Partnership (SSCP) training pool and is delivered as multi agency training, this continues to be delivered as virtual training due to COVID. This type of approach to training has proved to be more accessible and time efficient, and staff have found it easier to complete the necessary hours of training.

Whilst level 3 training figures appear to have deteriorated this year, this relates to an increase in number of staff requiring level three training to support young people 16-17yr admitted to adult wards. This risk is currently mitigated, and very few 16-17yr old are going to adult wards and the majority of young people of this age are admitted to Alice ward. Those young people who choose an adult pathway are flagged and each admission risk assessed. There is always a senior nurse on Alice ward 24hrs a day for Safeguarding support and advice for young people who are admitted to other departments in the Trust.
Both Named Professionals have completed level 4 training this Year, and Trust board training was completed in March 2022 by Named nurse for Safeguarding children and the adult safeguarding practitioner.

13.2 Adult safeguarding training

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Training compliance continues to be monitored against the Trust target of 92%. Training figures for March 2022 were:

Level 1	**96.8%**
Level 2	**96%**
Level 3	**31%**
Level 4	**100%**
Dols	**88%**
MCA	**86.7%**
Prevent	**92.9%**

The Intercollegiate Document-Adult Safeguarding: Roles and Competencies for Health Care Staff states that one of the most important principles of safeguarding is that it is everyone's responsibility. Each professional and organisation must do everything they can to ensure that adults at risk are protected from abuse, harm, and neglect.

Level 1 & 2 Adult Safeguarding training – there has been a consistent level of staff compliance. The percentage throughout 2021-22 has been above 92% target. Level 4 Adult training is for named professionals and is now at 100% compliance.

Level 3 Adult Safeguarding Training is for all registered health care staff who engages in assessing, planning, intervening, and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). The requirement for Level 3 is a minimum of 8 hours of safeguarding learning over a 3-year period with a mixture of e-learning and face to face training expected. Level 3 Adult Safeguarding training has been available since January 2021.

The joint Adult and Children's Safeguarding Priorities for 2020-21 'Improve Level 3 Adult safeguarding training and develop an Adult safeguarding training passport' This has been a continual focus during 2021-22 to improve the overall staff training percentage. There has been significant improvement from July 2021 where the percentage was 5.1% to the trust wide percentage of 31% in March 2022. 53% of staff have completed over 4 hours of training.

The Adult safeguarding training passport is now in use across the trust and bespoke training sessions have already commenced across the trust to support improving staff competencies, knowledge, skills, attitudes & values in Adult Safeguarding Level 3. These are recorded in the training passports and on ESR.

Delivery of level 3 adult safeguarding training has continued to be challenging throughout 2021/22 due to limited e-learning courses being available and number of places available face to face due to social distancing and some being cancelled due to Covid-19. During June 2021, another training needs analysis was undertaken to identify those who meet the criteria to complete Adult Safeguarding Level 3 training. Various ways have been reviewed to provide staff training and increase staff compliance. In addition to the eLearning method, an additional one day Zoom training session was commenced in September 2021 with a limited number of between 15 -18 staff per session per month. This has proved to be very successful across all disciplines and continues throughout 22/23.

MCA/DOLS Training

Although this has continued to be below target for 2020/21 there have been improvements made. The improvement is likely to be due to the implementation of the eLearning modules being available for clinical staff to complete. Application of knowledge is being tested via audit to understand areas for improvement.

Prevent training

Prevent training remains above target at 92.9% for the end of 2021/22.

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13. Quality assurance and audits

13.1 Audit

Assuring the quality of both professional practice and organisational processes and structures, depends on robust internal and cross-agency audit systems. The Trust's safeguarding web page is a great resource for staff and provides access to policies, procedures, contact numbers and up to date safeguarding information.

The following audits have been undertaken during 2021/22:

We continue to take part in the Monthly Female Genital Mutilation (FGM) Information Standard (1610 FGM prevalence data set collection) prevalence is checked monthly and should be uploaded onto their website. This Standard commenced in April 2014. However, to date no data has been uploaded from this Trust.

Monthly documentation Audit - The aim of the audit is to provide assurance that we are highlighting on admission those children who may be high risk. Some aspects of the audit includes ensuring that we know if the child is on a protection plan; who the child's legal guardian is; that we are liaising with their social care workers and consent is gained to share information.

An MCA documentation audit was conducted in Q4 of 21/22 across the Trust. The purpose of the audit was;

- To understand the extent to which the MCA Policy has embedded in the organisation and to assess the quality of the MCA documentation
- To ensure that the MCA and code of practice is being used appropriately across the Trust
- To be able to provide assurance to the CCG and CQC that we are following the MCA code of practice

The audit results are being analysed and due to be presented in Q2 of 22/23 with recommendations.

2021/22 also saw the introduction of quarterly general safeguarding audits on Tendable completed by the adult safeguarding practitioners to assess staff knowledge on how to make a referral and where to find relevant information.

13.2 Assurance and Performance monitoring:

Quarterly safeguarding children and adult dashboard – the dashboards are populated quarterly and are shared with the CCG for them to monitor the Trust's safeguarding compliance.

Themes and trends analysis for safeguarding referrals and incidents recorded at RJAH are discussed quarterly with Shropshire CCG Safeguarding lead.

An action plan has been developed to meet the requirements of the Safeguarding, Accountability & Assurance Framework (August 19). This is reviewed by the Trust Safeguarding Committee quarterly.

14. Associated Risks

There are a total of ten related safeguarding risks on the Trust risk register a reduction of 5 from the previous year. All related risks are monitored through the Trust Safeguarding Committee on a quarterly basis.

15. Associated policies

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Policy Workplan Updated March 2021	Owner	Renewal Date
Recruitment & selection	SP	
Missing child & adult policy	SM/AW	Jan-24
Child Death and bereavement policy	SM	Oct-22
Managing Allegations	HR/SM/SEA	Sep-24
Guidelines for children who were not brought to appointments	SM	Dec-24
Prevent Policy	SM/RK	Aug-22
Restrictive intervention and clinical holding of children and young people	SM	Nov-24
Protection and Safeguarding of Vulnerable Adults (Adults with care and support needs) Policy	KH/AW	Jan-24
Shropshire multi Agency guidance and procedure (DOLS)	System	
Guidelines for Deprivation of liberty Safeguards (DOLS)	AW/KH	Jan-25
Assessing Patient's Mental Capacity Policy	AW/KH	Jan-25
Management of serious incident policy	SR	May-22
Chaperone Policy	LR	Jul-22
Care of Adults with a Learning Disability on admission to RJAH	AW	Mar-24
Safeguarding Supervision Policy (new)	AW	Mar-24
Restrictive Practices Policy		

Key
Due at next committee
In Date
Approved at another Committee
New

16. Progress with the Key priorities for 2021/22

Joint Adult & Children's Safeguarding Priorities for 2021/22		
Priority	**Objectives**	**Achieved**
Improve compliance with Level 3 Adult safeguarding training	• Develop action plan to increase availability of level 3 safeguarding training available within the organisation by Q1 • Monitor training levels monthly and develop trajectory for achieving compliance target	**Partially achieved – improvement from 5% to 31% in year**
Improve Pre-operative pathway communication to identify Safeguarding and related concerns	• Development of safety questionnaire for adult pre-op • Review safety questions asked at paediatric pre-op to include use of social media • Review pre-operative alert system and communication to wider organisation	**Pre-op alert updated and safety questions asked. Further training required for staff to embed process**
Monitoring our WNB and DNA policy	• Conduct regular audit and identify actions for improvement	**Monitored monthly but remains a priority for the Trust**
Mental Health provision	• Review and update associated policies • Establish staff training needs • Conduct staff self-assessment • Introduce Mental Health Champions and/or expansion of Mental Health First Aider (MHFA) role within clinical settings	**Achieved – SLA with MPFT agreed. Regular training introduced**
Compliance with NHSE Learning Disabilities standards	• Conduct self-assessment against standards to identify areas for improvement • Establish staff training needs • Improve identification of patients accessing services with Learning Disabilities (LD) • Improve patient communication	**Self-assessment completed and this work continues to be a quality improvement for 22/23**
Implementation of LPS	• Establish implementation group with upward reporting to Safeguarding Committee (SGC)	**This will be carried**

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	• Increase organisational awareness of LPS in Q1/Q2 • Attend system wide multi-professional meetings to ensure collaborative approach • Review key documents when available (Impact assessment, Code of Practice, Training and Workforce strategy)	**forward for 22/23**

16.1 Joint Adult and Children's Safeguarding Priorities for 2021/22

Two out of the six objectives were fully achieved for 2021/22. Three objectives were partially achieved. Implementation of LPS was delayed so this priority has been included in the 22/23 priorities.

- The Adult level 3 Safeguarding training has continued to be a challenge due to the number of staff requiring training, and the lack of availability of administration structures to monitor and record the 8hrs of training required for each staff member. This year's priority includes developing an administration role in the team to coordinate and report training as there is a general feeling that many staff only need another 1-2hrs to achieve compliance and this will significantly raise training figures. Whole day training has now been included in the training options and this allows staff to achieve compliance in one day

- Improve Pre-operative pathway communication to identify Safeguarding and related concerns has made some progress with safety questions being asked to patients and pre-op alerts include any safeguarding information. There is further education and training required for all members of MDT in pre-op to embed the changes in process.

- Monitoring our WNB / DNA policy this priority has not progressed as well as we would have liked and we have seen some deterioration in some quarters. However, WNB rates have on the whole remained under the 10% target rate set by the CCG. This priority will continue next year and will focus on ensuring administration processes are improved for sending out appointments and text reminders as well as ensuring the safeguarding systems are robust and followed through. The aim is to repeat the WNB audit this year.

16.2 Key priorities for 2022/23

Joint Adult & Children's Safeguarding Priorities for 2022/23		
Priority	**Objectives**	
Continue to Improve compliance with Level 3 Adult safeguarding training	• Update the safeguarding training directory to make it user friendly for staff to meet level 3 safeguarding training compliance. • Continue to monitor training levels monthly and develop an updated trajectory for achieving compliance target • Develop an administration role to assist in the coordination and recording of training	
Continue to Improve Pre-operative pathway communication to identify Safeguarding and related concerns	• Increased training and education for pre-op MDT • Audit of pre-operative alert system and communication to wider organisation • Engage with implementation of new EPR system	
Monitoring our WNB and DNA policy	• Review administration process for sending out appointments	

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	• Conduct a repeat audit of processes followed when children are not brought to clinic • Continue to monitor figures in the paediatric forum and report to CCG in the safeguarding Dashboard	
Implementation of LPS	• Establish implementation group with upward reporting to Safeguarding Committee (SGC) • Increase organisational awareness of LPS in Q1/Q2 • Attend system wide multi-professional meetings to ensure collaborative approach • Review key documents (Impact assessment, Code of Practice, Training and Workforce strategy) and submit response to consultation	
Prioritise Domestic abuse training for this year's level 3 compliance for both adults and children	• Embed updates from the domestic abuse bill 2021 • Training should be accessed via Leap for Learning & Shropshire Joint training	
Nominate lead professional for Mental Health:	• Nominate a Lead practitioner for Mental Health • Consider mental health champions	

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Conclusion

This annual report evidence progress with regard to safeguarding priorities in 2021/22, although we recognise that there is always more work to be done. Whist level 3 safeguarding adult training figures remain below target we have made significant improvements since last year. Increased availability of training and strengthened administration will enable more real time reporting of these training figures in 22/23.

The report demonstrates an increase in both adult and children safeguarding referrals in 22/23 and an increase in contact with the organisation from distressed patients thought to be linked with increased waiting times for surgery. Domestic abuse cases have seen an increase and therefore we have included this as one of our key priorities for 22/23.

Leadership and governance arrangements continue to be strengthened with actions regularly monitored giving accountability within the Assurance Framework. We will continue to forge links with other local partnership agencies and contribute to cross board initiatives.

Our aspiration is to raise the profile of safeguarding within the organisation and work collectively towards becoming outstanding for 'Safe' within the CQC framework. This will ensure our staff are confident to access the right service at the right time, to ensure we play our part in keeping children and adults with care and support needs safe from harm.

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Appendix One: Annual Training Report for Child Safeguarding & Adults at 31st of March 2022

Children safeguarding data

	Completed "in date" Child Protection Training Level 1			Completed "in date" Child Protection Training Level 2			Completed "in date" Child Protection Training Level 3			Completed "in date" Child Protection Training Level 4		
	3 yearly training			3 yearly training			3 yearly training			3 yearly training		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Assurance & Standards Team	252	240	95.2%	21	20	95.2%	2	1	50.0%	0	0	
Clinical Services Unit	321	312	97.2%	259	251	96.9%	9	7	77.8%	0	0	
MSK Delivery Unit	480	466	97.1%	411	396	96.4%	22	10	45.5%	0	0	
Office of the CEO	11	11	100.0%	0	0		0	0		0	0	
Specialist Delivery Unit	324	313	96.6%	275	262	95.3%	51	43	84.3%	2	2	100.0%
Support Services Unit	157	150	95.5%	1	1	100.0%	0	0		0	0	
Covid-19 Vaccination Centre	1	0	0.0%	1	0	0.0%	0	0		0	0	
Bank Staff	150	141	94.0%	103	96	93.2%	0	0		0	0	
Total without bank staff	**1546**	**1492**	**96.5%**	**968**	**930**	**96.1%**	**84**	**61**	**72.6%**	**2**	**2**	**100.0%**
TRUST WIDE TOTAL	**1696**	**1633**	**96.3%**	**1071**	**1026**	**95.8%**	**84**	**61**	**72.6%**	**2**	**2**	**100.0%**

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	Completed "in date" EPALS			Completed "in date" Prevent Training		
	4 yearly training			3 yearly training		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Assurance & Standards Team	1	1	100.0%	254	242	95.3%
Clinical Services Unit	0	0		330	311	94.2%
MSK Delivery Unit	37	34	91.9%	487	463	95.1%
Office of the CEO	0	0		11	10	90.9%
Specialist Delivery Unit	20	18	90.0%	338	309	91.4%
Support Services Unit	0	0		164	152	92.7%
Covid-19 Vaccination Centre	0	0		1	0	0.0%
Bank Staff	0	0		164	138	84.1%
Total without bank staff	**58**	**53**	**91.4%**	**1585**	**1487**	**93.8%**
TRUST WIDE TOTAL	**58**	**53**	**91.4%**	**1749**	**1625**	**92.9%**

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Adult safeguarding data

										Further information available on the next tab and small summary table below				
	Completed "in date" Adults Safeguarding Awareness Training Level 1			Completed "in date" Adults Safeguarding Training Level 2			Completed "in date" Adults Safeguarding Training Level 3			Completed Safeguarding Adults Level 3 Face to Face Training			Completed Safeguarding Adults Level 3 E-Learning	
	3 yearly training			3 yearly training			3 yearly training							
Unit	Number to complete	No's completed	% complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number Attended Level 3 F2F Course Delivered by Training Solution Limited (3 hours)	Number Attended Level 3 F2F Course Delivered by SPIC (4 hours)	Number Attended Workshop (Zoom) Level 3 Adults (Delivered by SPIC)	Number Completed Future Learn E-learning	Number Completed Skills for Health E-Learning
Assurance and Standards Team	252	245	97.2%	21	20	95.2%	1	1	100.0%	0	0	0	0	0
Clinical Services Unit	321	313	97.5%	259	252	97.3%	97	42	43.3%	39	10	26	50	11
MSK Delivery Unit	480	468	97.5%	411	399	97.1%	218	55	25.2%	78	15	32	112	8
Office of the CEO	11	11	100.0%	0	0		0	0		0	0	0	0	0
Specialist Delivery Unit	324	317	97.8%	275	261	94.9%	161	59	36.6%	65	18	29	77	11
Support Services Unit	157	153	97.5%	1	1	100.0%	0	0		0	0	0	0	0
Covid-19 Vaccination Centre	1	0	0.0%	1	0	0.0%	0	0		0	0	0	0	0
Bank Staff	150	135	90.0%	103	95	92.2%	22	1	4.5%	6	0	0	8	0
Total without Bank Staff	**1546**	**1507**	**97.5%**	**968**	**933**	**96.4%**	**477**	**157**	**32.9%**	**182**	**43**	**87**	**239**	**30**
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**1696**	**1642**	**96.8%**	**1071**	**1028**	**96.0%**	**499**	**158**	**31.7%**	**188**	**43**	**87**	**247**	**30**

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DOLS, MCA and Prevent Training Compliance - 31 March 2022

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	Completed "in date" DOLS Training			Completed "in date" Mental Capacity Act Training			Completed "in date" Prevent Training		
	3 yearly training			3 yearly training			3 yearly training		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Assurance & Standards Team	12	5	41.7%	13	6	46.2%	254	242	95.3%
Clinical Services Unit	74	71	95.9%	208	185	88.9%	330	311	94.2%
MSK Delivery Unit	204	185	90.7%	218	191	87.6%	487	463	95.1%
Office of the CEO	0	0		0	0		11	10	90.9%
Specialist Delivery Unit	166	141	84.9%	182	157	86.3%	338	309	91.4%
Support Services Unit	1	0	0.0%	1	0	0.0%	164	152	92.7%
Covid-19 Vaccination Centre	0	0		0	0		1	0	0.0%
Bank Staff	0	0		0	0		164	138	84.1%
Total without bank staff	**457**	**402**	**88.0%**	**622**	**539**	**86.7%**	**1585**	**1487**	**93.8%**
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**457**	**402**	**88.0%**	**622**	**539**	**86.7%**	**1749**	**1625**	**92.9%**

The Robert Jones and Agnes Hunt Orthopaedic Hospital
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Dementia Training Compliance - 31 March 2022

	Completed "in date" Dementia Workshop		
	3 Yearly		
Unit	Number to complete	No's completed	% Complete
Assurance & Standards Team	20	19	95.0%
Clinical Services Unit	250	232	92.8%
MSK Delivery Unit	372	325	87.4%
Office of the CEO	0	0	
Specialist Delivery Unit	226	193	85.4%
Support Services Unit	0	0	
Covid-19 Vaccination Centre	0	0	
Bank Staff	98	73	74.5%
Total without bank staff	**868**	**769**	**88.6%**
TRUST WIDE TOTAL	**966**	**842**	**87.2%**

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
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Appendix 2

Abbreviations list

CCG	Clinical Commissioning Group
CPD	Continuous Professional Development
CQC	Care Quality Commission
DNA	Did Not Attend
DOLS	Deprivation of liberty safeguards
FGM	Female Genital Mutilation
ICD	Intercollegiate Document
IMCA	Independent Mental Capacity Advocate
LADO	Local Area Designated Officer
LD	Learning Disabilities
LPA	Lasting Power of Attorney
LPS	Liberty Protection of Safeguards
MCA	Mental Capacity Act
MCAA	Mental Capacity Amendment Act
MHFA	Mental Health First Aider
MSP	Making Safeguarding Personal
NHSE	NHS England
NSSO	Nominated Safeguarding Senior Officer
RAID	Rapid Assessment, Intervention & Discharge
SAR's	Safeguarding Adult Review
SATH	Shrewsbury and Telford Hospital
SGC	Safeguarding Committee
SOCJAC	Serious and Organised Crime Joint Action Group
SOP	Standard Operating Procedure
SSCP	Shropshire Safeguarding Community Partnership
SNAHP	Senior Nurses and Allied Health Professionals meeting
STING	Shropshire and Telford Implementation Network Group
TNA	Training Need Analysis
WNB	Was Not Brought

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Reference Information

Author:	Alison Harper MSK, Governance Lead, Matthew Hughes, Gov bank admin assistant	Paper date:	6 July 2022
Executive Sponsor:	Sara Ellis, Interim Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality / Performance
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The purpose of this report is to provide insight into what patients think about their experience of care received at the RJAH between April 2021- March 2022.

The Trusts collects patient experience data as an active part of monitoring the quality of care which provides an important "health check" of the services we provide as well as promoting a strong culture of listening to patients and improving services.

2. Executive Summary

This report outlines the Trust's performance and includes trends and themes arising from formal complaints, PALS concerns and other sources of patient feedback between April 2021 – March 2022

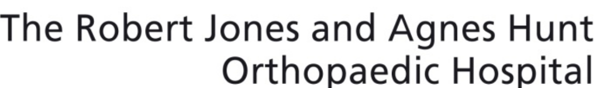
The table below shows overall patient feedback received for 2021/2022 compared 2020/2021:

Feedback	2020/21	2021/22	Diff from 2020/21 to 2021/22	% Change
Complaints	71	115	44	61.9%
Local resolution	30	19	-11	-36.6%
PALS concerns	201	206	5	2.5%
PALS enquiries	2509	3667	1158	46.1%
Compliments	4937	6281	1344	27.2%

Complaints have increased from last year with the top theme being patient delays with treatment dates which can be attributed to the impact of the ongoing COVID situation with the Trust facing many operational pressures

Conclusion:
The overall evidence collected in this report provides assurance that the hospital is delivering services that are truly patient centred. Our patients rate their experience as being exceptionally good and this is evidenced in the NHS Inpatient 2020 survey results where the RJAH was rated No 1 in the country for the second year running for overall patient experience and named as a top performing Trust across 137 Trusts in England.

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



#Caring for Patients
Patient Experience Annual Report
April 2021 - March 2022

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Highlights from 2021/2022

- The Patient Experience Strategy was refreshed for 2021-2024 setting out plans for the next three years
- RJAH was named as a top performing Trust in the NHS Inpatient 2020 survey results with and was rated No 1 in the country for the second year running for overall patient experience.
- 6281 compliments or acknowledgement of thanks were received.
- FFT results continue to be very high with 97.9% of 17,501 patients asked, said their experience was good or very good.
- 115 Complaints were received, an average of 9.6 per month above the monthly target of 8 . This has increased by 44 when compared to last year.
- There were 3 complex complaints
- 76% of standard complaints were responded to within 25 working days,
- 97% of all complaints had an action plan including nil action plans improved from last year
- 11 complaints were re-opened, after receiving their original response no themes identified
- 206 PALS concerns received, increased by 5 from last year. 40 PALS concerns became a complaint, 11 of which were initiated by the Trust.
- 3667 PALS enquiries and web enquiries, received, increased by 46%.
- There were 2 cases referred to the Parliamentary & Health Service Ombudsman (PHSO) for independent review, 1 for Rheumatology and 1 for Paediatric Surgery
- Questions asked on the IQVIA feedback system continue to be high

Themes

- Complaints are on the increase and the top theme is patient delays with treatment dates which can be attributed to the impact of the ongoing COVID situation with the Trust facing many operational pressures. An increase in Rheumatology service complaints is also noted from last year.
- There is an increasing trend for complaints about medical staff attitude and for PALS concerns on volunteer attitude.
- Complaint action plan completion has improved to help evidence learning from complaints.
- Comments from negative FFT on wait in clinic is on the decrease following outpatient improvement work in 2020/21 on improving communication and waiting times

Actions being taken

- Deep dive into the Rheumatology service complaints is to be undertaken by Governance Lead and Unit A.C.N for Specialist
- Review of classification of complex patients complaints to help manage patient expectations and complaint timescales
- More resolution at concerns at PALS level to reduce complaints with explanation of reason for delays
- Progress with work plan in Patient Experience Strategy
- Work with ICS patient experience partners to look at how to share resources and work collaboratively

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Heat Map Summary April 21 – March 2022

	target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total 2021
Total Complaints received in month	8	10	4	17	5	8	11	9	13	6	8	13	11	115
Standard complaints									12	6	7	12	11	48
complex complaints									1	0	1	1	0	3
% Standard Complaints Response Rate Within 25 Days due in month (from KPI)	100%	88.89%	66.67%	50%	71%	100%	100%	73%	91%	67%	71%	86%	50%	76%
% Complex Complaints Response Rate Within 40 Days due in month (from KPI)	100%								n/a	n/a	100%	n/a	n/a	100%
Standard complaints responded to in 25 working days target (due to close in month)	no target	8	6	2	10	7	9	8	10	6	5	6	5	82
Standard complaints due to be responded to in 25 working days target		9	9	6	14	7	9	11	11	9	7	7	10	109
Complex complaints responded to in 40 working days target									0	0	1	0	0	1
Complex complaints due to be responded to in 40 working days target									0	0	1	0	0	1
avg working days to close a complaint		27	27	22	22	22	23	27	25	15	25	23	18	23
PALS converted to complaint - Initiated by Patient		2	2	2	1	8	2	1	4	1	1	3	2	29
PALS converted to complaint - Initiated by Trust		1	2	2	1	0	1	1	1	0	2	0	0	11
% Complaints progressed from PALS	no target	30%	100%	24%	40%	100%	27%	22%	38%	17%	38%	23%	18%	40%
Complaint FULLY upheld	no target	1	0	4	0	2	1	5	3	2	3	3	4	28
Complaint NOT upheld	no target	5	3	10	5	3	1	2	4	2	1	3	1	40
Complaint PARTIALLY upheld	no target	4	1	3	0	3	9	2	6	1	4	1	6	40
re-opened complaint	0	0	0	2	0	2	0	1	2	1	1	1	1	11
Complaints with action plan	100%	100%	100%	29%	40%	50%	60%	100%	100%	100%	100%	100%	100%	82%
Complaints referred to the Ombudsman	0	0	0	0	0	1	0	0	0	1	0	0	0	2
Local resolutions	no target	3	3	3	2	1	1	2	0	0	2	0	1	18
PALS concerns	no target	7	13	12	20	21	15	23	26	13	20	18	18	206
PALS enquiries	no target	286	283	334	289	290	300	323	337	289	290	299	347	3667
FFT	95%	97.5%	97.4%	96.6%	96.4%	96.8%	96.7%	97.9%	97.7%	98.5%	98.1%	97.7%	97.9%	97%
negative FFT scores (not Good or very good)	no target	29	33	41	41	32	45	33	36	22	32	43	39	426
Compliments	no target	429	297	326	331	378	360	383	422	764	883	861	847	6281

Key	
green is used where targets have been met	(green)
red where targets have not been met	(red)

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Introduction

Delivering quality services has three essential elements including clinical effectiveness and outcomes, delivering safe care, and ensuring services are patient centred in terms of patients having a good patient experience

The Trusts collects patient experience data as an active part of monitoring the quality of care to ensure that patients receive the best experience of care possible at each phase of their pathways and interaction with our staff.

The Trust aspires to provide patients with world class care which includes providing patient with the best experience of care possible at each phase of their pathways and interaction with our staff.

Patient Experience Strategy 2021-2024

During 2021/2022 the Trust refreshed the Patient Experience Strategy 2021-2024 which builds upon the strategy from 2017-2020, setting out the Trust ambitions for the next three years and to continue to put patient experience at the heart of everything we do.
The Strategy focused on a number of areas to achieve excellence in patient experience.
These include:

- leadership
- organisational culture
- collecting feedback: capacity and capability to effectively collect feedback
- analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other quality measures
- reporting and publication: patient feedback to drive quality improvement and learning: the ability to use feedback effectively and systematically for quality improvement and organisational learning

National Adult Inpatient Survey 2020 results

In October 2021, the results of the Adult Inpatient Survey 2020 by the Care Quality Commission were released. Overall, the Trust was named as one of the organisations placed in the top band of Trusts across England delivering results that are considered “much better than expected”.

The Adult Inpatient Survey includes 137 NHS acute trusts in the country and reveals what just over 73,000 adults who had stayed in hospital for at least one night during November 2020 said about the care they received.

A total of 1,250 RJAH patients were asked to complete the survey and 910 returned it. This equates to a response rate of almost 74% - well above the national average.

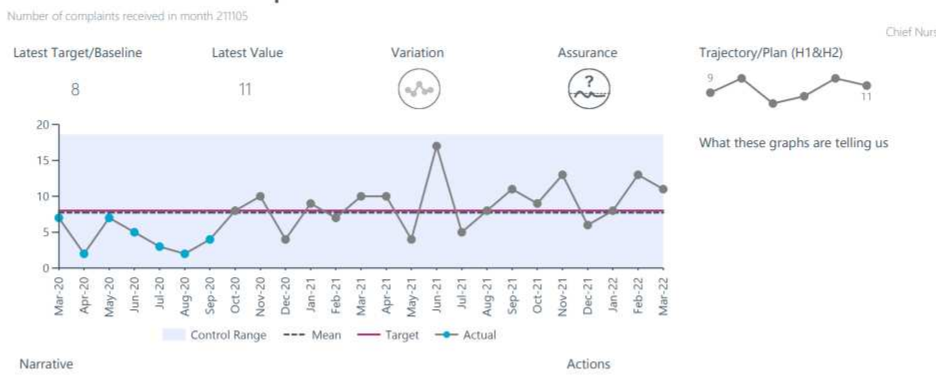
Some of the stand-out findings to celebrate were:

- Overall patient experience: RJAH rated No 1 in the country for the second year running
- Hospital food: Our food has been rated No 1 in the country for the 15th time in the last 16 years
- Cleanliness of wards and rooms: Our cleanliness came out on top in the survey for the second year
- Confidence in nurses: RJAH was also rated top in this category
- Confidence in doctors: Patients rated our doctors No 1 in the survey
- Patient respect and dignity: RJAH scored top for this question

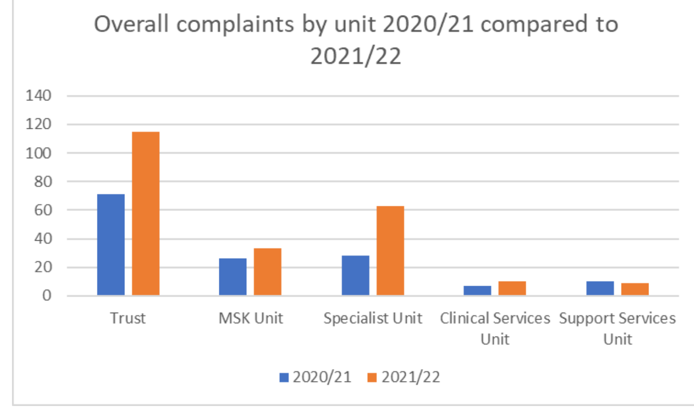
Only one question has been identified as requiring improvement “did you not mind waiting as long as did for admission” which had decreased from 86% in 2019 to 59% in 2020 for patients giving a positive core

Formal Complaints

- There were 115 formal complaints received in 2021/22, an increase from last year by 44, 62%. June 21 received 17 complaints (7 were on waiting times and 8 on clinical care and treatment across a number of specialities).
- Complaints have been categorised into complex and standard complaints since November 2021. There have been 3 complex complaints in 2021/22
  -1 CRP 1121-05 complex complaint for Clwyd ward in November 21 as this involved getting comments from the nurse agency on staff attitude.
  -1 CRP 0122-01 complex complaint for Spinal Disorders in January 22 as issues covered multiple specialities.
  -1 CRP 0322-02 Arthroplasty as this involved complex medical history and outcome of knee revision surgery.
- The Specialist Unit received the highest number of complaints (Specialist 63, MSK 33, CSU 10, SSU 9).
- The top reasons for a patient making a complaint were waiting for treatment dates 31, staff values and behaviour (28) and integrated care (18). See table of subjects below:
- 68 (59%) complaints relating to clinical care and 47 were operational issues
- 40% (40) complaints originated from PALS, 11 were converted by the Trust to complaint.
- The average number of complaints per month was 9.5



Complaints by Unit



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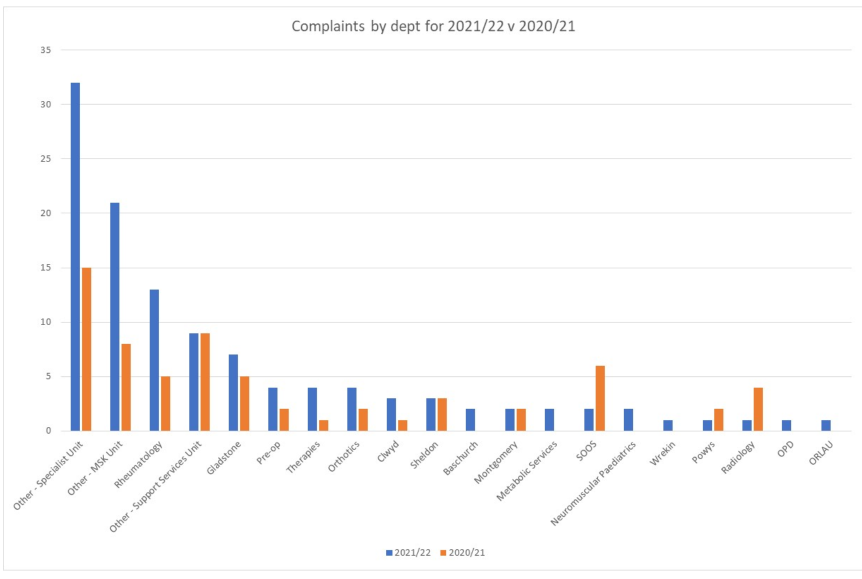
Complaints by department

The top themes of complaints are other Specialist and other MSK then the Rheumatology Service.



Top themes of Complaints:

- See below a comparison between 2020-21 and 2021-22's top theme of complaints by subject. The increase in complaints can be explained by the ongoing pressures impacted by the COVID pandemic especially for the wait for treatment dates after elective service were paused during 2020/21. Staff values and behaviour has also increased significantly from last year

	2020-21	2021-22
Appointments including delays and cancellations	19	31
Values & Behaviours (Staff)	6	28
Integrated Care	19	18
Communications	6	8
Admissions, discharge and transfers	8	7
Patient Care including Nutrition / Hydration	5	6

Complaints by staff attitude

Complaint on staff attitude have seen an increase and table below shows breakdown by staff category and speciaty. Complaints are reported in the Medical staff appraisals so Medical staff are sighted on the complaint.

18 are from medical staff, (7 are from Rheumatology), Nurisng staff (5) across a number of areas.

Row Labels	AHP staff	Consultant	Nursing Staff - va	Reception	Grand Tota
Rheumatology		7			7
Arthroplasty		3	1		4
Spinal Disorders		3			3
Neurology		3			3
Estates				2	2
Gladstone			2		2
Facilities				1	1
Foot & Ankle		1			1
Pre-Op - Hand & Upper Limb				1	1
Sports Injuries		1			1
Therapies - Physiotherap	1				1
Metabolic			1		1
Sheldon			1		1
Grand Total	1	18	5	3	28

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

Complaint Performance

The Trust is required to acknowledge all responses within three working days; this target was met. There is an internal target to resolve standard complaints within 25 working days and complex complaints within 40 working days. (40 working days was agreed for December 21 reporting)

The graph below shows the standard complaint response rate per month:

- During 2021-22, 76% (82 out of 109) standard complaints were closed within 25 working days. The months only to meet the closure target were August 2021 and September 21.
- Reasons for delays include awaiting comments from contributors, Governance staffing issues and sign off at exec level.
- For complex complaints there was 100% response rate.

Actions being taken to improve the Complaints response timescales:-

- Governance Team support with drafting of complaints.
- Complaint tracker set up on a dashboard
- Complaints have been classified as standard and complex with timescales amended to 40 days for complex complaints from Nov 21.

Complaints re-opened

- 11 complaints were re-opened where a patient was dissatisfied with their response, no trends identified. Patient to be offered opportunity of face-to-face meeting as part of resolution.

Complaints Upheld

28 complaints were fully upheld complaints, 40 partially upheld and 40 not upheld.

Definition of upheld complaints If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld. Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld. If a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld, the complaint should be recorded as partially upheld.

PALS concerns received

PALS concerns/enquiries

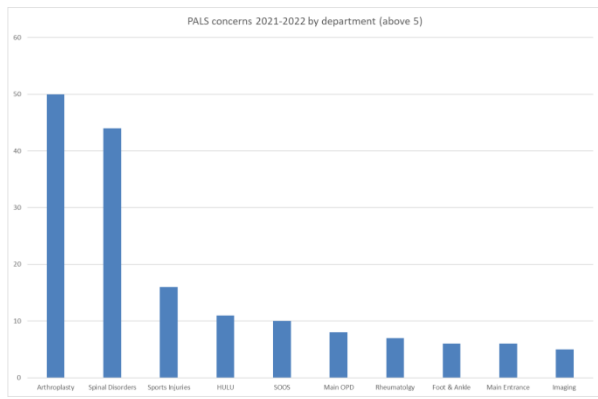
- In 2021-22, there were 206 PALS concerns received, 5 more than in the previous year.
- The top 4 reasons for a patient contacting PALS were:
    - Delay to admission and appointments treatment dates (93) (Arthroplasty 24, Spinal Disorders 28, Knee and Sports 13).
    - Integrated care/management of future care (32) (Arthroplasty 11 and Spinal Disorders 5).
    - Communication issues (29) such as communication between staff, letter content not accurate, delay in test results

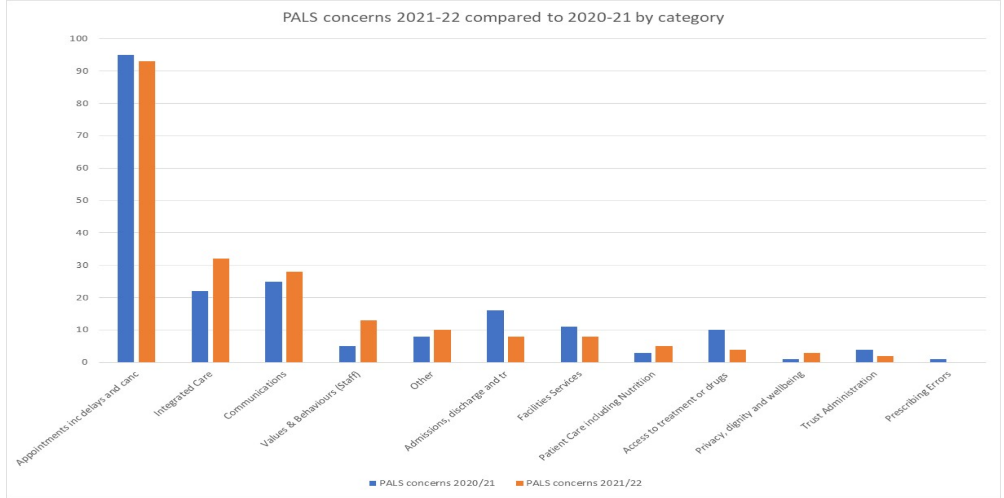
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

- Staff values and behaviours (13), 5 are medical staff across several specialites, 2 nursing 5 reception/admin (4 main entrance volunteers)

➢ 3667 PALS enquiries were received in 2021-22, a 46.1% increase on the previous year. These include the RJAH emails and emails on the website and the main theme is patients asking when their treatment date will be including GP expedite letters.

The graphs below show PALS concerns received by department for 2021/20 (for above 5)





Locally resolved issues

There were 18 local resolutions reported from the ward/department. 5 were from Gladstone and 6 from Therapies. These are concerns resolved on the spot by ward or department staff.

Cases referred to the Parliamentary & Health Service Ombudsman (PHSO)

2 cases were referred to the PHSO

- 1 case was referred in August 2021 for a complaint in September 2020 (CRP 0920-02) regarding delay to treatment of a metabolic patient due to receive denosumab injection within 6 months of previous injection. PHSO investigation ongoing and initial findings confirm that they plan to uphold this complaint.
- 1 case referred in January 2022 regarding a complaint from October 2019, about a patient's treatment for back problems between 27 February 2019 until 12 August 2019. Investigation is ongoing

Learning from Complaints

The Trust recognises the opportunity that patient feedback provides as an important “health check” and valuable insight how we can improve and design services better. It is for this reason the Trust is committed to increasing the percentage of complaints with resultant action plans.

Complaints Action Plan:

CRP ref No.	Date complaint received:	Date complaint reply due:	Date action plan completed: Dept/ward:

Learning Identified/actions following the complaint:
Questions you may wish to consider when identifying learning:

- What are the issues that need addressing/improving and what could you possibly do to address these issues?
- What are the possible implications of not addressing these issues?
- Who else might you need to involve/consult? (e.g. other managers, departments)
- How and where could you share your learning from the complaint?
- Actions need should be SMART (Specific, Measurable, Achievable, Realistic, Timely)

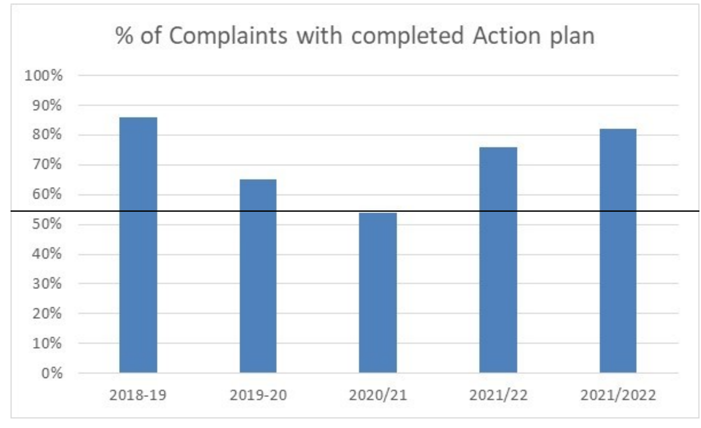
– If you feel there are no lessons to be learnt from this complaint and no changes in practice required, please input N/A and give a clear reason for this)

Issues raised/Identified/	Key actions required to achieve the improvement/learning?	Person Responsible (name and job title)	Date (specific by which action to be achieved)	Progress: (How will you evidence this action is completed?)
1.				
2.				
3.				
4.				

Will you be sharing this complaint at any meetings? Yes/No
If yes, please provide details below and send the outcome of that discussion to the Governance Lead/Governance Assistant who requested comments for the complaint or rjah.complaints@nhs.net
Meeting name:
Date:

Action Plan completed by:

- 97% of complaints had an action plan and this has improved since last year. I the last 6 months 100% of complaints had an action plan.
- Actions plans are produced when service improvements are identified as part of the complaint investigation for *those complaints that are fully upheld or partially upheld.*
- A new format action plan was introduced with relevant prompt to encourage staff completion.



Please see below some examples of actions following a complaint:

CRP 0122-02 Rheumatology
Patient requests a new clinic letter which confirms whether they have Ehlers-Danlos as they say that the letter, they received is ambiguous.
Outcome: clinic note amended with apology to the patient

CRP 0122-03, Montgomery Unit
Patient unhappy with wait to see the consultant and then wait for the Xray team as was told could be seen earlier and this did not happen.
Outcome: Complaint to be shared with staff with a view to ensuring that staff keep patients informed of current clinic waiting times especially those patients requesting to be seen outside of their allocated appointment times.

CRP 0222-04, Powys ward
Patient lost their dentures on the ward and reported she had left them on bedside table overnight and is claiming the cost of replacement.
Outcome
Complaint to be shared with ward staff and denture pots to be provided on the ward.
Patient reimbursed 50% of replacement cost.

CRP 0122-04 Paediatric Neurology
The parent of a child feels the consultant did not listen to the patient or investigate their symptoms sufficiently.
Outcome: Consultant has confirmed that she has reflected on patients comments and has learnt from them. Consultant has said that she will consider how she addresses her patients and their family members in future, and how this can be improved further to prevent future complaints.

Friends and Family Test (FFT)

The FFT question "Overall, how was your experience of our service" is designed to be a quick and simple mechanism for patients and other people who use NHS services to give their feedback.

FFT data is collected in real time using the IQVIA patient feedback system and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment). The Trust has re-introduced paper comments cards and iPads to collect this data for those patients wanting to give their feedback whilst still on the ward or in clinic.

- For 2021/22, 17,501 patients completed a FFT survey and 97.5% of patients (inpatients and outpatients) said they would rate their experience as good or very good.
- The response rate has increased when compared to 2020/21 due to FFT data collection being paused from April 2020-Dec 2020 and extra clinics and areas added to the SMS texting process including Radiology.
- A message has been added to the SMS text a patient receives so advise that if they need help to access the link to contact PALS so that their feedback can be captured.

The chart below shows the average FFT score per month

The results for the Trust over the last five years are below based on the average percentage of FFT score (inpatients and outpatients).

	2017/18	2018/19	2019/20	2020/21	2021/22
National Average	96%	96%	96%	94%*	94%
Highest Score	100%	100%	100%	100%*	100%
Lowest Score	64%	76%	73%	65%*	73%
The Robert Jones and Agnes Hunt	99%	99%	99%	98%	98%

*For 2020/2021 national data collection for FFT was paused from April 20 - November 20, so data only available for December 2020- March 2021

The Trust is committed to improving the percentage of patients who would rate their experience as good or very good.

The top themes of the negative comments from FFT scores are shown below for 2021/2022

- Wait in clinic comments are seen to be on the decrease in the last 6 months. This can be explained by the work undertaken as part of the quality priority for 2021/22 looking at improved communication to patients accessing outpatient services including waiting times.
- The comments received on cancelled surgery are due to the recent staffing issues in theatres due to COVID-19
- FFT results are shared in Unit, department and Speciality level Governance Quality reports with trends of low scores monitored monthly

theme of FFT scores	Quarter 1 2021	Quarter 2 2021	Quarter 3 2021	Quarter 4 2021	Grand Total
wait in clinic	34	36	23	17	110
outcome of appointment	21	24	20	15	80
No comment	7	14	12	17	50
staff attitude	12	7	10	18	47
cancellation of surgery	2	5	12	15	34
Poor communication	5	9		12	26
IPC issues	8	6	4	5	23
Compliment	5	3	5	6	19
Other	0	6	0	7	13
booking issue	5	4	4		13
Environment & Facilities	1	4	1	1	7
nursing staff	3			1	4
Grand Total	**103**	**118**	**91**	**114**	**426**

Collecting Patient feedback:

As well as being asked the FFT question, patients are asked several other questions about their visit for inpatients and outpatients.

The results for 2021/22 for the inpatient and outpatient surveys are shown below with all questions receiving high scores:

Inpatients & Day Case Survey (after 1 April 2020) - Trend Heatmap

We would like to know what you thought of the experience you had on the ward where you spent the most of your time during this stay at the RJAH

Question text	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
1. Overall, how was your experience of our service? Please can you tell us why you gave your answer:	98	97	98	97	97	98	97	97	98	98	97	96	97
Total	98	97	98	97	97	98	97	97	98	98	97	96	97

About your care

Question text	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
7. Were staff caring and compassionate?	98	99	98	98	97	99	98	98	98	99	99	98	98
8. Did you like the food provided, if you were offered any? (If not please leave blank)	89	90	90	90	89	89	90	89	90	91	90	89	90
9. Did you feel the ward was clean?	99	100	99	99	99	99	99	99	99	99	99	99	99
10. Did you find the staff welcoming and friendly?	98	99	99	99	97	99	98	98	99	99	98	98	98
11. Did you feel that the noise levels were acceptable at night?	88	89	87	86	88	90	87	88	86	82	88	84	87
12. Did the staff practice good hand hygiene?	98	99	99	98	99	99	98	99	99	98	98	98	99
13. Was your privacy/ dignity & comfort respected?	99	98	98	99	98	99	99	99	99	99	99	99	99
14. Was your admission date changed by the hospital?	85	89	91	87	91	88	89	89	89	87	86	85	88
15. After leaving hospital, did you get enough support from staff ?	92	89	94	89	89	92	87	89	88	93	91	89	90
16. Were you involved as much as you wanted to be in decisions about your care and treatment?	96	95	95	95	93	94	91	95	95	96	93	93	94
Total	94	95	95	94	94	95	94	95	95	94	94	94	95
Overall	95	95	96	95	95	95	94	95	95	95	95	94	95
Total number of surveys	192	238	224	228	217	280	319	317	213	161	190	230	2,809

Outpatients Survey (after 1 April 2020) - Trend Heatmap

We would like you to think about your recent experiences of our service

Question text	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
1. Overall, how was your experience of our service? Please can you tell us why you gave your answer:	96	96	95	95	95	95	96	96	97	97	97	97	96
Total	96	96	95	95	95	95	96	96	97	97	97	97	96

About your care

Question text	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
3. Did you feel that the department was clean?	99	99	99	99	99	99	99	98	99	99	99	99	99
4. Were you informed about waiting times?	82	83	83	85	84	84	85	82	84	87	85	85	84
5. Did you find the staff welcoming and friendly?	98	98	98	98	98	98	98	98	98	98	98	98	98
6. Was your privacy/ dignity & comfort respected?	99	99	99	99	99	98	99	99	99	99	99	99	99
7. Did the Health Care Professional explain the procedure satisfactorily? (if you had one - if not please leave blank)	98	98	98	98	97	98	98	98	98	99	98	98	98
8. Were staff caring and compassionate?	98	98	98	98	98	97	98	98	98	98	98	98	98
9. Did the Healthcare Professional introduce themselves?	97	97	97	98	98	97	98	98	97	97	97	98	97
10. Did the Health Care Professional listen to you?	99	99	99	99	98	98	99	99	99	98	99	99	99
Total	96	96	96	97	96	96	97	96	97	97	97	97	97
Overall	96	96	96	97	96	96	97	96	97	97	97	97	96
Total number of surveys	973	946	975	889	813	1,072	1,135	1,262	1,044	1,326	1,369	1,444	13,248

Patient Panel forum (PP)

Prior to the start of the current pandemic, the Trust had an active Patient Panel (PP) forum that met every 2 months. The purpose of the PP is to work in partnership with staff, patients and local stakeholders to develop concepts and models of co-production to ensure services are patient cantered as well as to support the implementation and monitoring of the Patient Experience strategy.

Meetings have been put on hold as a majority of members did not have the technology to use MS Teams and to meet virtually.
Despite this many members continue to be involved in activities where possible in the following activities:

- Reviewing Patient Information leaflets and other policies such as the Privacy and Dignity Policy, Refreshed Patient Experience Strategy
- Attending meetings on Teams like the Patient Initiated Follow Up group, Accessible Care group, Patient Experience committee, Learning and Disability group.
- CEO, Clinical Chair, NED stakeholder interview panels, observations of care, NOA Orthopaedic Patient Group, Joint school, Staff celebration awards, Clinical audit, patient stories
- Reviewing Estate plans for the new adult changing places facility in the main entrance.

Following adverts to recruit new members, 12 patients have expressed an interest to get involved.

Patient Stories, and Compliments

The Trust uses patient stories as a source of patient insight and the Trust Board often starts with a patient story. Covid-19 has brought challenges with presenting patient stories, so the Trust has introduced videoing patient stories using MS Teams.

6281 patient compliments were received

The Trust also collects patient comments and narratives from many mediums including the NHS choices website, the IQVIA feedback system, compliments letters and social media received via twitter and face book. These are shared with the clinical teams.

There have been two patient stories shared at the Trust Board in 2021/2022,

- One in May 2021 about a patient having a femoral replacement operation under the care of the Tumour Team in September 2020 and was very complimentarily about the treatment she had received praising the staff that cared for her and saying there was nothing the Trust could improve on
- The other was from longstanding patient of the Midlands Centre of Spinal injuries Unit, In September 2021 and he spoke about the improvements he had seen on the Unit since being admitted in 2002. This patient also spoke on being a patient panel member and his involvement in the Accessible Care group and reviewing plans for the new changing places facility in the main entrance.

The Trust work in partnership with Shropshire Healthwatch. The were 4 comments received from Healthwatch Shropshire from 1 July 2021 to 31 December 2021.These comments have been shared with the relevant clinical teams but there is no patient id to investigate.

Working in partnership with Shropshire Integrated Care System (ICS)

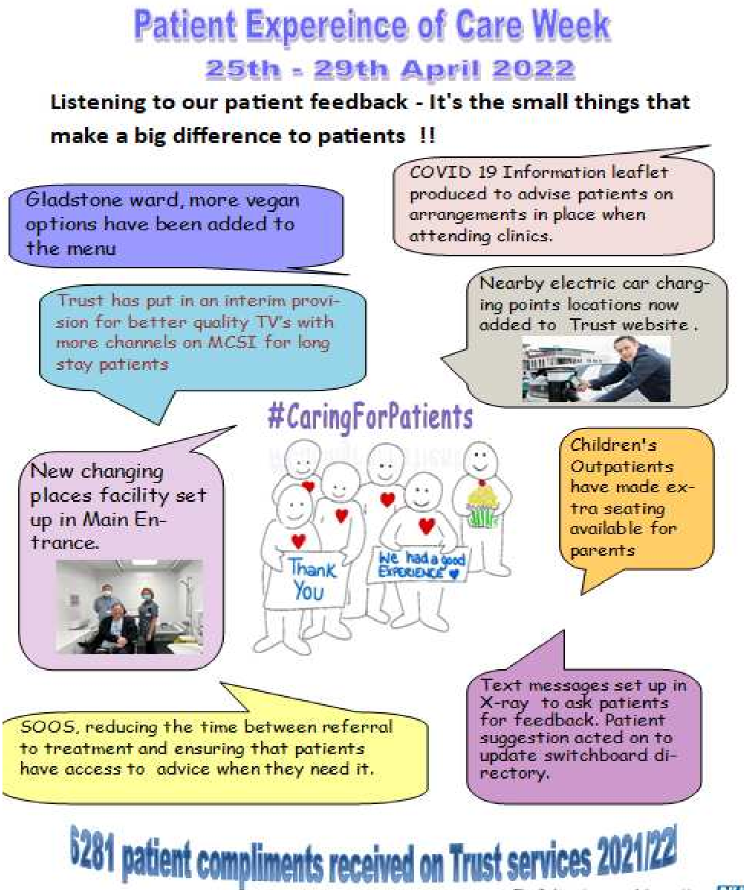
The Trust is working with local partners to have an ICS-wide joined up approach to Seeking, responding to and learning from patient/user experience-centred feedback. A paper on user experience was presented to the ICS Quality and Safety Committee in Dec 2021, it received a good level of interest and support, however, due to the current COVID-19 pressures, it was thought to work towards a longer-term plan with some achievable steps in the shorter term.

ICS Patient Experience Leads met on 2 February 2022 to look at how we could improve sharing of patient stories as an ICS and share patient story resource.

Conclusion

The overall evidence collected in this report provides assurance that the hospital is delivering services that are truly patient centred. Our patients rate their experience as being exceptionally good and this is evidenced in the NHS Inpatient 2020 survey results where the RJAH was rated No 1 in the country for the second year running for overall patient experience and named as a top performing Trust across 137 Trusts in England.

See the poster below from Patient Experience of Care Week, to celebrate improvements made from patient feedback in 2021/2022.



Chair's Assurance Report
IPC Quality Assurance Committee 14 June 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	6 July 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	29 June 2022
Paper Reviewed by:	Sara Ellis Anderson, Chief Nurse, and Patient Safety Officer	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the IPC Quality Assurance Committee meeting held on 14 June 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of all items relating to infection, prevention, and control to the IPC Quality Assurance (QA) Committee. This Committee is responsible for seeking assurance on the IPC of the services it delivers in order that it may provide appropriate assurance to the Board.

At the Board meeting in April, it was agreed the IPC QA Committee would report directly to the Board of Directors until further notice, removing all IPC agenda items from the Quality and Safety Committee and realigning to the IPC QA Committee.

2.2 Summary

- All members of the Committee were in attendance and therefore quorate
- The Committee received the IPC Improvement Plan, IPC Quality Report and IPC Live Dashboard for assurance purposes.
- The Committee deferred the IPC Annual Report which was presented in draft format.
- Further assurance is to be provided on the following:
  - Housekeeper roles/deep cleaning team – although approved by the System (and noted as a high priority) there has been no approval for funding to be sourced. The current process of having to gain approval from the ICS governance to use the Trusts funds has prolonged the implementation of the roles.
  - Training compliance – consideration to be given as to whether the correct employees were being asked to do the relevant training. A timeframe of newly rolled out training is to be embedded to ensure staff have time to complete.

2.3. Conclusion

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

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the IPC Quality Assurance Committee which met on 14 June 2022. The meeting was quorate with 4 Non-Executive Directors and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Paul Kingston	Non-Executive Director
Martin Newsholme	Non-Executive Director
Penny Venables	Non-Executive Director
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow	Chief Medical Officer
Craig Macbeth	Chief Finance and Planning Officer
Kirsty Foskett	Head of Clinical Governance and Quality
In Attendance:	
Shelley Ramtuhul	Trust Secretary/Director of Clinical Governance
Jacqueline Barnes	NHSEI Improvement Director
Nick Huband	Director of Estates and Facilities
Apologies:	
Apologies noted from Stacey Keegan, Interim CEO	

3.2 Actions from the Previous Meeting

The minutes and actions from the previous meeting were approved as an accurate record.

All actions except one were noted as completed. An action relating to further information being reported into the quarterly infection control report is on track to be delivered in July.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There was no declaration of interest shared	N/A	
2. IPC Improvement Plan		
The Trust highlighted six new actions which have been recorded to align the exit criteria to the improvement plan. A risk was raised in relation to the Trust not being able to implement the housekeeper role.	No	Concerns were raised in relation to no approval being received in relation to the funding. The

The Trust confirmed the housekeeping roles and roaming deep cleaning team business case had been approved by both the Trust and the System. Concerns were raised in relation to no funding being identified and the current process of having to gain approval from the ICS governance has prolonged the implementation of the roles. The Committee discussed the possibility of gaining legal advice and to prepare a letter outlining the concerns raised by the Trust. The Committee agreed to escalate to the Board of Directors for action.		current process of having to gain approval from the ICS governance to use the Trusts funds has prolonged the implementation of the roles.
3. IPC Live Data Dashboard		
The Trust demonstrated the live data dashboard to the Committee which was commended by the Board. The Committee asked for a monthly report to be presented to provided real time assurance to the Committee. The Trust agreed to investigate if something similar can be created for cleanliness to provide triangulation of Quality Assurance.	Yes	
4. IPC Board Assurance Framework		
Since the last presentation of the IPC BAF (in December), the Trust confirmed that twelve elements of the framework had made progress highlighting that there are currently no red rated actions within the framework. The Committee welcomed a further update in the next few months.	Yes	
5. IPC Quality Report		
The key highlights included: ▪ IPC Audit Programme going to IPC Committee in June ▪ IPC training programme, communication with Unit Leads, Matrons and Managers to encourage compliance ▪ Fortnightly training reports have been requested to support monitoring to ensure a focus on improving IPC training compliance Concerns were raised regarding the training compliance and whether the correct employees were being asked to complete the relevant training. A timeframe of newly rolled out training is to be embedded to ensure staff have time to complete and are not being reported as non-complaint once aligned to individuals.	Partial	Further assurance is to be provided on training compliance. A timeframe of newly rolled out training is to be embedded. The Committee asked for support from the People Committee.
6. Deep Dive – Surgical Site Infections		
It was noted that there is no single factor to contribute to a period of increased SSI's and advised of the following actions: ▪ Improved documentation ▪ Review SOP and practices regarding patient warning. This is being considered up as part of the One Together document and working group ▪ Improve patient education and managing wounds at home ▪ IPC team to commence post discharge surveillance ▪ Wound Care Policy will be presented at Patient Safety Committee for approval	Yes	

The Board encouraged the Trust to investigate ways to find out if the infections were hospital acquired to which the Trust explained they have gained support from the CCG, GPs and System.		
7. One Together Action Plan		
The Committee considered the action plan and asked for a review to be completed on the completion dates to ensure they were timely. The Trust agreed to complete the review at the next IPC working group meeting.	Yes	
8. IPC Annual Report		
The Trust explained the IPC Annual Report was presented in draft format and therefore deferred to the next meeting.	N/A	
9. Chair Report from the IPC Committee		
The Committee noted the chairs report, there were no areas of escalation identified. The Trust confirmed a workplan for the Committee has been devised and the MSSA decolonisation report had been received.	Yes	
10. Work Plan		
The Committee noted the workplan which is a standard agenda item for the Committee to reflect upon after each meeting. The members of the meeting were content with the items aligned to the Committee.	Yes	
11. Attendance Matrix		
The Committee received the matrix for information only.	Yes	

3.4 Approvals

Approval Sought	Outcome
None to note	

3.6 Risks to be Escalated

The following areas are to be highlighted to the Board as further assurance has been requested:

- Housekeeper roles/deep cleaning team – although approved by the System (and noted as a high priority) there has been no approval for funding to be sourced. The current process of having to gain approval from the ICS governance to use the Trusts funds has prolonged the implementation of the roles.
- Training compliance – consideration is to be given as to whether the correct employees were being asked to do the relevant training. A timeframe of newly rolled out training is to be embedded to ensure staff have time to complete and not recorded as non-compliant.

4. Conclusion

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

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.