The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 01.05.2024

MEETING

1 May 2024 09:30 BST

PUBLISHED

29 April 2024

Agenda

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Veterans MDT Meeting Room	1 May 2024	09:30 BST

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9.1	Next Meeting: 03 July 2024			-

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
06 MARCH 2024 AT 12:15PM IN MEETING ROOM 1, MAIN ENTRANCE AT RJAH
MINUTES OF MEETING

Voting Members in Attendance

Name	Role	Attending
Harry Turner	Chair (until 1pm)	✓
Sarfraz Nawaz	Non-Executive Director	×
Martin Newsholme	Non-Executive Director	✓
Penny Venables	Non-Executive Director (via MS Teams)	×
Lindsey Webb	Non-Executive Director	✓
Martin Evans	Non-Executive Director (Chair from 1pm)	✓
Stacey Keegan	Chief Executive Officer (until 1pm)	✓
Craig Macbeth	Chief Finance and Planning Officer	✓
Paul Kavanagh Fields	Chief Nurse and Patient Safety Officer	✓
Ruth Longfellow	Chief Medical Officer	✓
Mike Carr	Deputy CEO and Chief Operating Officer	✓

Others in Attendance

Name	Role	Attending
Paul Maubach	Associate Non-Executive Director	✓
John Pepper	Associate Non-Executive Director	×
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minutes)	✓
Chris Hudson	Head of Communications	✓
Simon Jones	Governor (observing)	✓
Sheila Hughes	Governor (observing)	✓
Colin Chapman	Governor (observing)	✓
Katrina Morphet	Governor (observing)	✓
Karina Wright	Governor (observing) and Presenting	✓
Victoria Rankin	Midland CSU – Board Development (observing)	✓
David Frith	Midland CSU – Board Development (observing)	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting. HT informed the Board that himself and SK will be excused from the meeting from 1pm and thanked ME and MC for deputising in their absence.
1.1	**Apologies**
	Apologies were noted from Sarfraz Nawaz, John Pepper and Lindsey Webb. It was noted that the Board was quorate.
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 10 January 2024 were approved as an accurate record subject to the following amendment: • Declaration of Interest - *PV informed the Board that she is has been elected as the substantive Chair for Sandwell Leisure Trust.*
1.4	**Matters Arising and Action Log**
	There were no further matters to raise.

Ref	Discussion and Action Points
	The Board agreed to close all four actions recorded on the action log: • Trust Strategy has been added to the Council of Governors Committee workplan. • Risk appetite reflection has been included within the Board development workplan. • Health inequalities deep dive is due to be presented to the public Board in July. • Safe staffing reviews have been added to the Board workplan.
2.0	**Service Story – ASCOT Trial**
	The Board welcomed Karina Wright to the meeting, who joined to share a presentation on the ASCOT trail. Karina highlighted the following: • There has been a partnership with Oswestry and Keele for over 20 years. • They appoint 3 professors, 3 lectures and 10 research associates along with 15 PHD students which are based at RJAH. • The cell lab started in 1996 and supporting in manufacturing new cell therapies. • The Trust has treated 600+ patients. • ACI – involves 2 surgery, arthroscopic surgery following injury and then the transplantation of the grown cells. • Other clinical trials at RJAH include – REACT, ACTIVE, ASCOT and ACT2 • The ASCOT trial was completed, and an end of trial celebration took place. The event considered the learning for next trial, experiences of the patients and shared information with patient on how they contributed to research in the future. • A patient story was shared with the Board. • A special thank you was extended to the late Professor James Richardson and recently retired Professor Sally Roberts. On behalf of the Board, HT expressed thanks to Karina and the team for the timely presentation.
3.0	**Chair and CEO Update**
	Chair Update HT informed the Board that he attended an NHS Chair conference in London. The key focus points from the conference included: • Impact and growth • Improving patient experience and patient quality • Overall Board development and improvement. HT reminded the member of the meeting that the Trust have already established an improvement team which supported initiatives across the organisation. • A briefing note on the workforce long term plan • A recurring theme throughout the presentation was productivity. From attending the conference HT was reassured that all of the current elements raised at the conference have been topics of discussion at RJAH. HT added there is a revised NHS leadership framework which will support the performance of NHS Board. The framework is design to also support with appraisal/personal development and recruitment. The Board will be adopting this new approach in line with the guidance. **CEO Update** Before presenting the CEO report, SK reflected upon the busy period with the NHS and the importance of the Trust focusing on driving improvements for a better future. SK highlighted the following key points from the paper: • **Planning** – although the Trust is formally awaiting the planning guidance from NHSE, the team have commenced in compiling the operational and financial plans for 2024/25. • **Industrial Action** - last week saw the conclusion of the latest round of industrial action by junior doctors as part of the dispute overpay between the BMA and the government. On behalf of the Board, SK thanked the staff for their hard work to mitigate the impact on our patients and keeping the organisation safe. • **This is me event -** the Trust applied to NHS England in relation to our WDES agenda and were successful in securing funding for a special event. 'This Is Me' event was a huge success. It included stalls from different charities and organisations, speakers and interactive activities. A big thank you to Caroline Nokes-Lawrence and the Organisational Development Team for pulling it all together. • **Green Plan** - our new reuseable scheme starting in our Denbigh's Restaurant last month with a soft launch. The scheme is part of our journey in removing single-use items across the Denbigh's Restaurant service. The support from staff has been very positive and the Trust are

Ref	Discussion and Action Points
	proud of our Estates and Facilities team for really driving this work forward and being a leader within the NHS. • **Chief Nursing Officer's Award** - Claire Partridge, who works within our Practice Development Team, has won the award for Healthcare Support Workers in the 'commitment to quality of care' category. In winning the honour, she becomes the first Healthcare Support Worker (HCSW) from STW to be recognised for the prize. • **Bone Idols Awards** - the Bone and Soft Tissue Tumour Service have won the Team of the Year Award at the Bone Cancer Research Trust's (BCRT) Bone Idols Awards. The team – who work on Montgomery Unit and Oswald Ward – were nominated by patients, who praised them for providing outstanding holistic care throughout the patient journey, from diagnosis, surgery, rehabilitation and then ongoing support and monitoring. • **MyCleaning Awards** - Congratulations to Abi Davies, Deputy Housekeeping Manager, who was shortlisted as a finalist in the awards – which are a national celebration of all thing's healthcare cleaning and domestics, aiming to shine a light on the profile of healthcare cleaning and the knowledge and expertise required in these roles. • **STAR award** - Gemma Sweetman, Ward Sister, was a winner for her commitment to ensuring the Trust did their bit to support with system pressures throughout the busy festive period. • **STAR award** - Midland Centre for Spinal Injuries (MCSI) in recognition of their actions which saved a colleague's life. A staff nurse who works in the Outpatient Department on the unit fell dangerously ill and experienced a heart attack while on shift at the end of last year. The Board congratulated all staff on their achievements. The Board noted the update – there were no queries raised.
	HT and SK left the meeting.
3.0	**Risk and Governance**
3.1	**Corporate Risk Register**
	The Board considered the corporate risk register, DM highlighted the following key points: • The report is a high-level summary of risks with a score of 15 or above. • The assurance committees discussed the risks aligned to their remit through the month of December. • The report highlights the movements of the 10 risks which are presented or consideration. • The risks aligned to the EPR implementation are specially reported through the DERIC Chair assurance report. The Board discussed the following: • The challenges faced within the System which has an overall effect on the organisation. • The importance of collaborative working across the providers to enable productive schemes and efficient ways of working. The Board agreed the discussion in relation to the System should be aligned to the Board Assurance Framework. It was noted that the risk would be aligned to the Board of Directors and not a separate assurance committee as it is overarching risk. DM reminded the Board; the Board Assurance Framework is tabled for discussion at the next Board meeting in April. The Board approved the Corporate Risk Register.
4.0	**Quality and Safety**
4.1	**Chief Nurse and Patient Safety Officer update (verbal)**
	PKF provided the following verbal update to the Board: • **Quality Strategy** – pleased to present the Quality Strategy to the Board for approval. PFK confirmed the Strategy had been considered through the relevant governance process and endorsed by the Quality and Safety Committee in February. The document is a 3-year strategy and aims aligned to the pathway of excellence. • **Nursing and AHP Strategy** – the Trust are currently compiling the 5-year Nursing and AHP Strategy. Key areas of focus include, plans for professionals, workforce quality accreditation and aspiration for the research focused organisation. The Strategy will be presented to the Board for approval in the coming months. • **Quality accreditation programme** – the first draft was shared with the Quality and Safety Committee which ensures the Trusts service are of a quality standards. The programme will also support the CQC requirements.

Ref	Discussion and Action Points
	• **CQC preparedness framework** – a tool has been created to align the approach to regulation alongside the changes which have been embed from KLOEs to quality statements. The Trust has established a CQC preparedness group to support managers. • **Sexual safety charter** - work continues to embed the recommendations from the charter. The Board thanked PKF for the verbal update – there were no questions raised.
4.2	**Chief Medical Officer update (verbal)**
	RL provided the following verbal update to the Board: • Industrial Action – thanked the staff for supporting the 5 days of action which gave junior doctors the opportunity to strike. The Trust continued to delivery activity whilst ensuring patient safety. • Operation Lazurite – the Trust continues to support the System as being the operational lead for the System. The Trust is working collaboratively with local GPs to provide care for the patients. The Board thanked RL for the verbal update – there were no questions raised.
4.3	**Performance Report – Quality and Safety Committee**
	The following points were highlighted from the Quality and Safety performance report: • 1 RJAH acquired klebsiella has been reported. A review is currently being completed; however, the case has been recorded as unavoidable. • 2 SSI has been reported. A one together action plan has commenced. The review will be presented through IPC improvement plan and presented to the Committee in due course. • 1 expected death has been recorded. The Trust were assured all processes have been followed. The Board noted the performance report, and no concerns were raised.
4.4	**Chair's Assurance Report – Quality and Safety Committee**
	In the absence of LW, PV supported in providing the following updates from the Quality and Safety Committee: • **EPRR annual report** – received the report and is presented to the Board for oversight. There were no concerns to raise to the Board. • **Quality Strategy** – the Committee endorsed the Strategy and is presented to the Board with a recommendation to approve. • **7 day working** – further assurance has been sought in relation to the 7-day working. The Committee requested further clarity on the safe provisions which are embedded to undertake the extra activity at the weekend ad gained reassured in relation to the blood provision following the presentation of the mitigations. • **Learning from deaths Q3 report** – the Committee received the report, there are no concerns to raise to the Board. The report is shared with the Board for oversight. • **Controls of infections** – there have been a noted increase in klebsiella cases. The Committee were assured that work has been undertaken, particularly within the MSCI wards. The infections have been linked to catheters. The Board noted the Chairs assurance report – there were no questions raised.
4.5	**EPRR Annual Report**
	The annual report is shared with the Board for oversight and good governance. The report was presented to the Quality and Safety Committee in January where members of the meeting reflected on the paper. The Board discussed the training exercises which can be organised to support in testing emergency plans. The Trust agreed with the suggestion and confirmed planning has commenced for an internal exercise. The members of the Committee were assured by the report presented. The Board noted the health and safety annual report.
4.6	**Learning from Deaths Q3 Report**
	The annual report is shared with the Board for oversight and good governance. The report was presented to the Quality and Safety Committee in January where members of the meeting reflected on the paper. • There were no areas of concern to escalate to the Board. • Lesson learnt are presented to multidisciplinary meetings to enhance oversight.

Ref	Discussion and Action Points
	The members of the Committee were assured by the report presented. The Board noted the health and safety annual report.
4.7	**Quality Strategy**
	The Committee welcomed the reviewed Strategy and endorsed the document to be presented to the Board of Directors for final consideration and approval. The Board provided the following feedback on the Strategy: • well written strategy. • highlighted the link to the System. • clear and articulate. The Board approved the Quality Strategy and commended the team on their work.
5.0	**People and Workforce**
5.1	**Workforce – Performance Report**
	DH highlighted the following areas from the workforce performance report: • Performance against all key performance metrics remains positive. • sickness absence target has been revised from 5.9% in December to 4.4% from January onwards as the Trust was consistently achieving the original target. • Reported 10 leavers within month (the Trusts average is 14) The Board commended the Trust for being able to sustain the performance against peers and national averages and queried how the Trust can develop further. There is consideration to be given to the working metrics in relation to employment experience and how can the Trust present the quality of the time. The Board noted the workforce performance report, and no concerns were raised.
5.2	**Chair's Assurance Report – People and Culture Committee**
	ME provided the following updates from the People and Culture Committee in January and February meetings: • **Revalidation Officer annual report** – the Committee supported the annual report which was presented to the Board of Directors in February at the private meeting. • **Gender pay gap report** – presented to the Board for approval. The work stream which has been identified following the annual review will be reported through the People and Culture Committee. • **EDI Annual Report** - commended the high-quality content report which noted significant progress over the past 6-12 month. The paper is presented to the Board for approval and development will be reported through the People and Culture Committee. • **Freedom to Speak Up Q3 report** – provided to the Board for oversight. The Committee was assured with processes in place to support. There have been no common themes or trends identified. • **Guardian of safe working Q3 report** – reviewed the report and confirmed there have been and no exception reported. There is ongoing work being undertaken with North Wales to develop a process to keep supporting the junior doctors who complete shifts at both sites. • **Risks** - reviewed the risk aligned to the Committee. • **Workforce dashboard** – received a live demonstration on the rich data being recorded and reported. It is pleasing to see the continued development of using the data and how it can be used to develop richer information. • **Workforce performance report** – commended the vacancies rates which have been reported as the lowest within the past 2 years. • **Training** - good progress noted for both for statutory and mandatory training as well as personal development reviews. • **Powys ward actions plan** – the Committee agreed to close the Powys ward action plan and realigned to business as usual for a ward perspective. This is following the receipt of the completed action plan. • **Theatre workforce approach** – there have been some potential opportunities identified to support staff, the Committee sought information from the Trust at the March meeting. The Board noted the chair report, and no concerns were raised.
5.3	**Freedom to Speak Up Q3 Report**
	PFK provided an overview of the freedom to speak up report, highlighting the following:

Ref	Discussion and Action Points
	• The report is provided on data with Q3 of 2023/24 (October – December). • There have been no common themes recorded. • All concerns raised have been responded too within the agreed timeframes. • Noted an increase in concerns and commended the Trust on the positive reporting culture. • Positive to note that staff are raising concerns in relation to patient safety issues along with staffing concerns. The Board noted the freedom to speak up Q3 report.
5.4	**Guardian of Safe Working Hours Q3 Report**
	RL provided an overview of the guardians safe working hours, there have been no exception reported and the Trust remains compliant. The Board noted the freedom to speak up Q3 report.
5.5	**Gender Pay Gap**
	Caroline presented the gender pay gap report to the board noting that it was a statutory responsibility to present the detail of the findings. Following the review there has been further work identified in order to support staff. Those areas include career progression, objectives, flexible working, as supporting staff through the menopause. The Board held the following discussion: • The Trust confirmed that both male and female staff members employed in the same job role are paid the same salary - there is no inequity within salary. • The report highlights areas in which the Trust can support gaps further, for example, encouraging and developing more female staff to progress. • Noted the Royal College is supportive of encouraging women surgery. The Board supported and approved the gender gap report and encourage the Trust to continue to think of initiative ways to support staff in the future.
5.6	**EDI Annual Report**
	The report tracks recommendations against the nine characteristics related to EDI. The Trust has worked hard to increase the awareness across the organisation and highlighted some of the actions which the Trust has taken include: • embedding staff network groups, • staff champions, • progress against the EDI strategy, The Board discussed the following: • Highlighted that cancer can be recorded as a disability act and encouraged the Trust to support staff which have been affected in the past. The Trust confirmed that there is awareness of this and have asked for support from the people services team to ensure processes embedded appropriately. • Discussed the options of recording learning disabilities as part of the Apollo implementation. The Trust confirmed this is being considered as part of the patient experience strategy. The Board approved the EDI annual report and thanked Caroline and the team for their continued hard work and progress over the past 12 months.
6.0	**Operations and Finance**
6.1	**Chief Operating Officer Update**
	MC provided the following verbal update to the Board: • MSK programme – transferring and combining the rheumatology services has commenced. • The Trust has been supporting in the development of pathways for arthritis. • The Trust continue to progress the MSST service and noted the positive progress. The next steps included gaining clinical data to complete an effectiveness review. • System contribution – providing mutual aid to SATH inpatient orthopaedic patients to support with system pressures and long waiting times. • Pleased to confirm the theatre utilisation was reported at 87%. • There has been a reported reduction in cancellations. • The Trust has completed over 900 theatre cases per month although the Trust aspire to deliver more. • Combined waiting list times and overdue follow ups have reported a reduction. • The Trust is leading the way for DNA rates over the past 12 months one of the best in the country.

Ref	Discussion and Action Points
	• Relaunched the health and inequalities strategy. A deep dive is scheduled for the Board meeting in the summer. • Industrial action created a shortfall of activity which totalled - 52 theatre cases and 13 outpatients' appointments. The Board welcomed a further reporting on the MSK transformation and what work the Trust can support with for both English and Welsh providers. The Board noted the report and thanked MC for the verbal update.
6.2	**Performance Report**
	MC highlight the following exceptions from the performance report: • **Overdue follow up backlog** – revalidation have been completed and has supported in driven improvements. • **Diagnostics** – noted the capacity issue in relation to ultrasound however, challenges noted within acquiring the correct skill mix to support the activity. The staff are committed to training staff. Noted that all other areas of diagnostics were achieved. • **Activity** – need to do more to become financial stable however, there has been a continued improvement reported throughout February and March. The Board discussed the following: • The positive outpatient performance - patients do not have to wait long for appoint. • Supported the pressure upon GPs and primary care by seeing patients earlier. • The requirement to improve communication between primary and secondary care was noted. • The Trust continues to make a positive contribution to the System by reducing pressure elsewhere. The Board noted the current performance position.
6.2	**Long Waiters Presentation**
	MC provided the following key highlighted on the long waiting patients: • There are no English patients over 104 weeks. • The Trust is on track to deliver the 78 weeks by March 2024 • In relation to the 65 weeks, the Trust is awaiting the planning guidance as the original request will not be achieved due to the national pressures. • There are 66 Welsh patients waiting over 104 weeks (this has decrease from previous month). • The Trust continue to address the imbalance between English and Welsh. • The Trust is working closely with Powys health board to support Welsh patients further. The Board were assured with the processes in place to support long waiting patients and commended the team for supporting the noted discrepancy between English and Welsh waiting lists.
6.3	**Finance Report**
	CM provided the following key highlighted from the Finance report: • The Trust realigned the plan in January and therefore the report relates to the revise forecast position submitted to NHSE. • The Trust reported a £23k shortfall in month. • There has been a £1.8m surplus in month which includes £1m received from the industrial action support. • Year to date, the Trust is reporting £400k shortfall of the revised plan. There is a total of £900k unplanned Industrial action support which is being tolerated by the system. • The original forecast of £3.6m deficit has improved to £1.3m • The Trust continue to consider mitigation in order to report a break-even financial year. The Board thanked CM for the update and noted the current financial position.
6.4	**Chairs' Assurance Report – Finance and Performance Committee**
	In the absence of SN, MN provided the following updates from the Finance and Performance Committee in January and February. • Long waiters – acknowledged the amount of work undertaken to support the 104 weeks and the Trust focusing is moving to 78 weeks. There have been several meetings where the Trust has discussed the English and Welsh discrepancy. It was suggested triangulation between the cohort of patient in relation to quality and safety should be considered.

Ref	Discussion and Action Points
	• **Finance position** – the Committee were assured on the likelihood of breakeven position. • **Contracts** – received the update on the number of contracts to be reviewed a task and finish group to be established to complete. • **Plan 2024/25** – considered the plan at the private meeting, key areas to considered included significant increase in activity, variation to plan, noted the significant gap to fulfil, suggested 20% higher activity to support slippage. The Board commended the financial position and were assured with the likelihood of a break event position. The Board discussed the challenging year a encouraged the Trust to consider the underlying current position with support with future activity.
6.5	**DERIC Committee**
	PV provided the following updates from the DERIC Committee which took place in January and February. • **EPR Implementation Assurance meeting** – agreed the scope of the meeting and approved the terms of reference. • **Chair Report EPR Implementation Assurance meeting** – pleasing meeting and received assurance on the improved relationship between the Trust and the System C. The Committee sought further assurance and information in line with the operational, digital and financial benefits. • Assured **system testing** session have been rolled out to wide cohorts of staff. • **Internal Audit review** – majority for the digital reviews' recommendation were reported as outstanding but the Committee were reassured the actions have been completed and evidence was to be sent to MIAA for completion. • **Business case for the innovation team** – noted as work on progress. The case will be presented to the Exectuvie Team meeting for consideration and expected at DERIC in April. • **Education Strategy** – the team is currently undertaking work with scoping across the organisation. The Board discussed the following: • A lot of fantastic work being undertaken and noted the potential of the Committee. • Consider how innovation can support the productivity challenge which the Trust faces. • Encourage teams to focus and actively contribute to innovation. • Commended the innovation club which reports into DERIC – supporting staff development improvement ideas. • Other areas of focus include, research and enhance the Keele Uni. partnerships and further improve on the green plan. The Board noted the update following the DERIC committee – there were no queries raised.
6.6	**Audit and Risk Committee**
	MN provided the following updates from the DERIC Committee which took place in December. • Endorsed the Review of Standing Financial Instructions and Scheme of Delegation policy ahead of presentation at the Board meeting. • Received and considered the code of corporate governance. There are a total of 89 recommendations which apply to the Trust. The Trust reported they are complaint with 82 recommendations. There are 3 recommendations which are not applicable to the Trust. The external audit representative at the meeting commended the paper which the Committee took assurance from. • Received 4 report internal audit report - committee effectiveness, safe staffing, finance, data quality which all reported substantival assurance. The final 2 reports are to be received in May along with the Head of internal audit opinion. • Commended the Trust for the work undertaken to complete the outstanding recommendations following concerns which were raised at the October meeting. The Board thanked MN for the update – there were no queries raised.
6.7	Review of Standing Financial Instructions and Scheme of Delegation **Policy**
	The policy was recommended to the Board for approval following consideration at the Audit and Risk Committee in February. The Board approved the Review of Standing Financial Instructions and Scheme of Delegation policy.

Ref	Discussion and Action Points
7.0	**Any Other Business**
7.1	**Questions and Committee from the Public**
	The Board welcomed comments and questions from governors in attendance at the meeting: • Please to note issues are being addressed. • Suggested a collaboration with the Oswestry Leisure Centre. • Thanked the Trust for their continued hard work. • Thanked the Trust for pursing ways to support Welsh patients further noting the discrepancies between the English and Welsh waiting lists. • Suggested a link to the ASCOT Trail is shared on the Trust website. • Commended the ASCOT Trial presentations – a legacy of Professor James Ricardson and a department which is a credit to the Trust.
7.0	**Any Other Business**
	There were no further items of business discussed by the Board.
8.0	**Date and time of next meeting**
	Public Board of Directors Meeting | 01 May 2024 | RJAH Conference Suite, Main Entrance

Board Members and Senior Leaders Declarations of Interests

First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From & To dd-mm-yy		Comments, including action taken to mitigate any potential conflict of interest.
					From	To	
Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	October 2006	Ongoing	
			Non-Financial Professional Interests	Chair of Dudley Integrated Care NHS Trust, Dudley	July 2019	June 2024	
			Financial Interests	In Form Solutions Management Consultancy	February 2024	Ongoing	
Sarfraz	Nawaz	Non Executive Director	Financial Interests	Executive Director of Finance at National Citizens Trust	18/09/2023	Ongoing	No conflict between role at NCS and RJAH
			Non-Financial Professional Interests	Member of CIPFA	01/2021	Ongoing	
Martin	Evans	Non Executive Director	Financial Interests	Non-Executive Director at Dudley Integrated Health and Care NHS Trust	01/04/2020	Ongoing	
			Financial Interests	Director at MJE Associates Ltd	01/04/2020	Ongoing	
Penny	Venables	Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	January 2021	Ongoing	
			Non-Financial Professional Interests	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	June 2020	Ongoing	
			Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	November 2023	Ongoing	
Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing	To my knowledge Shropdoc and RJAH do not trade with each other
			Financial Interests	Non executive director at Dudley Integrated Health & Care NHS Trust	01/02/2024	Ongoing	To my knowledge DIHC and RJAH do not trade with each other
			Financial Interests	None executive director at Warrington Housing Association	01/09/2018	Ongoing	Warrington Housing is not in the healthcare section and doesn't trade with RJAH
Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		Ongoing	
John	Pepper	Associate Non Executive Director	Financial Interests	NHS England GP Appraiser	01/07/2022	Ongoing	
Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA		Ongoing	
			Financial Interests	Senior Advisor on Primary Care Delivery, Department of Health and Social Care	01/11/2023	Ongoing	
			Financial Interests	Director and Owner of Maubach Consulting Ltd – through which I provide management consulting and advisory services to different organisations.If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing	
Atif	Ishaq	Associate Non Executive Director	Financial Interests	Data Product Director at Haleon Plc	2022	Ongoing	No conflict between role at Haleon and RJAH
			Financial Interests	Owner of Digital Clinician Ltd	2018	Ongoing	
			Financial Interests	Digital Advisor and Webmaster to Pharmacy Care Matters LTD	2011	Ongoing	
			Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	2011	Ongoing	
			Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	2011	Ongoing	
			Financial Interests	Self-employed webhosting provider	2011	Ongoing	
			Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	2017	Ongoing	
Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	November 2019	Ongoing	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Craig	Macbeth	Chief Finance and Planning Officer	No interest to declare	N/A	N/A	N/A	
Mike	Carr	Chief Operating Officer	Non-Financial Personal Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	May 2022	Ongoing	Withdraw from discussions as appropriate.
Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing	
Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A	

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director – Public Meeting, 1 May 2024

Author:		**Contributors:**
Name:	Stacey Keegan	Chris Hudson,
Role/Title:	Chief Executive Officer	Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

YES

Key issues and considerations:

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

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

Recommendations:

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

Acronyms	
NHS	National Health Service
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
AHP	Allied Health Professional
NJR	National Joint Registry
NOA	National Orthopaedic Alliance
GB	Great Britain
MSK	Musculoskeletal
AI	Artificial Intelligence
STW	Shropshire, Telford and Wrekin
PDF	Portable Document Format
HCA	Hospital Caterers Association
MCSI	Midland Centre for Spinal Injuries
IT	Information Technology

1. MSK Transformation Programme

We – along with system partners at Shropshire Council and Telford and Wrekin Council – have entered into an exciting new partnership with wellbeing tech company Good Boost. The collaboration will see a programme offered to help people across Shropshire, Telford and Wrekin with musculoskeletal (MSK) conditions such as arthritis, back and chronic pain as well as problems both pre- and post-surgery. Non-profit social enterprise Good Boost's technology harnesses artificial intelligence (AI) to create personalised exercise programmes and augmented reality games that customers access on bespoke, waterproof tablets. They provide aqua and land-based classes – though the initial offer in STW is largely pool-based aqua sessions.

2. Launching of new stakeholder bulletin

We are always looking for new ways to reach with and engage all stakeholders – both within our local health and care system and further afield. As part of that, we have recently launched a new stakeholder bulletin, called RJAH Connected, with the first issue going out in April. It is issued as an email bulletin and is best viewed in that format, though people can also download from below a copy of the latest and all previous editions in PDF form. Packed full of news and information, it is a great way to keep informed on all key developments at our hospital. Anyone wanting information on this bulletin, including how to get added to the distribution list, can read more on our Trust website.

3. Powys Health Board

In April we welcomed members of Powys Health Board for a second workshop here at RJAH with an opportunity to review where we are against the key workstreams that we are working in collaboration with to support our Welsh partners and patients. The workstreams include the optimisation of clinical pathways, capacity, clinical leadership and to support and input into the business case for a new state of the art health and care facility in Newtown.

4. New Therapy gym

We are enhancing the physical and mental wellbeing of our patients with the official opening of our newly refurbished therapy gym. A total of £120,000 has been invested in the work, which was carried out over an eight-week period. Improvements include white rock walls, which are infection prevention and control compliant; new flooring; upgraded personal protective equipment; and fresh paint work. The official ribbon cutting was carried out by Douglas Winterborn, 91, who has been a patient on the Midland Centre for Spinal Injuries since January this year and so is one of many reaping the benefits of this work.

5. Launching the Swan end of life care model

In the middle of April, the Trust launched and began embedding the Swan Model of Care to support and guide the care of patients and their loved ones that we care for at the end of their life and after they have died. It allows us to provide individualised but consistent care to every patient and their families. As part of the launch, a whole host of new resources were made available to staff on our staff intranet, and on each ward in the dedicated Swan boxes.

6. Apollo Electronic Patient Record project

We continue to push on with our Electronic Patient Record project. This represents the biggest single investment this organisation has ever made in a technological solution. We have completed a comprehensive review of our Programme Plan to ensure that it will enable us to deliver solutions fit for the Trust and our patients, tuned to the needs of our staff as users, and fully ready for operational and clinical use. As a result of that review, we took the decision to delay the 'Go Live' date from the end of April and hope to be in a position imminently to confirm new dates.

7. Human Factors training

Patient safety is a familiar phrase in the NHS. More than 75% of patient safety failures involve 'human factors and there is increasing acknowledgement that the safe delivery of high-quality healthcare is impacted by the manner in which humans delivering it interact with their environment. For that reason, I am delighted that, as a Trust, we have been able to launch a new training programme through our Human Factors Faculty which is open to clinical and non-clinical staff alike.

8. New solar panels going up on hospital site

The Trust has successfully bid for funding of £1.36 million from the Department of Health and Social Care to roll out more solar panels around the hospital site. The scheme will generate 1,151,994kWh a year, the equivalent of 600 tonnes of carbon emissions and represents a £294,000 saving. This is a great opportunity for the Trust to reduce its impact on the environment. It goes a long way to delivering the Trust Green Plan and will benefit the area for generations to come.

9. Leadership Excellence Award for Facilities Manager

Sian Langford, our Facilities Compliance Manager, has won a specialist industry accolade, in recognition of her leadership as part of a series of sustainability projects. She was presented with the Leadership Excellence Award by the Hospital Caterers Association (HCA) at their prestigious Presidents Dinner. Sian was nominated by Tim Radcliffe, Net Zero Food Programme Manager at NHS England, for her work on leading on several sustainability projects such as reducing single-use plastic on the hospital site, ensuring high-standards of food safety and decreasing food waste.

10. Local Heroes Awards

Staff and volunteers at RJAH have been recognised in the Local Heroes Awards, organised and ran by Oswestry Life magazine. Ellie Baldwin, a Healthcare Assistant, was hailed with the NHS Heroes Award, whilst the Volunteers Team at the Headley Court Veterans' Orthopaedic Centre were presented with the Volunteer of the Year Award. Oswestry Life magazine organise the Local Heroes Awards to honour and celebrate those who are making significant contributions to the local community through their time, actions, talents and dedication.

11. Unsung Hero Awards

It isn't just clinical staff who receive recognition for the care they provide patients at our hospital, as Jess Potts, an Assistive Technologist, knows. Jess works for a charity called Aspire and is based on the Midland Centre for Spinal Injuries (MCSI). She was shortlisted in the prestigious Unsung Hero Awards – which recognise the contributions of non-medical NHS staff and the work they do behind the scenes. Jess was a shortlisted finalist in the IT and Digital Award (Individual) category. Her role is around enabling, training, supporting and introducing patients to ways that they can access IT and Kate's nomination praised her for 'changing and enriching the lives of so many patients and staff'.

12. RJAH Stars Award

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

- Rich Howell, our Senior Software Developer, has been named as the April winner. He has been praised for his determination to develop a new wellbeing portal, named Our Space. Our Space is due to launch in June and will be a one-stop-shop for staff, featuring a range of resources and information. This is a great example of an unsung hero going above and beyond for the Trust and prioritising others. As a Trust, we are committed to supporting our staff, recognising that their wellbeing is fundamental to the smooth running of the hospital, having a positive impact on patient care and supporting morale.

- Matty Mackenzie, who works in the Building Team, won the award for March after being described as a 'true RJAH Star' for his hard work and dedication. He was nominated by Jenny Evans, Communications Apprentice, who spent a day shadowing Matty in his role as part of a wider communications piece shared amongst staff. Matty is an absolute asset to the Trust – his knowledge and skills used to support the operations and development of the hospital site are invaluable.

Congratulations to both of our latest winners!

11. Conclusion

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

Committee / Group / Meeting, Date

Board of Directors, 1 May 2024

Author:	Contributors:
Name: Dylan Murphy Role/Title: Trust Secretary	Name: Mary Bardsley Role/Title: Assistant Trust Secretary

Report sign-off:

n/a

Is the report suitable for publication?:

YES

Key issues and considerations:

The Board Assurance Framework (BAF) outlines the key risks to delivery of the Trust's objectives and the mitigations in place to address those risks. The BAF has undergone significant revision to reflect the updated strategic objectives and the updated risk appetite. Presentation of the BAF has also been revised to provide a greater level of clarity and assurance.

BAF themes

The revised BAF features a number of high-level, simplified themes:

1. Continued focus on excellence in quality and safety;
2. Creating a sustainable workforce;
3. Delivering the financial plan;
4. Delivering the required levels of productivity, performance and activity;
5. Delivering innovation, growth and achieving systemic improvements;
6. Responding to opportunities and challenges in the wider health and care system; and
7. Responding to a significant disruptive event.

Strategic risks

Each theme has an associated strategic risk. That sets out the high-level risk to delivery of that BAF theme.

The risk scores are presented in a "heatmap" at **Attachment A**. The detail of those risks is included at Attachment C.

Contributory factors

Each strategic risk on the BAF identifies various factors that are relevant to that theme / strategic risk. Some of these are controls, which the Trust has in place to mitigate the risks. Others are factors which could increase the risk.

The BAF themes, strategic risks, and contributory factors / controls are summarised at **Attachment B**.

BAF presentation

The BAF strategic risk template has been revised in an attempt to provide sufficient information to understand:

- The key risks facing the Trust which may affect its ability to deliver its objectives / statutory duties;
- How existing / planned activity contributes to reducing the risks to delivery of those objectives / duties;
- The rationale for the current risk score;
- The rationale for the target risk score and the plan to achieve it, including consideration of the factors the Trust are able / looking to affect in order to reduce the score;
- The controls that are in place; what they are trying to achieve; and how robust they are;
- What the gaps are, and what the plan is to plug those gaps.

Initial versions of the templates for each risk are included at **Attachment C**.

Corporate objectives and risk appetite:

The Trust has agreed the following strategic objectives:

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

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

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

The headline risk appetite categories and associated target risk scores are:

Risk category	Risk appetite	Risk tolerance – target score
Quality	Cautious	6
Finance	Open	9
Workforce	Seek	12
Regulatory	Open	9
Reputational	Open	9

Each of the BAF strategic risks are aligned to the objectives and refer to the relevant risk appetite target score(s).

Recommendations:

The Board is asked to:

1. NOTE and FORMALLY ADOPT the revised BAF report
2. NOTE the next steps for review and further development of the content

Report development and engagement history:

The updated corporate objectives and risk appetite statement were considered and agreed by the Board in November 2023.

At the January 2024 round of meetings, the Board committees were asked to consider the key risks to delivery of the strategic objectives relevant to their remit (with reference to the strategic objectives / risk appetite, rather than from the existing BAF document).

At the March 2024 private session, the Board considered the outcome of the committee discussions and made further comments on the proposed BAF.

Following the March 2024 Board meeting, further discussions were held with the Executive Team to agree the content of the revised BAF.

Next steps:

Individual elements of the BAF will be allocated to sub-committees of the Board for oversight, as indicated on each strategic risk template. The Board itself will retain oversight of BAF 6, which is "Responding to opportunities and challenges in the wider health and care system".

The Board / committees will be asked to:

- Review the "contributory factors and associated controls" and consider the level of assurance that should be recorded against each; and
- Consider the need for additional actions to address gaps in controls

Attachment A – “Heatmap” of strategic risks

Likelihood	Consequence: (1) Insignificant	(2) Minor	(3) Moderate	(4) Major	(5) Catastrophic
(5) Almost certain					
(4) Likely			**BAF 7** (disruptive event)		
(3) Occasionally / Possible				**BAF 4** (productivity / performance) **BAF 5** (innovation and growth) **BAF 6** (system working)	**BAF 2** (sustainable workforce) **BAF 3** (financial plan delivery)
(2) Unlikely					**BAF 1** (quality and safety)
(1) Rare					

Attachment B: BAF themes, associated strategic risks and contributory factors

Themes / LEAD EXEC Lead "Committee"	Strategic Risk	Contributory factors and associated controls	Risk Appetite / target
1. Continued focus on excellence in quality and safety. **PKF / RL** **Quality and Safety Committee**	• If the Trust does not have robust policies, procedures and practices in place to promote the quality and safety of services • Then there is a risk that insufficient organisational focus is placed on the quality and safety of services • Resulting in increased incidence of avoidable harm, reduction in patient satisfaction and failure to deliver excellent standards of care	• Clinical staffing – compliance with safe staffing requirements. • Maintenance of robust quality / clinical governance arrangements – development and implementation of quality strategy. • Maintenance of robust quality / clinical governance arrangements – learning from feedback / patient safety walkabouts. • Maintenance of robust quality / clinical governance arrangements – learning from quality spot checks, incidents / complaints / legal claims etc.. • Maintenance of robust quality / clinical governance arrangements – learning from deaths. • Maintenance of robust quality / clinical governance arrangements - Clinical Effectiveness monitoring and reporting arrangements • Maintenance of robust quality / clinical governance arrangements – patient engagement and learning from patient experience • Maintenance of robust infection prevention and control (IPC) governance arrangements / training programme. • Successful implementation of the EPR. Inhibiting factors: • Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending. Mitigations include: ➢ Compliance with NOF requirements (and any quality-related performance criteria agreed with NHSE). ➢ Self-assessment against the CQC quality statements.	Quality Cautious: 6
2. Creating a sustainable workforce. **DH / PKF** **People and Culture Committee**	• If the Trust does not attract and retain staff with the appropriate skills and values, embrace equality, diversity and inclusion, and be regarded as an employer of choice • Then it will be unable to deliver planned activity and/or promote an inclusive, supportive culture for staff • Resulting in reduced patient satisfaction; an inability to address inequality of service provision; reputational damage, adversely affecting efforts to retain/recruit staff	• "Growing for the future": Effective, targeted recruitment: ➢ Trust-wide recruitment strategy / plan ➢ Recruitment and retention of clinical staff to ensure appropriate skills mix ➢ Efficient recruitment process • "Growing for the future" / "New ways of working and delivering care": Effective, targeted recruitment – ➢ focus on key roles / "pressure points" that drive activity ➢ Retention / staff development initiatives • "Looking after our people": ➢ staff support networks ➢ cost of living support ➢ support to international recruits • "New ways of working and delivering care": Staff development: ➢ Effective "onboarding" / induction process ➢ Robust PDR process ➢ Development programmes and support arrangements, including: Career cafes; Leadership Development Programme; Apprenticeships etc. • "New ways of working and delivering care": Staff recognition schemes • "New ways of working and delivering care" / "Belonging in the NHS": Staff engagement / communication, including: ➢ FTSU; ➢ Staff Briefings; ➢ "Question Time"… • "Belonging in the NHS" - EDI initiatives / training programmes, including:	Workforce Seek: 12

Attachment B: BAF themes, associated strategic risks and contributory factors

Themes / LEAD EXEC Lead "Committee"	Strategic Risk	Contributory factors and associated controls	Risk Appetite / target
		➢ Oliver McGowan training; ➢ Menopause awareness; Inhibiting factors: • Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending. Mitigations include: ➢ Compliance with NOF requirements (and any performance criteria agreed with NHSE). ➢ Development / implementation of "new ways of working".	
3. Delivering the financial plan. **CM** **Finance and Performance Committee**	• If the Trust is unable to deliver its financial plan • Then it will lead to regulatory intervention and impact on future investment • Resulting in the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc	• Delivery of efficiency plans / cost improvement programmes. • Productivity gains, including improved theatre productivity. • Temporary staffing controls, including bank and agency. • In Job / out of job plan – reduction to no more than 20% than total activity. • Delivery of activity plans for NHS and private patients. Plus: • Development of a financial strategy for development of the veterans' centre. Inhibiting factors: • Additional saving / efficiency requirements imposed in-year. Mitigations include: ➢ Compliance with NOF requirements (and any finance-related performance criteria agreed with NHSE). ➢ Scenario planning for in-year changes to the plan. • Industrial action. Mitigations include: ➢ Contingency planning for staff shortages.	Finance Open: 9
4. Delivering the required levels of productivity, performance and activity. **MC** **Finance and Performance Committee**	• If the Trust does not have sufficient capacity to deliver the activity plan within agreed resourcing levels • Then it will be unable to address waiting list targets and will face a shortfall in income / fail to deliver the financial plan • Resulting in increased waiting times; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from system partners / regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust's ability to act independently in pursuit of its objectives).	• Accurate planning assumptions. • Delivery of the new theatre build. • Clinical engagement / leadership. • Successful implementation of the EPR. • Recruitment & retention, including focus on key roles / "pressure points" that drive activity. • Development of system-wide MSK service. • Effective processes and pathways to maximise efficiency / productivity. • Implementation and consistent application of e-job planning. • Intensive waiting-list management processes, including effective validation. • Increasing the proportion of activity delivered within job plans. • Constructive engagement with STW / other partners. Inhibiting factors: • Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending. Mitigations include: ➢ Compliance with NOF requirements (and any performance criteria agreed with NHSE). • Industrial action. Mitigations include: ➢ Contingency planning for staff shortages.	Quality Cautious: 6 Finance Open: 9

Attachment B: BAF themes, associated strategic risks and contributory factors

Themes / LEAD EXEC Lead "Committee"	Strategic Risk	Contributory factors and associated controls	Risk Appetite / target
5. Delivering innovation, growth and achieving systemic improvements. **RL** **Digital, Education, Research, Innovation and Commercialisation Committee**	• If the Trust does not have the required infrastructure / capacity / expertise to support innovation / growth; or governance processes / funding regimes place constraints on the Trust's ability to act • Then it will not be able to identify / pursue opportunities to innovate, develop commercial opportunities and deliver systemic improvements • Resulting in a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services).	• Workforce development / engagement. • Effective clinical engagement / leadership. • Effective plans to support recruitment / retention / skills mix. • Delivery of finance and activity plans / reduction in waiting lists. • Development of system-wide MSK service (as BAF 6). • Plans for building upon the elective surgery hub / paediatric hub status (as BAF 6). • Developing services with Welsh providers (as BAF 6). • Strategic alliances with specialist orthopaedic providers (as BAF 6). • Developing veterans / military support services, including rehab services (as BAF 6). Plus: • Approval and delivery of a digital / data strategy. • Approval and delivery of an income growth / commercialisation strategy (including private patients). • Approval and delivery of a research strategy. • Approval and delivery of an innovation strategy. • Approval of an education strategy. Inhibiting factors: • Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending. Mitigations include: ➢ Compliance with NOF requirements (and any performance criteria agreed with NHSE).	Quality Cautious: 6 Finance Open: 9 Reputational / Regulatory Open: 9
6. Responding to opportunities and challenges in the wider health and care system. **SK** **Board of Directors**	• If the Trust does not strengthen its joint-working arrangements with partners governance processes / funding regimes place constraints on the Trust's ability to implement such arrangements • Then it will not maximise opportunities to address health inequalities; improve outcomes / services for patients; support national and system priorities; enhance staff experience; or deliver efficiencies • Resulting in lost opportunities to contribute to the delivery of national and local objectives; potential loss of accreditation status; and potential failure to achieve NHS oversight framework targets (leading to burdensome reporting requirements and/or enforcement action / constraints on the Trust's ability to act independently in pursuit of its objectives).	• Provider collaborative arrangements within STW. • Strategic alliances with specialist orthopaedic providers. • Plans for building upon the elective surgery hub / paediatric hub status. • Developing services with Welsh providers. • Developing veterans / military support services, including rehab services. • Workforce strategy and associated plans. • Estates strategy and associated plans. • Constructive engagement with STW / other partners. • Constructive engagement with regulators, including via CQC "keep in touch meetings" etc. Inhibiting factors: • Failure to deliver finance and activity plans / reduce in waiting lists. • Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending. Mitigations include: ➢ Compliance with NOF requirements (and any performance criteria agreed with NHSE).	Reputational / Regulatory Open: 9
7. Responding to a significant disruptive event. **MC / RL / PKF**	• If the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack • Then it will be unable to provide an adequate response to the immediate need and/or maintain	• Critical incident / EPRR / business continuity plans. • Robust critical incident / EPRR / business continuity procedures . • Robust testing / auditing of arrangements for EPRR. • IT security policy / practices. • IT system testing / auditing programme. • IPC policy / practice / training.	Quality Cautious: 6

Attachment B: BAF themes, associated strategic risks and contributory factors

Themes / LEAD EXEC Lead "Committee"	Strategic Risk	Contributory factors and associated controls	Risk Appetite / target
Quality and Safety Committee / Digital, Education, Research, Innovation and Commercialisation Committee	other key services due to unavailability of the required resources / staff • Resulting in potential patient harm, increased waiting times etc	• Strong links with system plans, including mutual aid arrangements.	

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Continued focus on excellence in quality and safety.	BAF 1
IF…	the Trust does not have robust policies, procedures and practices in place to promote the quality and safety of services
THEN…	there is a risk that insufficient organisational focus is placed on the quality and safety of services
RESULTING IN…	increased incidence of avoidable harm and reduction in patient satisfaction

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	
Enhance productivity and value for money	

Risk Appetite and tolerance:		Quality – Cautious: 6	
Assurance Committee:		Quality and Safety Committee	
Executive Owner (strategic lead):		Chief Nurse, Paul Kavanagh-Fields / Chief Medical Officer, Ruth Longfellow	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

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

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Rationale for the current score, including an explanation of any movement:
The Trust has robust arrangements in place but must continue to be vigilant and ensure policies and procedures are adhered to, and safety remains the primary consideration when any developments / innovations are considered.
Rationale for the target score and the plan to reduce the risk:
The Trust is able to reduce the likelihood of this risk through: 1. Having a culture that emphasises the primary importance of patient safety; and 2. Implementing appropriate policies, procedures and working practices that ensure quality and safety.

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance* –** *what is the current level of assurance that this control is in place, and is effective?*
1	Clinical staffing – compliance with safe staffing requirements	Safer staffing / Guardian of Safe Working Hours reports into Quality and Safety Committee	Reduce risks through compliance with national safe staffing requirements.	Strong?
2	Maintenance of robust quality / clinical governance arrangements – development and implementation of quality strategy	Quality Strategy approved at Quality and Safety Committee	Maintaining and promoting quality through an agreed strategy.	Strong / Medium?
3	Maintenance of robust quality / clinical governance arrangements – learning from feedback / patient safety walkabouts	Patient Safety Meeting, reporting into Quality and Safety Committee.	Maintaining and promoting quality and safety through a culture of openness and learning.	Strong / Medium?
4	Maintenance of robust quality / clinical governance arrangements – learning from quality spot checks, incidents / complaints / legal claims etc..	Patient Safety Meeting, reporting into Quality and Safety Committee.	Maintaining and promoting quality and safety through continuous review / learning.	Strong / Medium?
5	Maintenance of robust quality / clinical governance arrangements – learning from deaths	Patient Safety Meeting, reporting into Quality and Safety Committee.	Maintaining and promoting quality and safety through continuous review / learning.	Strong / Medium?
6	Maintenance of robust quality / clinical governance arrangements - Clinical Effectiveness monitoring and reporting arrangements	Clinical Effectiveness Meeting, reporting into Quality and Safety Committee.	Maintaining and promoting quality and safety through continuous review / learning.	Strong / Medium?
7	Maintenance of robust quality / clinical governance arrangements – patient engagement and learning from patient experience	Patient Experience Meeting, reporting into Quality and Safety Committee.	Maintaining and promoting quality and safety through continuous review / learning.	Strong / Medium?
8	Maintenance of robust infection prevention and control (IPC) governance arrangements / training programme	IPC Meeting / IPC BAF reporting into Quality and Safety Committee.	Reduce risks by development of and adherence to robust IPC policies and procedures.	Strong / Medium?

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 1)

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance* –** *what is the current level of assurance that this control is in place, and is effective?*
9	Successful implementation of the EPR	EPR Implementation assurance meeting, reporting into DERIC Committee	Reduce risks through more effective communication of patient information.	Low (as not yet implemented)?
				**initial draft assurance rating, subject to review*

Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that quality / patient safety could be compromised.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any quality-related performance criteria agreed with NHSE). • Self-assessment against the CQC quality statements.

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	tbc				R / A / G?
2					
3					
4					
5					
6					

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Creating a sustainable workforce.	BAF 2
IF…	the Trust does not attract and retain staff with the appropriate skills and values, embrace equality, diversity and inclusion, and be regarded as an employer of choice
THEN…	it will be unable to deliver planned activity and/or promote an inclusive, supportive culture for staff
RESULTING IN…	reduced patient satisfaction; an inability to address inequality of service provision; reputational damage, adversely affecting efforts to retain/recruit staff

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	✓
3	Integrate MSK pathways within and across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	✓
Enhance productivity and value for money	✓

Risk Appetite and tolerance:		Workforce – Seek (risk tolerance at 12)	
Assurance Committee:		People & Culture Committee	
Executive Owner (strategic lead):		Denise Harnin, Chief People Officer / Paul Kavanagh-Fields, Chief Nursing Officer	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	
		Date Last Reviewed by the assurance Committee:	

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

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

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Rationale for the current score, including an explanation of any movement:
The Trust has made good progress in recruiting staff. There will need to be a continued focus on retention, development and innovative utilisation of staff to maximise the benefits of that progress.
Rationale for the target score and the plan to reduce the risk:
The Trust is unable to affect the national shortage in certain specialties or the wider financial pressures on the NHS. It can however reduce the likelihood of this risk through having effective plans and processes in place to: 1. Support the development and wellbeing of the workforce; 2. Attract and retain the required workforce; 3. Make best use of its workforce

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk?* **links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance –** *what is the current level of assurance that this control is in place, and is effective?*
1	"Growing for the future": Effective, targeted recruitment – Trust-wide recruitment strategy / plan	Reporting to People and Culture (P&C) Committee on: • Workforce strategy / plans (including workforce profile); • Recruitment trajectories; • Vacancy rates; etc	Ensure plans are in place to inform recruitment of the required staff to deliver the trust's objectives / statutory duties	Strong / Medium?
2	"Growing for the future": Effective, targeted recruitment - recruitment and retention of clinical staff to ensure appropriate skills mix	Reporting into P&C	Ensure plans are in place to recruit and effectively utilise staff to support delivery (as well as quality and safety)	Strong / Medium?
3	"Growing for the future": Effective, targeted recruitment - Efficient recruitment process	Reporting to P&C on: Recruitment timeline KPIs	Ensure recruitment of the required staff with minimum delay	Strong / Medium?
4	"Growing for the future" / "New ways of working and delivering care": Effective, targeted recruitment - focus on key roles / "pressure points" that drive activity	Reporting to P&C Ctte on: • International recruitment; • "Local" recruitment; • Recruitment plans for Theatres; • Recruitment plans for ???; • Recruitment trajectories; • Vacancy rates;	Ensure recruitment of the required staff to support delivery	Strong / Medium?
5	"Growing for the future" / "New ways of working and delivering care": Retention / staff development initiatives	Reporting to P&C on: Staff retention; Leadership development …	Ensure plans are in place to maintain / improve the retention of staff and promote development	Strong / Medium?
6	"Looking after our people" – staff support networks	Reporting to P&C on: • Staff survey results; • Sickness absence	Maintain / improve retention of staff through improved staff wellbeing	Medium?

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls* –** *what control measures are in place to address this risk? *links to NHS People Plan objectives*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance –** *what is the current level of assurance that this control is in place, and is effective?*
7	"Looking after our people" – cost of living support	Reporting to P&C	Maintain / improve retention of staff through improved staff wellbeing	Strong / Medium?
8	"Looking after our people" – other tbc	Reporting to P&C	Maintain / improve retention of staff through improved staff wellbeing	
9	"Looking after our people" - Support to international recruits	Reporting to P&C on support arrangements.	Maintain / improve the retention of international recruits through offering the required support	Medium?
10	"New ways of working and delivering care": Staff development - Effective "onboarding" / induction process	Reporting to P&C	Maintain / improve the retention of staff	Medium?
11	"New ways of working and delivering care": Staff development - Robust PDR process	Reporting to P&C on compliance with PDR completion	Maintain / improve the retention of staff and promote development	Medium?
12	"New ways of working and delivering care": Staff development – programmes and support arrangements, including: • Career cafes; • Leadership Development Programme; • Apprenticeships etc.	Reporting to P&C on the: • Delivery / development of the development programme (and other initiatives), including staff feedback; • Implementation of an Apprenticeships Policy.	Maintain / improve retention of staff and promote development	Medium?
13	"New ways of working and delivering care": Staff recognition schemes	Reporting to P&C	Maintain / improve the retention of staff	Strong / Medium?
14	"New ways of working and delivering care" / "Belonging in the NHS": Staff engagement / communication, including: • FTSU; • Staff Briefings; • "Question Time"…	Reporting to P&C	Maintain / improve retention of staff and through improved wellbeing and more effective communication	Strong / Medium?
15	"Belonging in the NHS" - EDI initiatives / training programmes, including: • Oliver McGowan training; • Menopause awareness; • Others tbc	Reporting to P&C on: EDS compliance; Training compliance figures.	Maintain / improve retention of staff through improved staff wellbeing	Medium?
				**initial draft assurance rating, subject to review*

BAF Risks, controls and assurances – 2024/25 (BAF 2)

Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to recruit as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE). • Self-assessment against the CQC quality statements. Development / implementation of "new ways of working".

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	tbc				R / A / G?
2					
3					
4					
5					
6					

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 3)

Delivering the financial plan	BAF 3
IF…	the Trust is unable to deliver its financial plan
THEN…	it will lead to regulatory intervention and impact on future investment
RESULTING IN…	the Trust being unable to deliver its objectives, which will have an adverse impact on patient care / patient experience etc

Related corporate objectives:		
1	Deliver high quality clinical services	
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Related system objectives:	
Improve outcomes in population health and healthcare	
Tackle inequalities in outcomes, experience and access	
Support broader social and economic development	
Enhance productivity and value for money	✓

Risk Appetite and tolerance:		Finance – Open: 9	
Assurance Committee:		Finance and Performance	
Executive Owner (strategic lead):		Chief Finance Officer, Craig Macbeth	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

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

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 3)

Rationale for the current score, including an explanation of any movement:
The plan contains a number of risks that will be affected by specific actions. These actions are overseen by the Financial Improvement Group. The risk score should reduce as those actions are delivered.
Rationale for the target score and the plan to reduce the risk:
The financial settlement for the system and the operation of NHS payment regimes are beyond the control of the Trust. The Trust has the ability to reduce the likelihood of this risk through accurate planning, the delivery of efficiencies and potential income growth (though there are resource and regulatory constraints on its ability to achieve those).

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance* –** *what is the current level of assurance that this control is in place, and is effective?*
1	Delivery of efficiency plans / cost improvement programmes.	Reporting into Finance and Performance Committee, informed by Financial Recovery Group.	Improve efficiency	Medium?
2	Productivity gains, including improved theatre productivity.	Reporting into Finance and Performance Committee	Improve efficiency	Medium?
3	Temporary staffing controls, including bank and agency	Reporting into People and Culture Committee	Reduce costs	Medium?
4	In Job / out of job plan – reduction to no more than 20% than total activity	Reporting into Finance and Performance Committee	Reduce costs	Medium?
5	Delivery of activity plans for NHS and private patients	Reporting into Finance and Performance Committee	Maximise income	Medium?
				**initial draft assurance rating, subject to review*

Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Additional saving / efficiency requirements (beyond plan) imposed by regulators during the year.	Increased targets, imposed in-year, would be more difficult to achieve.	Demonstrating delivery / capability, including: • Compliance with NOF requirements (and any finance-related performance criteria agreed with NHSE). Scenario planning for in-year changes to the plan.
2	Potential industrial action.	Reduction in staff availability would reduce the amount of activity (reducing income) and/or increase agency costs.	The likelihood of industrial action is outside the control of the Trust. The impact can be reduced through effective contingency planning.

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 3)

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status***
1	Development of a financial strategy for development of the veterans' centre	Increase income	Tbc	tbc	RED / AMBER (tbc)
2	tbc				
					**initial draft status rating, subject to review*

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 4)

Delivering the required levels of productivity, performance and activity.	BAF 4
IF…	the Trust does not have sufficient capacity to deliver the activity plan
THEN…	it will be unable to address waiting list targets and will face a shortfall in income
RESULTING IN…	increased waiting times; an adverse impact on patient experience, potentially resulting in patient harm; increased scrutiny from system partners / regulators (leading to burdensome reporting requirements and/or enforcement action which reduce capacity and place constraints on the Trust's ability to act independently in pursuit of its objectives).

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	
Enhance productivity and value for money	✓

Risk Appetite and tolerance:	Quality - Cautious: 6; Finance - Open: 9		
Assurance Committee:	Finance and Performance (primarily)		
Executive Owner (strategic lead):	Chief Operating Officer, Mike Carr		
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	n/a	**< >**	4	4
Likelihood	4	3	**< >**	n/a	**< >**	3	2
Total	**16**	**12**	**< >**	**n/a**	**< >**	**12**	**8**

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 4)

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

Rationale for the current score, including an explanation of any movement:
The initial score reflects the position if the situation was unchanged from 2023/4. The agreed / current score reflects the position reflected in the current plan, recognising that even if the plan is successfully delivered this will not reflect the Trust's ambition to improve the position and provide quicker treatment for patients.
Rationale for the target score and the plan to reduce the risk:
The Trust has limited ability to affect the wider demand for services. It can however reduce the likelihood of this risk through: 1. Ensuring its plans are as accurate as possible; 2. Ensuring its activity is delivered as efficiently as possible; 3. Developing / maintaining the necessary infrastructure / workforce to deliver the activity. This target relates to the end of the 2023-28 strategic plan period

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance* –** *what is the current level of assurance that this control is in place, and is effective?*
1	Accurate planning assumptions	Monitoring the delivery of trajectories at Finance and Performance Committee (F&P).	To support delivery and enable early identification of issues that require addressing	Medium?
2	Delivery of the new theatre build	Assurance reporting to F&P	Increase capacity and the volume of activity delivered.	Medium / Low? (as not yet implemented)
3	Effective clinical leadership / engagement	Tbc	To develop effective plans and drive delivery	Medium?
4	Successful implementation of the EPR	Assurance reporting to DERIC, via EPR Implementation Assurance Meeting.	Increase efficiency / productivity	Medium / Low? (as not yet implemented)
5	Recruitment & retention, including focus on key roles / "pressure points" that drive activity	Assurance reporting to P&C.	Increase capacity and the volume of activity delivered.	Strong / Medium ?
6	Development of system-wide MSK service	Reporting and assurance via F&P Committee and Board.	Increase efficiency / productivity / capacity	Medium?
7	Effective processes and pathways to maximise efficiency / productivity	Assurance reporting to F&P	Increase efficiency / productivity	Medium?
8	Implementation and consistent application of e-job planning	Assurance reporting to F&P	Increase efficiency / productivity	Strong / Medium ?
9	Intensive waiting-list management processes, including effective validation.	Assurance reporting to F&P	Increase efficiency / productivity	Medium?

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 4)

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance* –** *what is the current level of assurance that this control is in place, and is effective?*
10	Increasing the proportion of activity delivered withing job plans	Assurance reporting to F&P (see BAF 3)	Increase efficiency / productivity	Medium?
11	Constructive engagement with STW / other partners.	Reporting and assurance via F&P Committee and Board.	To develop effective plans and drive delivery	Strong / Medium ?
				**initial draft assurance rating, subject to review*

Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to recruit as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).
2	Potential industrial action.	Reduction in staff availability would reduce the amount of activity (reducing income) and/or increase agency costs.	The likelihood of industrial action is outside the control of the Trust. The impact can be reduced through effective contingency planning.

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
	tbc				R / A / G

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

Delivering innovation, growth and achieving systemic improvements.	BAF 5
IF…	the Trust does not have the required infrastructure / capacity / expertise to support innovation / growth; or governance processes / funding regimes place constraints on the Trust's ability to act
THEN…	it will not be able to identify / pursue opportunities to innovate, develop commercial opportunities and deliver systemic improvements
RESULTING IN…	a failure to maximise opportunities to improve staff experience, clinical outcomes, patient satisfaction and increase income (which could be reinvested in services).

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	✓
Enhance productivity and value for money	✓

Risk Appetite and tolerance:		Quality - Cautious: 6; Finance - Open: 9; Reputational / Regulatory - Open: 9	
Assurance Committee:		Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee	
Executive Owner (strategic lead):		Chief Medical Officer – Ruth Longfellow	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	n/a	**< >**	4	4
Likelihood	4	3	**< >**	n/a	**< >**	3	2
Total	**16**	**12**	**< >**	**n/a**	**< >**	**12**	**8**

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

Rationale for the current score, including an explanation of any movement:
Work is required to develop the required infrastructure / capacity / expertise to deliver this strategic theme. Failure to deliver it will result in missed opportunities but will have limited impact on the Trust's ability to deliver its current, core service.
Rationale for the target score and the plan to reduce the risk:
This risk is within the control of the Trust to mitigate. There will however be capacity / financial constraints affecting the Trust's ability to pursue these goals.

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance* –** *what is the current level of assurance that this control is in place, and is effective?*
1	Workforce development / engagement.	Reporting via People and Culture Committee (See BAF 2)	See BAF 2	Strong / Medium?
2	Effective clinical engagement / leadership	Tbc	To develop effective plans and drive delivery	Medium?
3	Effective plans to support recruitment / retention / skills mix.	Reporting via People and Culture Committee (see BAF 2)	See BAF 2	Strong / Medium?
4	Delivery of finance and activity plans / reduction in waiting lists.	Reporting via Finance and Performance Committee	Growth into new markets / innovation will be difficult to achieve / prioritise until core services are being delivered in line with NHSE expectations.	Medium?
5	Implementation of effective provider collaborative arrangements within STW (as BAF 6)	Reporting to Board	Improved working within STW partners to improve services / deliver efficiencies etc.	Medium
6	Plans for building upon the elective surgery hub / paediatric hub status (as BAF 6).	Reporting to Board	Improve services and increase income, providing greater resilience to the Trust (and by extension, the STW system)	Medium?
7	Developing services with Welsh providers (as BAF 6).	Reporting to Board	Improved working within Welsh partners to improve services / increase income, providing greater resilience to the Trust (and by extension, the STW system)	Medium?
8	Strategic alliances with specialist orthopaedic providers (as BAF 6).	Reporting to Board	Improved working within specialist partners to improve services / deliver efficiencies etc.	Medium ?
9	Developing veterans / military support services, including rehab services (as BAF 6).	Reporting to Board	Improved working within partners to improve services / increase income, providing greater resilience to the Trust (and by extension, the STW system)	Medium / Low?
				**initial draft assurance rating, subject to review*

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 5)

Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to recruit as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status***
1	Approval and delivery of a digital / data strategy.	Reporting to DERIC Committee	Tbc	Tbc	AMBER?
2	Approval and delivery of an income growth / commercialisation strategy (including private patients).	Reporting to DERIC Committee	Tbc	Tbc	RED?
3	Approval and delivery of a research strategy.	Reporting to DERIC Committee	Tbc	Tbc	AMBER?
4	Approval and delivery of Innovation strategy.	Reporting to DERIC Committee	Tbc	Tbc	AMBER / RED?
5	Approval and delivery of and education strategy.	Reporting to DERIC Committee	Tbc	Tbc	AMBER / RED?
	tbc				
					**initial draft status rating, subject to review*

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

Responding to opportunities and challenges in the wider health and care system.	BAF 6
IF…	the Trust does not strengthen its joint-working arrangements with partners, or governance processes / funding regimes place constraints on the Trust's ability to implement such arrangements
THEN…	it will not maximise opportunities to address health inequalities; improve outcomes / services for patients; support national and system priorities; enhance staff experience; or deliver efficiencies
RESULTING IN…	lost opportunities to contribute to the delivery of national and local objectives; potential loss of accreditation status; and potential failure to achieve NHS oversight framework targets.

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	✓
3	Integrate MSK pathways within and across STW	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	✓
Enhance productivity and value for money	✓

Risk Appetite and tolerance:		Reputational / Regulatory - Open: 9	
Assurance Committee:		Board of Directors	
Executive Owner (strategic lead):		Chief Executive, Stacey Keegan	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	4	4	**< >**	n/a	**< >**	4	4
Likelihood	4	3	**< >**	n/a	**< >**	3	2
Total	**16**	**12**	**< >**	**n/a**	**< >**	**12**	**8**

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

Rationale for the current score, including an explanation of any movement:
This risk is partly within the control of the Trust to mitigate. It is however dependent on the cooperation of partners and may be affected by capacity / financial constraints (on the Trust itself, or on partner organisations).
Rationale for the target score and the plan to reduce the risk:
The Trust is developing relationships within and beyond STW. As noted above, progress is dependent on the cooperation of partners and may be affected by capacity / financial constraints (on the Trust itself, or on partner organisations).

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance –** *what is the current level of assurance that this control is in place, and is effective?*
1	Implementation of effective provider collaborative arrangements within STW.	Reporting to Board	Improved working within STW partners to improve services / deliver efficiencies etc.	Medium
2	Strategic alliances with specialist orthopaedic providers.	Reporting to Board	Improved working within specialist partners to improve services / deliver efficiencies etc.	Medium ?
3	Plans for building upon the elective surgery hub / paediatric hub status.	Reporting to Board	Improve services and increase income, providing greater resilience to the Trust (and by extension, the STW system)	Medium?
4	Developing services with Welsh providers.	Reporting to Board	Improved working within Welsh partners to improve services / increase income, providing greater resilience to the Trust (and by extension, the STW system)	Medium?
5	Developing veterans / military support services, including rehab services.	Reporting to Board	Improved working within partners to improve services / increase income, providing greater resilience to the Trust (and by extension, the STW system)	Medium / Low?
6	Workforce strategy and associated plans.	Reporting via People and Culture Committee (See BAF 2)	To support development of the required workforce to deliver the objectives	Strong / Medium?
7	Estates strategy and associated plans.	Reporting via Finance and Performance Committee	To support provision of the necessary infrastructure to deliver the objectives	Medium / Low?
8	Constructive engagement with STW / Other partners (as BAF 4)	Reporting and assurance via F&P Committee and Board.	To develop effective plans and drive delivery	Strong / Medium ?
9	Constructive engagement with regulators, including via CQC keep-in-touch meetings etc.	Reporting and assurance via F&P Committee and Board.	To provide assurance to regulators and minimise the risk of intervention	Medium?
				**initial draft assurance rating, subject to review*

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 6)

Ref.	**Description of inhibiting factors –** *what additional factors may adversely affect delivery and add to this risk?*	**Potential impact –** *how will this affect the consequence or likelihood?*	**Potential mitigations –** *how might this be avoided / mitigated?*
1	Capacity / capability – including the potential impact of burdensome reporting requirements and/or regulatory intervention, including recruitment "freeze" or constraints on spending.	If resources are constrained, there is a risk that the Trust will not be able to act as planned.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).
2	Failure to deliver finance and activity plans / reduce waiting lists.	Growth into new markets / innovation will be difficult to achieve / prioritise until core services are being delivered in line with NHSE expectations.	Demonstrating delivery / capability through: • Compliance with NOF requirements (and any performance criteria agreed with NHSE).

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	tbc				R / A / G?
2					
3					
4					
5					
6					

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

Responding to a significant disruptive event.	BAF 7
IF…	the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack
THEN…	it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources / staff
RESULTING IN…	potential patient harm, increased waiting times etc

Related corporate objectives:		
1	Deliver high quality clinical services	✓
2	Develop our Veterans service as a nationally recognised centre	
3	Integrate MSK pathways within and across STW	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	

Related system objectives:	
Improve outcomes in population health and healthcare	✓
Tackle inequalities in outcomes, experience and access	✓
Support broader social and economic development	
Enhance productivity and value for money	

Risk Appetite and tolerance:		Quality - Cautious: 7	
Assurance Committee:		Quality and Safety Committee / Digital, Education, Research, Innovation and Commercialisation Committee	
Executive Owner (strategic lead):		Mike Carr, Chief Operating Officer	
Risk Owner (overall managerial lead):			
Date Opened:	01/05/2024	**Date Last Reviewed by the Board:**	n/a
		Date Last Reviewed by the assurance Committee:	n/a

	INITIAL RISK SCORE (BEFORE MITIGATION)	AGREED RISK SCORE (WHEN ADDED TO BAF)	Direction of travel to…	PREVIOUS SCORE	Direction of travel to…	CURRENT SCORE	TARGET
Consequence	5	3	**< >**	n/a	**< >**	3	2
Likelihood	4	4	**< >**	n/a	**< >**	4	4
Total	**20**	**12**	**< >**	**n/a**	**< >**	**12**	**8**

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

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

Rationale for the current score, including an explanation of any movement:
The described risk relates to a lack of adequate plans to respond to potentially disruptive external events. The Trust cannot reduce the likelihood of those external events taking place. It can however reduce the likelihood that such events, should they occur, would result in significant disruption. Technically, having adequate plans in place would reduce the "likelihood" of the risk. As the aim of the plans is to mitigate the impact of potentially disruptive events, it is easier to understand the controls as affecting the "consequence" of the risk.
Rationale for the target score and the plan to reduce the risk:
The Trust is not able to influence external events that could have a significant impact on the Trust. The Trust does however have the ability to reduce the impact such events have on the Trust's ability to operate, whether through protective measures (particularly in relation to IT threats), or through robust plans and procedures to react to such events.

Contributory factors and associated controls				
Ref.	**Description of contributory factor and associated controls –** *what control measures are in place to address this risk?*	**Sources of assurances –** *how does the Board receive assurance on these controls?*	**Intended impact of control –** *how will this control affect the consequence or the likelihood?*	**Level of assurance –** *what is the current level of assurance that this control is in place, and is effective?*
1	Critical incident / EPRR / business continuity plans	Annual external assessment of EPRR, as reported to Q&S	Reduce the impact of a potentially disruptive event through an effective response.	Strong / Medium?
2	Robust critical incident / EPRR / business continuity procedures	Annual external assessment of EPRR, as reported to Q&S	Reduce the impact of a potentially disruptive event through an effective response.	Strong / Medium?
3	Robust testing / auditing of arrangements for EPRR	Annual external assessment of EPRR, as reported to Q&S	Reduce the impact of a potentially disruptive event through strengthening policies / procedures.	Strong / Medium?
4	IT security policy / practices	Regular reporting to DERIC Committee	Reduce the likelihood of a cyber attack or other unauthorised / accidental loss of data through effective controls.	Strong / Medium?
5	IT system testing / auditing programme	Regular reporting to DERIC Committee	Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures.	Strong / Medium?
6	IPC policy / practice / training	Regular reporting to Quality and Safety Committee, via IPC Meeting	Reduce the likelihood / impact of a potentially disruptive event through strengthening systems / procedures / practices.	Strong / Medium?
7	Strong links with system plans, including mutual aid arrangements	Annual external assessment of EPRR, as reported to Q&S	Reduce the impact of a potentially disruptive event through collective learning / provision of mutual aid etc.	Medium?
				**initial draft assurance rating, subject to review*

BAF – Strategic Risks, controls and assurances – 2024/25 (BAF 7)

Additional actions to address gaps in controls					
Ref.	**Description of additional mitigating action –** *what additional actions need to be taken to address this risk?*	**Intended impact of mitigation –** *how will this affect the consequence or likelihood?*	**Owner –** *who is responsible for implementing / overseeing this action?*	**Deadline -** *when will this be done?*	**Status**
1	tbc				R / A / G?
2					
3					
4					
5					
6					

Corporate Risk Summary

Committee / Group / Meeting, Date

Board of Directors, 1 May 2024

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

Report sign-off:

N/A

Is the report suitable for publication:

Yes

Key issues and considerations:

Strategic versus operational risk

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

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

Risk Management Group

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

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

As part of the Trust's wider risk management process:

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

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

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

"Corporate risks" considered by Board committees during April meetings:

Ref	Title	Exec Owner	Oversight Committee/s	Score reported to APR Ctte	Score reported to FEB Ctte	Comment
3027	~~Variable Income Performance linked to Elective Activity Performance~~ Productivity stretch in activity plans not delivered leading to loss of income	Mike Carr	F&P / P&C	16	16	It was agreed at the Risk Management Group that the previous risk be closed and a new risk created. For this report, the revised content is shown in relation to the content of the previous risk. Future reports will report this content under the new risk number.
1511	Compromise to patient data due to cyber attack (Malware)	Simon Adams	DERIC	16	16	This risk reflects a corresponding BAF entry and remains high.
2934	Patient waiting times outside of national targets	Mike Carr	F&P	n/a	16	The current risk description reflects the previous focus on achieving the waiting list reduction targets for 104 weeks, 78 weeks etc. Performance against long waits has been regularly considered at the Committee and good progress has been made against target. Thought is now being given to recasting the risk to focus on the patient experience and the impact of long waits, rather than performance against national performance requirements (as they do not take account of the disparity between English and Welsh waiting targets).
3135	Homecare Pharmacy Services	Mike Carr	Q&S	16	16	This has been reworked since it was last presented to split the clinical and financial elements. The 15 plus element relates to the clinical element (while the financial element has been reduced to a 12)
3078	There is a risk that the tumour service may not be able to maintain delivery	Ruth Longfellow	F&P	16	16	Score remains at 16. Retained on CRR. Unable to appoint as hoped at end of year. Post readvertised - remains high until appointee starts.
3096	~~PACS Procurement Timeline~~ Procurement of trust Radiology systems resulting in unavailability of service	Mike Carr	DERIC	20	16	This risk has been reworked and rescored, resulting in an increase from a 16 to a 20 rated risk.
3097	Insourcing Arrangements - Regulatory Intervention	Craig Macbeth	F&P	15	15	Score remains at 15. Retained on CRR. Situation under regular review and is considered at private Board. Scoring will be revisited to reflect the situation as it develops.

"Corporate risks" considered by Board committees during February meetings, subsequently reduced / closed:

Ref	Title	Exec Owner	Oversight Committee/s	Score reported to APR Ctte	Score reported to FEB Ctte	Comment
2996	Organisational capacity impacting on the effectiveness of Clinical Research	Ruth Longfellow	DERIC	**10**	**15**	This score has been reduced on review (on reflection following the risk management training).
3054	Financial Plan Delivery - Industrial Action	Craig Macbeth	F&P	**8**	**16**	Score reduced and risk removed from CRR.
3056	Non-compliance with Legislation/Guidance Relating to FFP3 Face Masks	Paul Kavanagh-Fields	Q&S	**9**	**15**	Risk reduced to 9. The Trust has procured an external provider to attend site for 15 days to carry out fit mask testing on identified staff. Dates are booked and fit-testing has commenced.
3131	Safe Storage of Medicines – Pharmacy	Dawn Forrest (Exec Owner tbc)	Q&S	**n/a**	**16**	Risk added following review of arrangements by Head of Pharmacy. Storage of excess fluids and flammable products is in breach of best practice and of COSSH guidance. Risk subsequently confirmed as closed.

Potential "corporate risks" currently in development previously reported to the comittees:

Ref	Title	Exec Owner	Oversight Committee/s	Score reported to APR Ctte	Score reported to FEB Ctte	Comment
3007	Diabetic demand into the Orthotics service	Mike Carr	Q&S / P&C	**Tbc**	**n/a**	Risk relating to *Diabetic demand into the Orthotics service* is under development. The implications of this emerging risk are being overseen by the Patient Safety Meeting

Strategic objectives and associated risks:

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

Recommendations:

That the Board NOTE the risks rated at 15 or above, and the movement in risks rated at 15 or above, as considered by the Board Committees during April 2024.

Report development and engagement history:

The Risk Management Group is in operation to ensure appropriate check and challenge of high rated risks.

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

Next steps:

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

Risk Management training will continue, including targeted support to key individuals / teams. The training and Risk Management Policy have been updated to reflect the revised risk appetite.

Policy Approval Framework

Committee / Group / Meeting, Date

Board of Directors, 1 May 2024

Author: Contributors:

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

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

Is the report suitable for publication:

Yes

Key issues and considerations:

According to the Schedule of Matters Reserved to the Board of Directors, the Board is responsible for "Approval and revision of Trust-wide Policy Management guidance".

Policy management arrangements are set out in the Trust's Policy Approval Framework.

Following discussion at recent committee meetings, a number of revisions are proposed to that Framework to provide further guidance on how it should operate. Those revisions include:

- Reinforcing the point that the Board committees' role extends to polices that provide "a set of guiding or governing principles" which meet a number of criteria. In doing so, the revised Framework makes a distinction between:
  1. the sort of high-level policies that should be considered at committee level; and
  2. other, more operational "policies" than might be better categorised as procedures (but are commonly understood as "policies", so to re-categorise them would be a significant, potentially confusing, disruptive exercise).
- Placing a responsibility on the relevant Executive Director to decide which of those two categories a particular "policy" falls under.
- Enabling committees, by exception, to request sight of policies that are initially deemed not in scope of the committee ratification process.

Strategic objectives and associated risks:

The Trust's policies may contribute to the delivery of any of the Trust's, or the system's, strategic objectives.

Recommendations:

That the Board:
APPROVE the proposed revisions to the Policy Approval Framework.

Report development and engagement history:

The Trust's scheme of reservation and delegation places particular responsibilities on the Board and its committees in relation to the review and approval of policies. These responsibilities are reflected in the Trust's Policy Approval Framework. That Framework was last updated in March 2023. The main revisions at that point were to provided clarity on:

1. The role of the Board in approving a small number of core, corporate policies that relate to effective governance. Those policies require ownership at Board level and the Board is expected to be familiar with their content. There are also a couple of policies which are to be approved by the Audit and Risk Committee.
2. The role of committees in ratifying certain policies relevant to their remit. Such policies may be technical in nature and committees do not need to be familiar with their content. Committees do

however require assurance that such policies have been developed in accordance with a robust process.

There was a subsequent request at the Quality and Safety Committee to further review the Framework to clarify which "polices" required ratification at Board committee level. The proposed revisions were reported verbally to the Committee in April. The Committee was supportive of the proposed approach.

Next steps:

Following approval:

1. An updated version of the Framework will be uploaded to the Trust's intranet and communicated to staff; and
2. Reporting arrangements will be implemented to enable committees to perform their functions in line with the revised Framework.

Attachment:

Policy Approval Framework – v13 (with tracked changes visible)

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Title:	Policy Approval Framework		
Unique Identifier:	POL001	**Document Type:**	Policy
Version Number:	132.0	**Status:**	Approved
Responsible Director:	Chief Nurse and Patient Safety Officer		
Author:	Trust Secretary		
Scope:	Trust Wide		
Replaces:	Version 112.0		
To be Read in Conjunction with the Following Documents: (list related policies)	• Corporate Records Management Policy • Equality Impact Assessment Procedure		
Keywords:	Policy, Procedure, SOP, document management		

Considered By Responsible Director:	Chief Nurse and Patient Safety Officer	**Date Endorsed:**	~~03/05/2023~~ 23/04/2024
Endorsed By:	Executive Team	**Date Approved:**	~~25/04/2023~~25/04/2024
Approved By:	Trust Board	**Date Approved:**	~~03/05/2023~~
Issue Date:	~~03/05/2023~~	**Review Date:**	~~03/05/2026~~

Security Level:	**Open Access** X	**Restricted**	**Confidential**

Trust Values

Contents

Version Control Sheet

Record of Amendments to: Policy Framework v12.0				
Section	**Amendment**	**Deletion**	**Addition**	**Reason**
3 and 4	Revisions to numbering			Updated numbering to reflect additional sections.
3.2	Revision to definition			To provide greater clarity
3.3	Revision to definition			To provide greater clarity
3.7			Additional text to cross-refer to key considerations.	To provide greater clarity
3.8			New section on "Subject matter experts"	To define the role of "subject matter experts" in the process.
4.2			Additional text on committees' ability to request additional information / input in the process.	To provide a mechanism for committees to receive assurance on "policies" not normally in scope
4.3			New section on "Other management / advisory / assurance Groups"	To define the role of these groups in the process.
4.8	Revisions to description of Executive Directors' roles			To provide greater clarity.
5.2.1	Revision to cross-reference paragraph number			To reflect changes to numbering
Attachment			Flowchart added	To present the process in an alternative manner.

Record of Amendments to: Policy Framework v11.0				
Section	**Amendment**	**Deletion**	**Addition**	**Reason**
Cover	Revision of title to Policy Approval Framework			To provide clarity on the purpose of the framework
Throughout	Replacing "Policy" with "Framework" when referring to this document.			To avoid confusion between this document and the policies it refers to.
Throughout	Minor formatting and presentational changes			To provide greater clarity.
3.0	Replacing definition of "Matters Reserved for the Board".	Removal of "Document agreed by the Board which formally sets out the matters which it reserves to itself to approve."	Addition of "Matters which the Board has reserves to itself to approve."	To provide a more accurate definition.
3.0			Addition of definitions of "Approval" and "Ratification"	To provide clarity on the respective roles of the Board and committees.

Record of Amendments to: Policy Framework v11.0				
Section	**Amendment**	**Deletion**	**Addition**	**Reason**
4.	Reordering of roles and responsibilities section			To reflect the hierarchy of Board, then Committees, then individual post holders / roles
4	Replacing the previous section on individual committees' roles with revised content.			Reflecting the principles outlined in the revised Framework in relation to "approval" and "ratification".
4.14	Replacing the previous "Document Author" content			Reflecting the Policy Authors' responsibility to provide the committee with the necessary information.
5.1.2	Amendment of "policy style and format" section.	Removal of previous detail on policy formatting.	Sign-posting to the policy / procedure format.	Future-proofing the Framework document and avoidance of repetition.
5.1.4	Renaming the "consultation" section and content.	Removal of previous references to "consultation"	Addition of references to "engagement"	To make a distinction between engagement and consultation.
5.2	Reworking of previous "Policy Ratification" section.	Removal of previous table.	Addition of reference to "Approval" as well as "Ratification". Addition of table that reflects the SORD.	To reflect the requirements set out elsewhere in the Framework.
5.2.1	Revision of "New Policies" section	Removal of "All new policies must be consulted on with relevant staff groups before being submitted to the appropriate ratifying body for ratification."	Addition of "All new policies must be developed in accordance with paragraph 4.14 before submission to the appropriate ratification / approval body."	To reflect the requirements set out elsewhere in the Framework.
6.1	Revision of "Implementation" section			To reflect the requirements set out elsewhere in the Framework.
6.4	Revision of "Training and Dissemination" section	Removal of references to "Training"	Addition of references to "Communication".	
Appendix		Removal of appended "Policy and Procedure" template		Future-proofing the Framework document and avoidance of repetition.
Record of Amendments to: Policy Framework v10.0				
Amendments approved by: Senior Leader Group 19/10/2021				**Date**
Section	**Amendment**	**Deletion**	**Addition**	**Reason**
Page one	Front sheet			Change of titles and dates
Page five	Change of title			
Page five	Update to the Committee names			
Page six	Update to the Committee names			
Page eight	Reporting timeframe			Aligned to the Audit and Risk Committee

Policy Approval Framework

1.0 Introduction

The policies and procedures of the Trust are intended to provide a framework to ensure that the work of the Trust is conducted in such a manner as to enable the organisation to provide world class care and fulfil its statutory and contractual obligations.

All new policies and procedures throughout the Trust will be developed and managed in accordance with this framework. Existing policies and procedures will be amended as they become due for revision and updating.

2.0 Purpose and Scope

2.1 Purpose

This framework has been developed to ensure that all policies have been approved at the appropriate level, are accessible, understandable and are reviewed within defined time periods.

2.2 Scope

This framework applies to all staff that are responsible for developing, drafting and authorising policies.

This policy does not include patient information leaflets, standard operating procedures (SOPs) or other procedures which will be subject to other guidance.

3.0 Definitions

3.1 Strategy

A long term plan to achieve an objective.

3.2 Policy

For the purposes of this approval framework, ~~A~~a policy is a set of guiding or governing principles, which meets all or most of the following criteria:

- It supports the Trust's ~~strategies~~strategic objectives
- It is a governing principle that mandates or constrains actions
- It has Trust wide application
- It will change infrequently and sets a course for the foreseeable future
- It helps ~~to~~ ensure ~~compliance~~ that arrangements are in place to comply with overarching principles, legislation, national policy directives or professional guidance
- It helps to reduce organisational risk

3.3 Procedures

A procedure is a required series of steps followed in a regular order in order to achieve a defined outcome. There are certain technical documents which are largely procedural in nature and are specific to particular activities which are nevertheless referred to as "policies". For the purposes of this approval framework, only "policies" that meet the criteria at section 3.2 require review / approval / ratification at the Board or its sub committees. The key test is whether they establish high-level, "governing principles". Detailed, chiefly procedural, "policies" which support the delivery of such policies should be approved by the relevant Executive Director, on the advice of the relevant subject matter experts.

3.4 Guideline

A guideline is a set of systematically developed standards or rules, which may assist in the decision about how to apply an agreed policy. Guidelines are often used to underpin a policy, and represent good practice.

3.5 Matters Reserved to the Board

Matters which the Board has reserves to itself to approve.

3.6 Approval
The Board or Committee approving the content of a policy.

3.7 Ratification
A Committee confirming that a policy has been developed in accordance with a robust process, reflecting the considerations outlined at section 4.10. The content of that policy should have been agreed by the appropriate advisory / subject matter expert group before presentation for ratification.

3.8 **Subject Matter Expert**
Any individual, or group, that has the expert, technical knowledge to develop and agree the content of a policy.

4.0 Roles and Responsibilities

4.1 Board of Directors
The Board sets the overall strategic direction of the Trust. The Board is responsible for approving core, corporate policies that relate to effective governance. These policies require ownership at Board level. The Board is expected to be familiar with the content of these corporate policies. The Board "approves" such policies.

4.2 All Committees of the Board
Generally, the committees' role is to provide assurance to the Board. The remit of the committees can be very broad and policies relating to that remit may be technical in nature. As such, the committees are not expected to be familiar with the detail outlined in such policies. Committees may seek assurance on the proposed content but the relevant executives are responsible for developing and proposing the content. The committees' role is to seek assurance that all relevant steps have been taken in the development of such policies before it "ratifies" them for adoption by the Trust.

In line with their general responsibilities around providing assurance to the Board, committees may also seek assurance on the existence of, and compliance with, policies that are relevant to their remit. In exceptional circumstances, if a committee requires particular assurance in relation to a particular "policy" not initially deemed to be in scope of this framework, it may request to review (and potentially) ratify that "policy".

4.3 Other management / assurance / advisory groups
There will be numerous fora within the Trust that discuss issues relevant to their area of work. These "subject matter expert" groups play a role in:

- Identifying the need for new policies;
- Developing the content of those policies;
- Keeping existing policies under review, to ensure the content remains valid;
- Proposing revisions to existing policies, as required; and
- Making recommendations to the appropriate Executive Director / committee on the necessary approvals / ratification.

For example:
When ratifying policies, committees will be dependent on the advice of relevant subject matter experts. Groups that report into Board committees have a role in reviewing and agreeing the content of any policies that are submitted to committees for ratification.

Executive Directors will also be dependent on the advice of relevant subject matter experts when considering the need for new policies, or the need for revision of existing policies.

~~4.3~~4.4 Audit and Risk Committee
The Audit and Risk Committee has a particular role in:

- Approving policies relating to counter-fraud and managing conflicts of interest. The committee is expected to be familiar with the content of these corporate policies.
- Reviewing the adequacy of certain policies on behalf of the Board (and making a recommendation to the Board on their approval). These chiefly relate to the corporate policies that are reserved for approval by the Board.

The Committee has an associated role to provide assurance to the Board that the Trust "***complies with its own policies and all relevant external regulations and standards of*** *governance and risk management".*

- Providing assurance to the Board on particular elements of the Annual Report and Accounts and associated financial policies (and making a recommendation to the Board on their approval).

4.5 People and Culture Committee

The People and Culture Committee has a particular role in monitoring and supporting the development of the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.

4.6 Chief Executive Officer

The Chief Executive Officer has overall responsibility for the strategic and operational management of the organisation which includes ensuring that all documents comply with all legal, statutory and good practice requirements.

4.7 Chief Nurse and Patient Safety Officer

The Chief Nurse and Patient Safety Officer is accountable to the Trust Board for ensuring compliance with this framework in all parts of the Trust.

4.8 Executive Directors

Executive Directors are accountable to the Chief Executive for:

- identifying the need for and ensuring the development of~~ing~~ policies relevant to their area of responsibility;
- assessing whether "policies" meet the threshold described at section 3.2 and therefore require consideration at Board / Board committee level;
- approving the content of policies not deemed to meet the threshold described at section 3.2;
- ensuring that these policies are reviewed, kept up to date, and reapproved as required; and
- ~~e~~ensuring the implementation of policies relevant to their area of responsibility.

4.9 Trust Secretary

The Trust Secretary is responsible for ensuring that policies have been through the correct approval procedure and meet the document control requirements before they are posted on the Trust's intranet and that copies of policies are published, filed and archived in accordance with this framework.

4.10 Policy Authors

The policy author must ensure policies have been developed, or revised:

1. With reference to relevant:
    a. Legislation;
    b. Regulatory requirements;
    c. Statutory guidance; and
    d. Good practice.
2. Having taken appropriate expert / professional advice;
3. Having involved the relevant advisory / decision-making groups within the Trust;
4. Having engaged key external stakeholders, where appropriate; and
5. With the support of the relevant senior executive.

4.11 All Staff, Contractors and Students

All staff, contractors and students must comply with the policies which apply to them. This includes temporary and agency staff.

5.0 The Development, Ratification, Publication and Archiving of a Policy

5.1 Policy Development

5.1.1 Executive Lead

The responsible director must determine if a new policy is required, this will include a review of existing documents to determine if an existing document should either be amended or replaced.

5.1.2 Policy Style and Format

All policies should be written in a style which is concise and clear using unambiguous terms and language and follow the Trust's template for policies / procedures (which is available on the Trust's intranet).

5.1.3 Equality

All Policies must be developed in accordance with the Trust's Policy on the Equality Delivery Scheme.

5.1.4 Engagement

Engagement is a key part of policy development. The policy author should identify any relevant stakeholders and their required level of involvement.

5.2 Policy Approval / Ratification

As described at section 3:

- "Approval" equates to the Board or Committee approving the content of a policy.
- "Ratification" equates to a Committee confirming that a policy has been developed in accordance with a robust process.

Policies must be approved / ratified in accordance with the Trust's scheme of reservation and delegation:

Board / Committee	Role
Board of Directors	Approval and revision of Trust-wide Policy Management guidance. Approval of key policies of general application throughout the Trust, including: • codes of conduct • health and safety policy • whistle blowing • business continuity • risk management Approval of any significant changes in accounting policies or practices. Approval of treasury policies, including foreign currency exposure and the use of financial derivatives.
Audit and Risk Committee	Approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Framework. These will include: • Counter Fraud Policy • Management of Conflicts of Interest Policy
Audit and Risk Committee	Review the adequacy of: • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications. • The policies and procedures for all work related to fraud and corruption as required by NHS Protect and best practice. • The policies and procedures promoting an anti-bribery and corruption culture. This will include the "Whistle blowing" and Standards of Business Conduct policies and the Declaration of Interests and Hospitality registers
Audit and Risk Committee	Review the Annual Report and Financial Statements before submission to the Board, focusing particularly on: • The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee; • Changes in, and compliance with, accounting policies and practices
Audit and Risk Committee	Seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management.
NED Remuneration and Appointment Committee	Recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the chair (except in respect of his own remuneration and terms of service) and the chief executive and any external advisers.
People Committee	Monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies.

If it is unclear which Committee is responsible for approving a policy, recommending approval of a policy, or ratifying a policy, the Executive Lead shall make a recommendation to the Executive Team on the proposed review / approval route.

5.2.1 New Policies

All new policies must be developed in accordance with paragraph 4.104 before submission to the appropriate ratification / approval body.

5.2.2 Review of existing policies

Policies will normally be reviewed every three years, unless agreed otherwise when it is approved. It is however conceivable that policies may need updating in the meantime to remain current and in line with national guidance and legislation.

~~If a policy is updated within its review date~~When an existing policy requires review, the following options are available to the author:

1. Minor changes which do not materially change the spirit of the policy can be made with the approval of the responsible Executive Director without recourse to the ratifying body; or
2. If a review results in the identification of material changes to the spirit of the policy or a significant~~n~~ impact on ~~existing processes~~the associated risks, the policy must be submitted to the appropriate ratifying body.

5.3 Publication of a Policy

The policy author is responsible for ensuring the policy, once ratified, is made available for publication on the Trust Intranet. In order to publish a policy, the following must be submitted to the Trust Secretary:

- The new / updated policy
- A copy of the minute confirming ratification
- A completed equality impact assessment

The Trust Secretary will establish procedures for the numbering of policies prior to publication and the filing, retention and archiving of policies that are no longer applicable or have been superseded.

6.0 Implementation and Monitoring of the Policy Framework

6.1 Implementation plan

All new or revised policies should be reviewed and ratified / approved in line with this framework from the date of approval by the Board.

6.2 Communication and Dissemination

This framework will be published on the staff intranet and communicated to staff via the regular corporate communication channels.

Staff can seek advice from their Director or the Trust Secretary if they require further guidance on the development of policy documents.

6.3 Monitoring

Compliance with this policy will be monitored on a rolling basis by the Trust Secretary. As part of the checks which are performed prior to any policy being uploaded onto the intranet, any policy which is not compliant will be returned to the document author for amendment. A summary of policies reviewed / approved / ratified during the year will be provide to the Audit and Risk Committee.

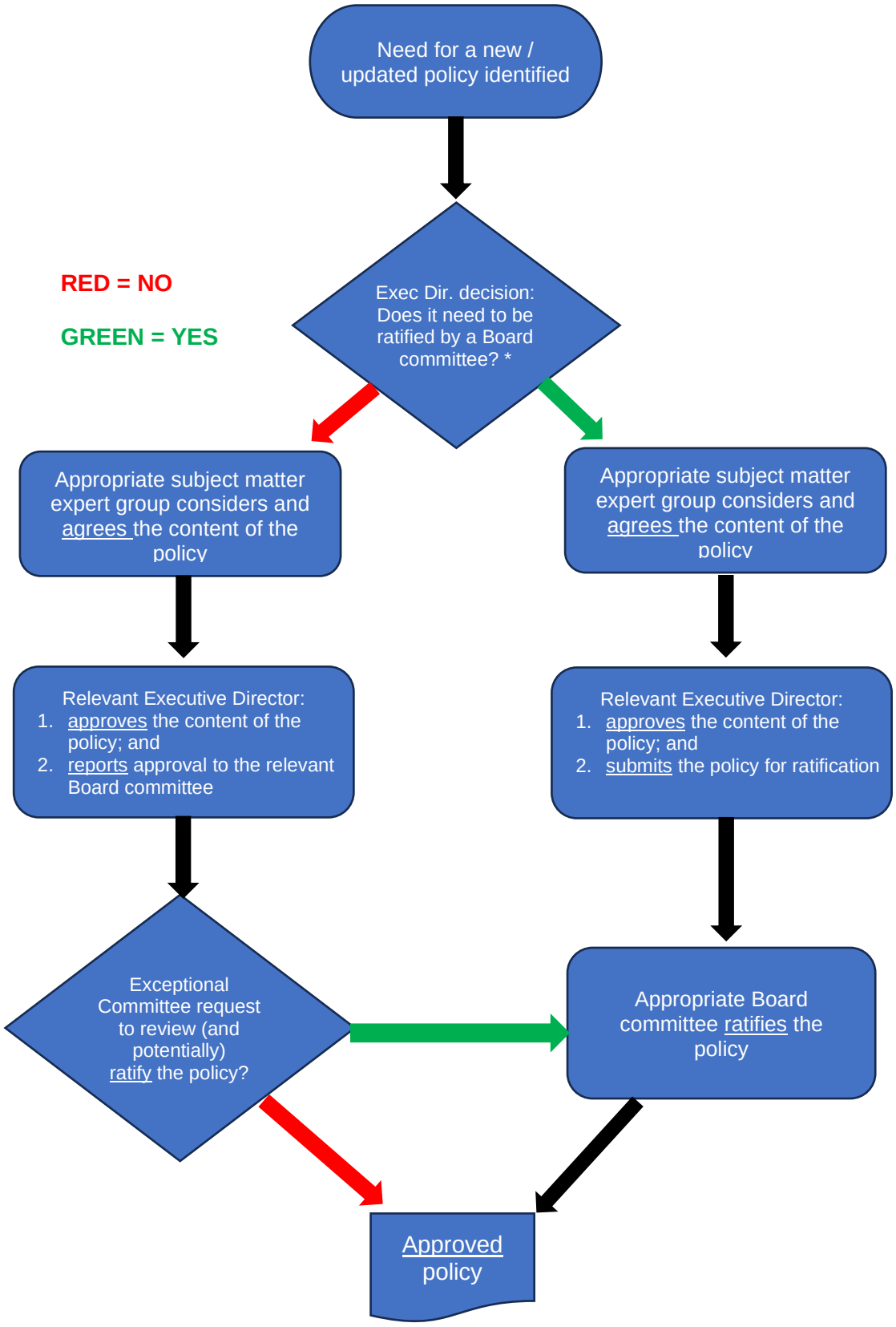
In addition, each ratifying body will receive a report at least quarterly on the status of policies within their remit.

6.4 Review

This framework will be subject to review no later than three years after its approval date.

ATTACHMENT: Policy development / revision flowchart

Attachment: Policy development / revision flowchart



*See sections 3.2 and 5.2.2 for guidance on when a Policy should be submitted for consideration by a Board committee.

Trust Board - Quality & Safety

March 2024 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

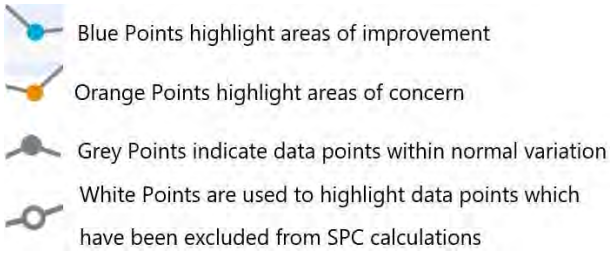
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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

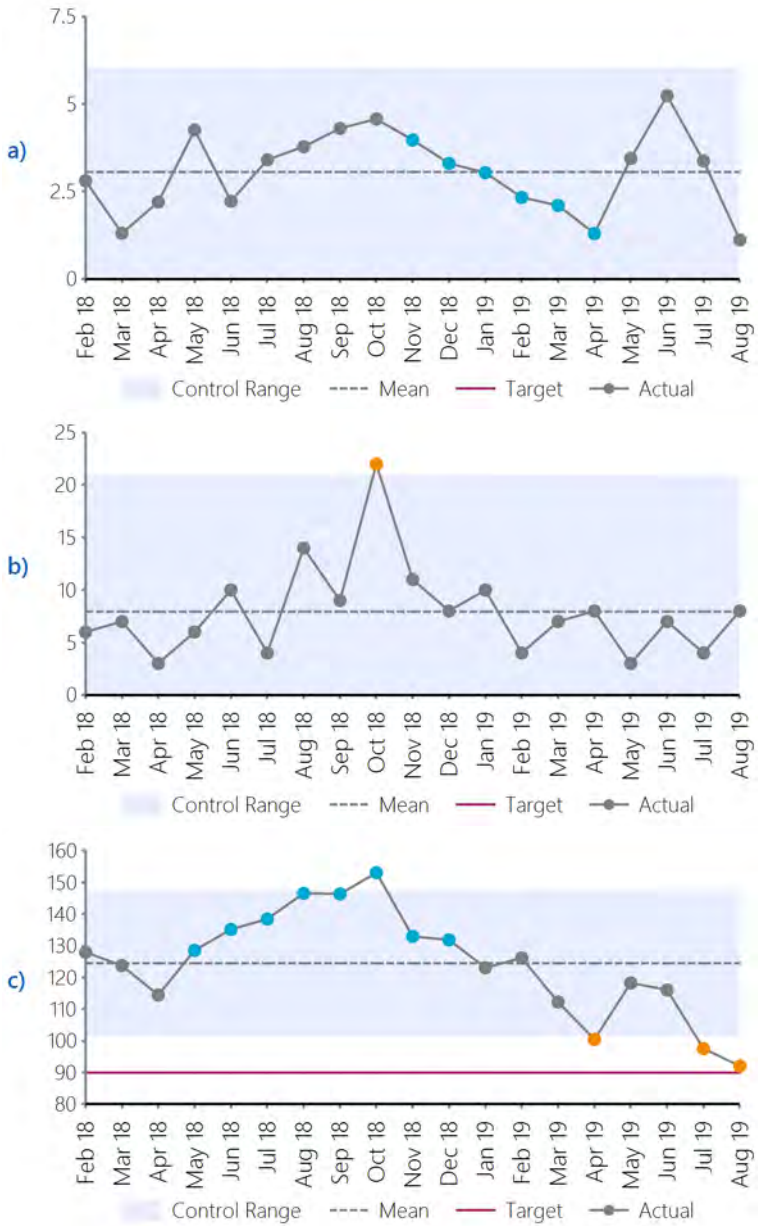


Some examples of these are shown in the images to the right:

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

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

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



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	9			?		04/03/24
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		04/03/24
RJAH Acquired E. Coli Bacteraemia	0	4		N/A to SPC	?	+	04/03/24
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	?		04/03/24
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		04/03/24
Surgical Site Infections	0	0			?	+	04/03/24
Outbreaks	0	0		N/A to SPC	P		04/03/24

Summary - Caring for Patients

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

RJAH Acquired E. Coli Bacteraemia

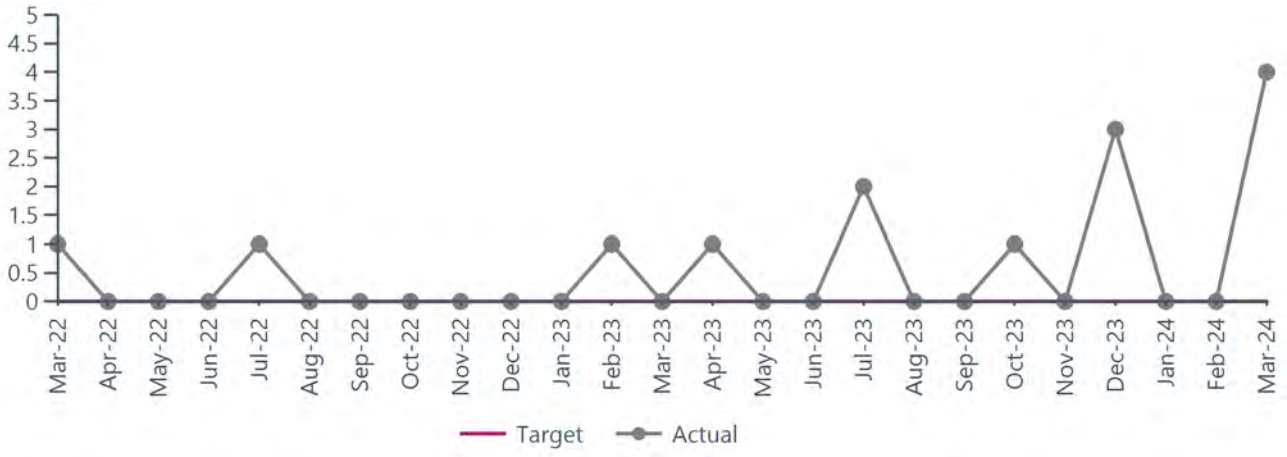
Number of cases of E. Coli Bacteraemia in Month. 211150

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	4	N/A to SPC	?

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

There were four cases of RJAH Acquired E. Coli Bacteraemia reported in March. At time of IPR production, three PIRs have been completed with the fourth scheduled for w/c 15th April.

Actions

The IPC Team will be completing a thematic review of all cases reported throughout 23/24. This will be taken to SNAHP for discussion and decisions on appropriate actions required.

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

Surgical Site Infections

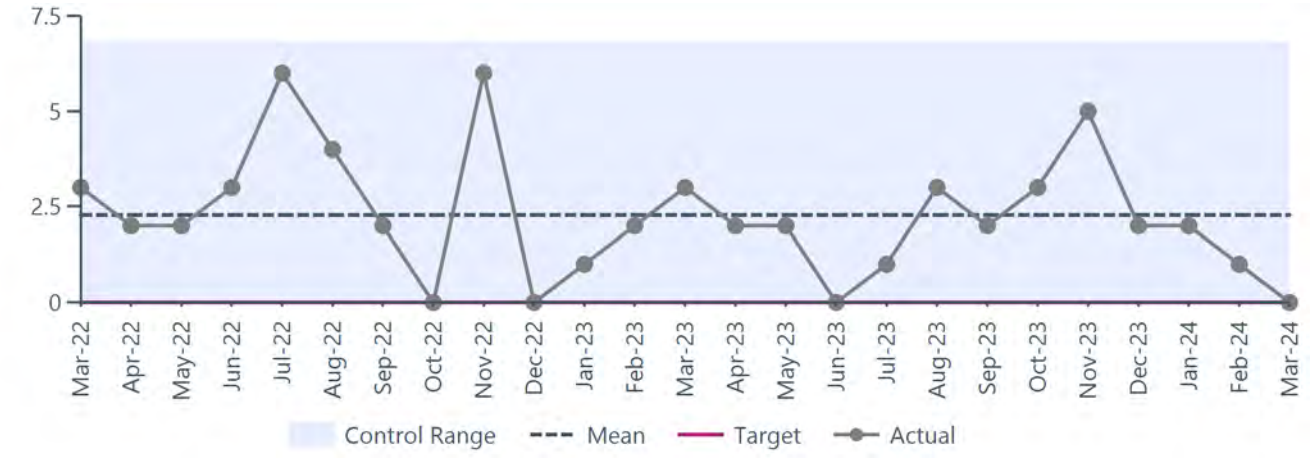
Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

Exec Lead
Chief Nurse and Patient Safety Officer

217727

Target/Plan	Latest Value	Variation	Assurance
0	0		

Trajectory



What these graphs are telling us

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

Narrative

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

There were three infections confirmed in March, these related to procedures that took place in January (2) and February (1). The IPC Team carry out case reviews within 30 days and are compliant with this process.

Actions

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

The IPC Clinical Lead has made enquiries with ROH to arrange a peer to peer review; timescales to be confirmed. The team will also be working with colleagues at ROH to produce some videos on processes within theatres that will be available to support staff.

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

Total Deaths

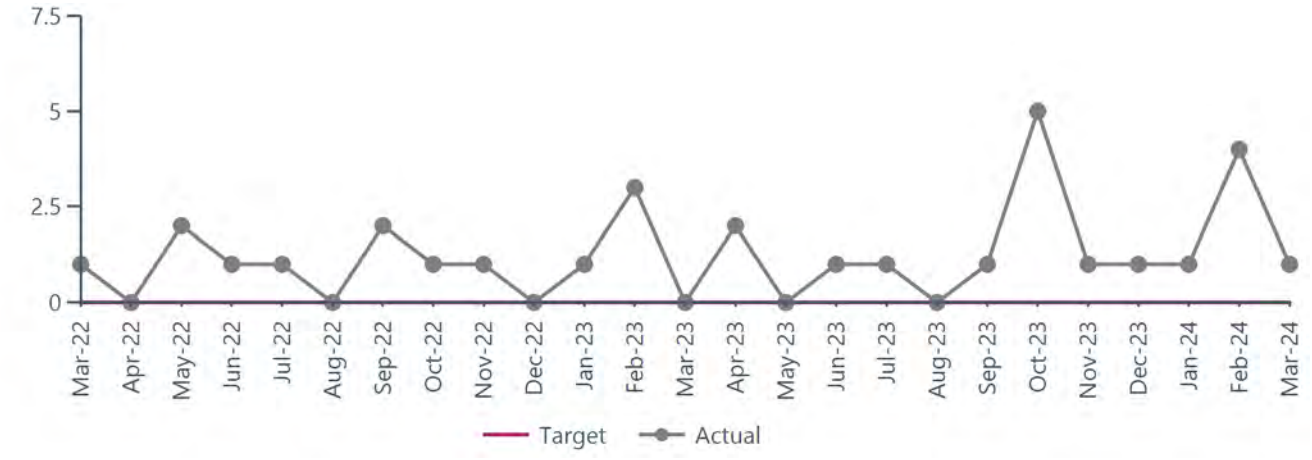
Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

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

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

There was one death within the Trust in March; this has been categorised as an expected death.

Actions

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	2	0	1	1	0	1	5	1	1	1	4	1

Chair's Assurance Report
Quality and Safety Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	01 May 2024
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer / Paul Kavanagh Fields, Chief Nurse and Patient Safety Officer	**Paper written on:**	25 April 2024
Paper Reviewed by:	Lindsey Webb, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

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

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

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

3. Assurance Report from Quality and Safety Committee

This report provides a summary of the items considered at the Quality and Safety Committee on 21 March 2024 and 18 April 2024. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

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

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

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

KPI Proposals 2024/25

The Committee considered and approved the revised key performance indications which are aligned to the quality and safety remit. The Committee requested a review by the Learning from Deaths lead to ensure appropriate KPIs are included..

IPC Theatres

The committee has requested further assurance at the next meeting in relation to variable levels of IPC standards within theatres. Recent leadership appointments have been made with progress noted by the IPC team.

Nursing and AHP Strategy
The Committee endorsed the Strategy and recommended the Board approves the document.

3.2 Areas of on-going monitoring with new developments

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

Corporate Risk Register
The Committee reviewed and endorsed the register ahead of presentation to the Board subject to the following amendments to risk 3135, homecare medicines:

- Agreed the impact on patient experience should be included given the noted increase in PALS concerns raised.
- Greater clarity on how the risk treatment impacted the risk score (including the development of the case of need).

Committee Annual Report and Terms of Reference.
The Committee considered the annual report. Although there were no areas of concern raised, it was agreed that the Chair of the meeting would reflect upon the self-assessment and consider actions to support improved effectiveness of the Committee ahead of presentation to the Board in June.

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

- 16 patient falls (14 low harm / 2 no harm)
- 2 acquired pressure ulcers.
- 2 complaints have been reopened and under review.
- 1 acquired case of klebsiella which was unavoidable.
- 4 deaths reported in February – 2 expected and 2 unexpected.
- 4 E-Coli infections in March reported – RJAH are collaborating with ROH.
- SSIs have decreased since November – case reviews are being completed and it was acknowledged the Trust is complaint with the processes.
- 62 medication errors in February and 41 errors reported in March which is above the tolerance level of 18 – the Trust has established a medical incidents task and finish group. The increased of reported was acknowledged as a positive reporting culture for the organisation. A locum technician has been appointed to support in the interim whilst business cases are processed. The Committee were reassured no patients have come to harm following the incidents.
- 62-day cancer target has not been met
- 2 complaints have been reopened and under review.

The Committee discussed the following to seek further assurance:

- Discharge plans – noted delays and decreased support from community care which has an effect on the Trust. There has been an increase in elective patients with no criteria to reside. This has been raised with the ICB.
- C Diff – the rates have been raised with NHSE as due to the nature of the cases some have been unavoidable.
- Falls – the Committee were informed there is no themes in relation to the patient falls.

HTA Report
The Committee were informed that the Trust are currently focusing on:

- Reviewing the anatomy sector and strengthen the governance processes following changes to guidelines.

- Address the back log of non-conformities biobank which has been recorded on the risk register.
- Governance process of the reporting of the HTA group through the relevant assurance committees is being considered. The Trust agreed to review the Regulatory Oversight Group and present the terms of reference to the relevant meeting in due course.

Legal Claims Q4 Report
The committee were assured with the process in place in relation to the Trusts legal claims. It was noted that 3 new CNST claims have been received within Q4 (2 of which are supported by ELPL claim)

Quality Priorities 2024/25
The Committee agreed the quality priorities for 2024/25 and requested a forward look at quality and safety measures in light of increased activity outlined in the annual plan.

Chair Report – IPC Meeting
Cleanliness within theatre was recently raised as a concern, business cases are being developed to support the request for increased cleaning and the IPC monitoring has increased in the interim. In order to gain further assurance, the Committee requested an IPC paper at the next meeting from the theatre leadership team .

One together and SSI report
The bi-annual assessment has been completed the Trust has reported a 94% compliance rate. There is a requirement to improve the following:

- the perioperative warming aspects and intraoperative patient warming which is being considered.
- the patient experience information which is being circulated is too complicated.
- gaps in processes for reducing the disruption of air flow within theatres and how staff traffic is managed.

The Committee were reassured with the collaborative working with ROH to devise a training video for the theatre staff.
The Committee asked for consideration to be given as to whether there were any themes with patients ie. BMI. It was noted that the themes identified will be shared with the multidisciplinary teams to encourage learning and actions.

3.3 Areas of assurance

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

Clinical Audit Forward Plan 2024/25
The Committee received and approved the forward plan. Assurance was received that the resource for completing clinical audits has improved and there has been a noted increase in clinical engagement. The Committee requested the Clinical Audit annual report for 2023/24 be presented in Q1.

Quality Accreditation
The Trust received a demonstration of the quality accreditation toolkit which has been devised to support the underpinning work in relation to the regulation and compliance of standards. The toolkit is aligned to the pathway of excellence framework for quality, safety and leadership. The ICB offered their support in reviewing from an external preceptive. The Committee commended the work undertaken and asked for a quarterly update on progress.

PSRIF and Patient Safety Improvement Plan
The Committee were assured with the processes in place in relation to PSIRF and improvement plan. It was noted that there have been no PSIs in March or April and actions are being monitored. The Trust agreed to present a Bioknotless Anchor summary once the report has been completed, this is

to include, affected patients, number of harms, admission to theatre and communications with the external providers.

Policy Tracker

The Committee noted the tracker and following a discussion, members of the meeting requested a review of the policy framework which has been tabled for approval.

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

- **Patient Experience Meeting** – The Committee noted the report and there are no concerns to escalate to the Board.
- **Patient Safety Meeting** – The Committee noted the report and approved the revised terms of refence. There are no concerns to escalate to the Board.
- **ICS Committee** – the ICB continue to find the diabetics transformation programme challenging. There remains a focus on long waiters and overdue follow ups however assurance is noted for the long waiters are not being harmed. In April, the Committee were informed that the management of change has commenced within the ICB.
- **Clinical Effectiveness Meeting** - The Committee noted the report and approved the revised terms of refence. There are no concerns to escalate to the Board.
- **Health Inequalities** – two areas of focus were noted as weight management and smoking cessation. An anchor institute self-assessment is to be completed within the next month and therefore the outcomes will be shared at the next meeting (May).
- **Safeguarding** – noted the changes within the structure of the team and commended the Trust after being accredited as a paediatric and adult surgical hub.
- **Drugs and Therapeutics** – the meeting is currently under review following the appointment of the new Chief Pharmacist. The Committee were assured that the incident last year in relation to potential diversion in medication was dealt with promptly and processes have been implemented to safeguard patients. There were no concerns to raise to the Board.
- **Health and Safety** – noted an increased security issues on the MSCI, these issues are linked to aggression and violence from patients, staff are being supported, with an increase in training and mental health support available. The Trust wish to have an SLA with MPFT in the future. The Committee were assured in relation to the fit mask testing risk has been mitigated and dates have been scheduled to complete the testing.

Patient Safety Visits

The Committee welcomed the presentation which outlines the visits completed throughout Q4. There has been positive feedback received following the visits and actions acted upon in a timely manner.

4.0 Conclusion / Recommendation

The Board is asked to:

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

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

A Nursing & Allied Health Professionals Strategy 2024-29

Our Standard is ***Outstanding Care***

www.rjah.nhs.uk

Staff on Kenyon

Dietician with patient

Contents

Researcher in lab

Staff in theatres

Student on Baschurch

Foreword by Chief Nurse and Patient Safety Officer

I am incredibly proud to share 'Our Standard is Outstanding Care' the new RJAH Nursing & AHP Strategy (2024 to 2029).

At RJAH the commitment to delivering excellence in care which is compassionate, innovative, and flexible highlights the unique contribution that Nurses and AHPs make daily. The key organisational Corporate Objectives, no matter the challenges that we face, that underpin the way in which we work, support and care for our patients, their families and each other are:

1. **Deliver high quality clinical services**
2. **Grow our services and workforce sustainably**
3. **Innovation, education & research at the heart of what we do**

We have experienced so much in the last three years. Our expertise, skill, flexibility, and determination to care has been tested more than any of us thought possible. However, we responded, we delivered, and we grew together. It is now time for us to realise our aspirations and potential for all the professions that have been shaped from the learning from our recent experiences.

This learning has been key to shaping the strategy for the next five years. Within this strategy we commit to improve every day, innovate our practice, and celebrate the diversity of our workforce in delivering new services in new ways. Whilst we have individual professional groups who contribute uniquely, when our Nurses and AHPs and support staff come together, they truly shine and do amazing things.

I am particularly pleased that so many of our staff and members of our communities were involved in developing the five commitments at the heart of this strategy. Our strategy aligns with the 'Seven Ps' as set out by Dame Ruth May, the Chief Nursing Office for England, whilst also addressing the more local priorities that our communities need us to address. Our strategy sets the direction of travel for the next five years and I would like to personally thank everyone for their time and energy for their contributions.

Through this strategy I will support the delivery of our commitments and ensure you are supported in the work that you undertake.

I would like to thank our nursing and AHPs who dedicated their time and energy to develop this strategy

Looking at the National picture, our Nursing and AHP strategy is aligned to the Chief Nursing Officer for England seven-point strategy which was designed to enable nurses to deliver the NHS Long Term Plan.

The 7 P's as set out by Ruth May (CNO) in November 2023 are:

1	Protecting our planet
2	Prevention, protection, promotion and reducing health inequalities
3	Person-centred practice
4	Public and patient safety
5	Professional leadership and integration
6	People and workforce development
7	Professional culture

The Allied Health Professionals (AHP) Strategy for England: AHPs Deliver was published in June 2022 and this details five 'Areas of Focus':

1	People First
2	Optimising Care
3	Social Justice: addressing health and care inequalities
4	Environmental sustainability
5	Strengthening and promoting the AHP community

Our commitments are firmly aligned with national and local direction and several strategic documents have been used to inform our commitments.

Our strategy upholds and promotes the key components of the professionalism of our Nurses and AHPs and underpins the therapeutic and trusting relationships necessary for delivering high quality, safe and compassionate care.

RJAH therefore expects all nursing staff demonstrate these qualities and act in accordance with Nursing, Midwifery Council Code (2015) principles of:

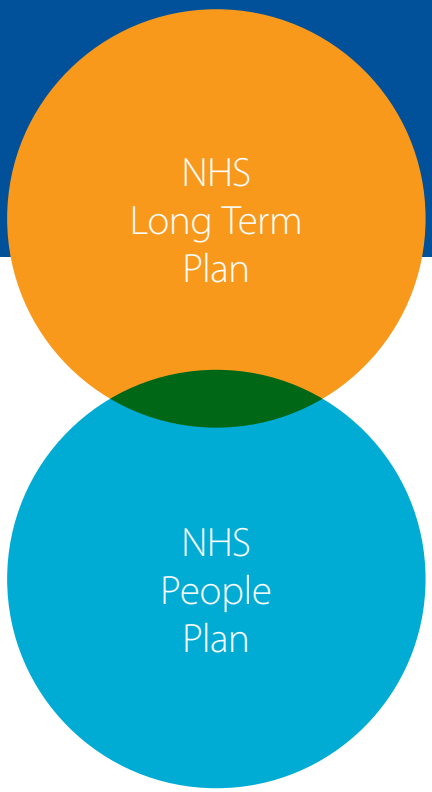
1	Prioritise people
2	Practice effectively
3	Preserve safety
4	Promote professionalism and trust

And all AHP staff to follow the Health and Care Professions Council (2016) standards of conduct, performance, and ethics:

1	Promote and protect the interests of the service users and carers
2	Communicate appropriately and effectively
3	Work within the limits of your knowledge and skills
4	Delegate appropriately
5	Respect confidentiality
6	Manage risk
7	Report concerns about safety
8	Be open when things go wrong
9	Be honest and trustworthy
10	Keep records of your work

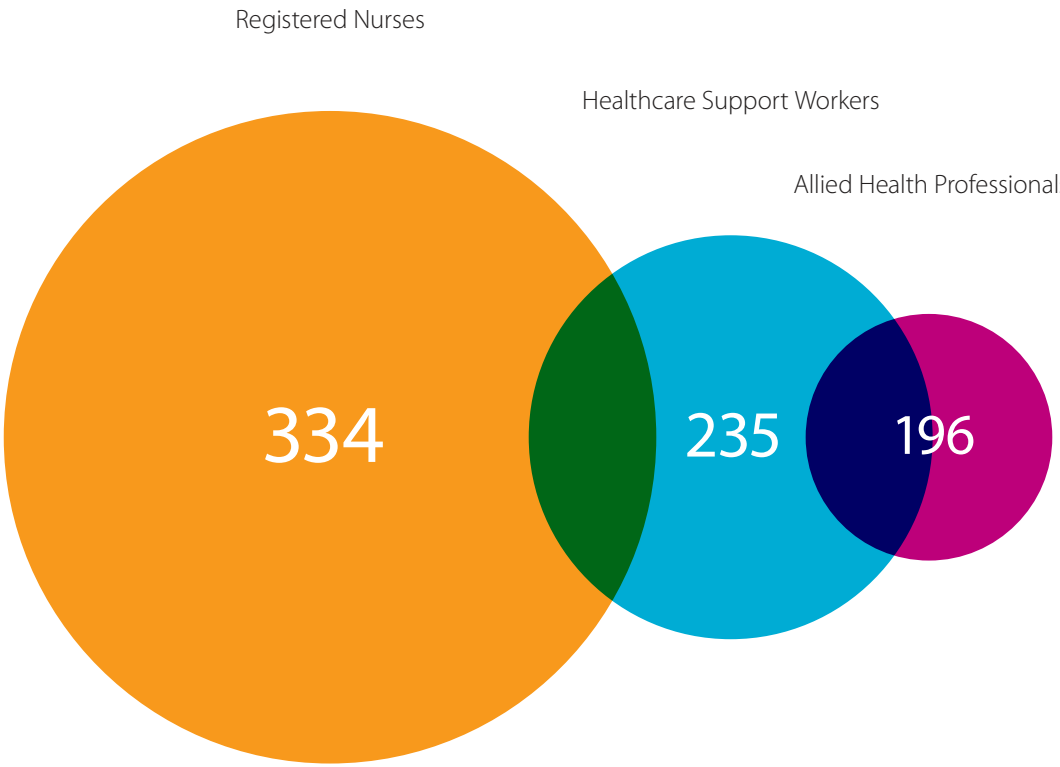
This Nursing and AHP strategy are supported and connected with our:

1	Trust Strategic Objectives
2	Trust Inclusion Priorities
3	Trust Quality Strategy
4	Trust People Strategy
5	Digital strategy
6	Patient engagement and experience strategy



It has also been developed to reflect the national and local policy drivers, particularly:

Who we are . . .



We have a number of diverse Nursing and AHP teams working within RJAH, examples of roles include;

Childrens Nurses

Nursing Associates

Operating Department Practitioners

Radiographers

Adult Nurses

Infection Prevention and Control Practitioners

Safeguarding Practitioners

Physiotherapists

Occupational Therapists

Dieticians

Podiatrists

Speech and Language Therapists

Co-Production

It was important that this strategy was co-produced via engagement with all nursing and AHP professionals in RJAH. All professionals have been encouraged to **engage across multiple platforms** including the Trust intranet. We also specifically attempted to engage those from under-represented groups. The engagement work was done between June 2023 and January 2024:

- Held **four workshops**, covering all localities
- Set up a **'survey monkey'** questionnaire that all staff could contribute to
- Met with or spoke to representatives from **under-represented groups**
- Consulted with **patient groups**
- Engaged with **regional colleagues**
- Studied key **national policy documents**
- Completed a **thematic analysis**
- Held a **Further Engagement Event** to test and refine findings
- **Staff survey**

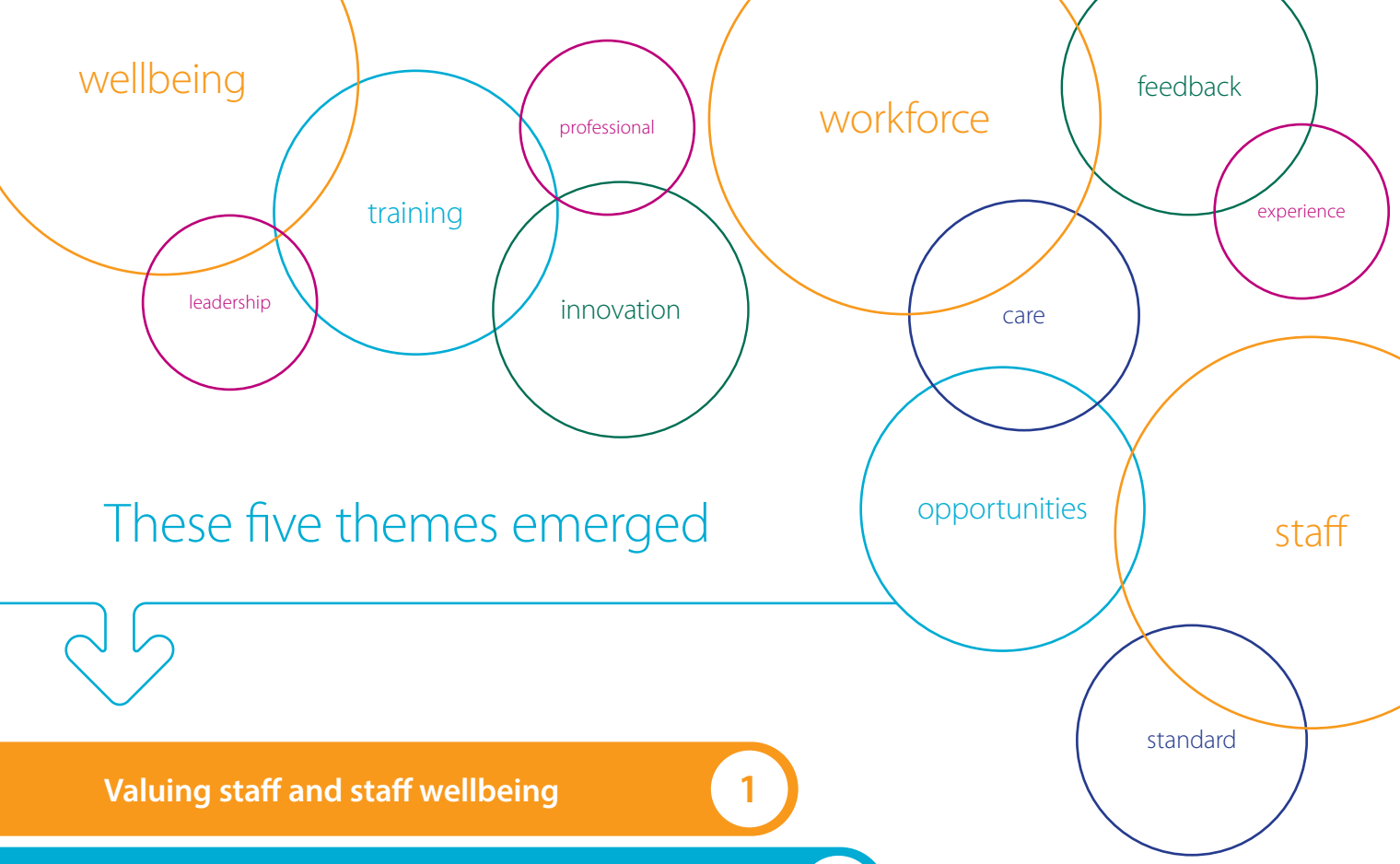
Engagement

6 focus groups with 39 members of staff across all disciplines producing 185 comments

58 survey responses producing 172 comments

Flip charts in Theatres creating 14 comments

Interactive whiteboard generating 22 comments



These five themes emerged

Valuing staff and staff wellbeing 1

Training, development, and education 2

Leadership and a strong professional voice 3

Outstanding quality care 4

Innovation and improvement 5

Commitments

This strategy builds on the **5 themes** and sets a trajectory for achieving our nursing, and AHP ambitions over the next five years. We have identified five commitments for development from listening to our staff and patients:

1. To provide outstanding care
2. Leadership and a strong professional voice
3. Inspiring and innovating
4. Develop and invest in our workforce
5. Well-being and valuing our people

Commitment One: To provide outstanding care	
1	Focus our attention on the delivery of the Trusts Quality Strategy and Quality Improvement Priorities which support us in the aim of delivering safe, effective and harm free care
2	Continue the roll out and embedding of PSIRF
3	Use technology to enhance care delivery
4	Implementation of a quality accreditation programme to drive continuous improvement in patient outcomes and experience
5	Delivering care, which is compassionate, evidence based and minimises harm

We will achieve this through:

- Developing and embedding a Quality Strategy Trust wide.
- Having an open culture where people report incidents and take responsibility for taking action to minimise risks.
- No patient will experience care in an environment shared with the opposite sex unless it is clinically necessary to do so.
- Producing a Nutrition and Hydration Strategy which will include improving the nutrition and hydration status of our patients, through screening and providing interventions when necessary.
- Delivering excellent and compassionate care consistently, reflecting the values of the Trust and our professions.
- Using our quality dashboard and Nursing and AHP quality indicators to make informed decisions that will continue to improve patient care.
- Roll out of the quality accreditation programme to promote and recognise outstanding care.
- Promoting a culture of shared learning, using mortality reviews, events, benchmarking, and positive experiences to inform our working practices.
- Providing patients, their families, and carers with a mechanism to raise concerns at the point of care, allowing for this to be actioned and addressed in real time.

Commitment Two: Leadership and a strong professional voice

1	Comprehensive leadership programmes available for all our Nurses and AHPs
2	Implementation of Shared decision-making councils empowering the voices of our nurses and AHPs
3	Create a culture of coaching, role modelling, engagement, and support
4	Building an inclusive environment to develop a diverse range of leaders

We will achieve this through:

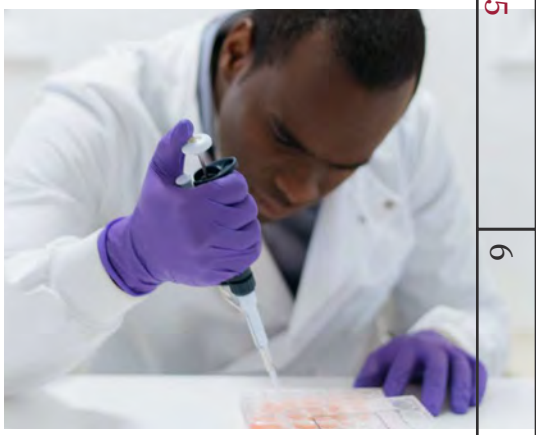
- Monitoring and ensuring professional and behavioural standards and Trust values are aligned with practice on the shop floor.
- Working collaboratively with NHSI and other NHS institutions to develop a best practice toolkit by sharing good practice from our career development pathways.
- Developing and implementing a bespoke Learning and Development Strategy for nursing and midwifery staff across the organisation, including supporting the Chief Nurse Fellow Programme and other models of continuous professional development which support the new models of care.
- Ensuring we have an effective Training and Education Strategy which underpins all the strategy commitments.
- Prioritising learning and supporting a just culture by promoting reflexivity and learning from near misses.
- We will implement plans to improve flexible opportunities for prospective retirees that includes Legacy Mentoring.
- We will continue to provide Health and Wellbeing and career Conversations.
- We will continue to work towards achieving Kite mark recognition for our preceptorship provision.
- We will provide restorative clinical supervision and support for our Nursing and AHP staff by embedding Professional Nurse/ AHP Advocates, signposting to Quality improvement and educational opportunities.

Commitment Three: Inspiring and innovating

1	Work to achieve a culture of Nurse and AHP led research, evidencing the impact of what we deliver
2	Support nurses and AHPs with an interest in clinical academic careers and education
3	Enable our staff to lead and participate in research by working with our Trust research team
4	Spread and share quality improvement capability for all nurses and AHP
5	Celebrating success and showcasing projects

We will achieve this through:

- Developing a Research and Innovation Strategy (aligned to the Chief Nursing Officer for England's strategic plan for research, 2021) that sets out the Trust's research and innovation vision, including how we aim to increase capacity in the field of research and innovation.
- Determine the core competencies, skills and experiences required to become successful research leader and clinical academic in the Trust.
- Developing a 'researcher' career map and framework and integrate a bespoke researcher development mentoring framework to support practitioner development.
- Building collaborative research and innovation partnerships and establish a 'research intern' scheme.
- Expanding our 'researcher -in -residence' model of research and establish a virtual 'applied health research hub' to develop our expertise in applied health research.
- Increasing the visibility of research led by Nurses and AHPs and strengthening structures for our clinical academic career pathway.
- Developing a road map for 'growing -our -own' clinical academic workforce from healthcare assistant right through to clinical academic and consultant level practitioner workforce.



4

Commitment Four: Develop and invest in our workforce through Train, Retain and Reform	
1	To attract and retain talented people with a shared sense of pride and ambition
2	Introduce new roles from Apprenticeships to Advanced Clinical Practice to complement our skill mix and support the changing needs of the population.
3	Develop a clear career framework which inspires and supports our staff at each point of their journey and reflects changing roles and opportunities
4	Providing education and training opportunities – Ensuring equal access to educational funding and an equitable model for protected learning time
5	We are the first choice for work for people in our communities
6	We support our next generation to access routes into health care professions, to develop a sustained future workforce talent pipeline

We will achieve this through:

- Growing a nursing, midwifery and AHP workforce that is resilient and sustainable using regular supervision, annual appraisal and career enhancing development opportunities.
- Partnering with universities, education providers and stakeholders to expand our clinical placement capacity, ensuring a holistic experience of learning for students and a quality environment for learning and practice development.
- Enabling a proactive and systemic approach to workforce expansion and transformation to promote effective recruitment and retention across all clinical disciplines.
- Consolidating the components of career maps projects, including implementation of new roles and the development of a suite of intergenerational career pathways and talent development opportunities.
- Working towards achieving a workforce that is truly representative of our community to help enhance service quality and ensure that the service reflects the needs of all staff.

5

Commitment Five: Well-being and valuing our people	
1	Creating a culture driven by meaningful recognition
2	Showing compassion to our staff as well as our patients
3	Ensuring the maturing workforce are supported to transfer their knowledge skills and expertise into relevant Roles
4	Annual Nursing and AHP recognition awards
5	Enhance staff networks internally and externally
6	Looking after our people - Our people will feel valued, nurtured, supported, and cared for and will recommend us as a great place to work

We will achieve this through:

- We will embed the right culture to improve retention.
- We will continue to embed an approach to enable our people to be physically, mentally, and emotionally healthy and well.
- We will understand and value all the different roles and professions that make up our workforce.
- We will celebrate the expertise of our people and embed celebration of learning, development, and research days.
- We will enable our people to move roles and open opportunity for cross discipline practice.
- We will provide rotational career opportunities, including across system partnership working.
- We will promote return to practice opportunities as part as out standard recruitment processes.
- We will improve our keeping in touch and exit processes.

Pathway to Excellence®

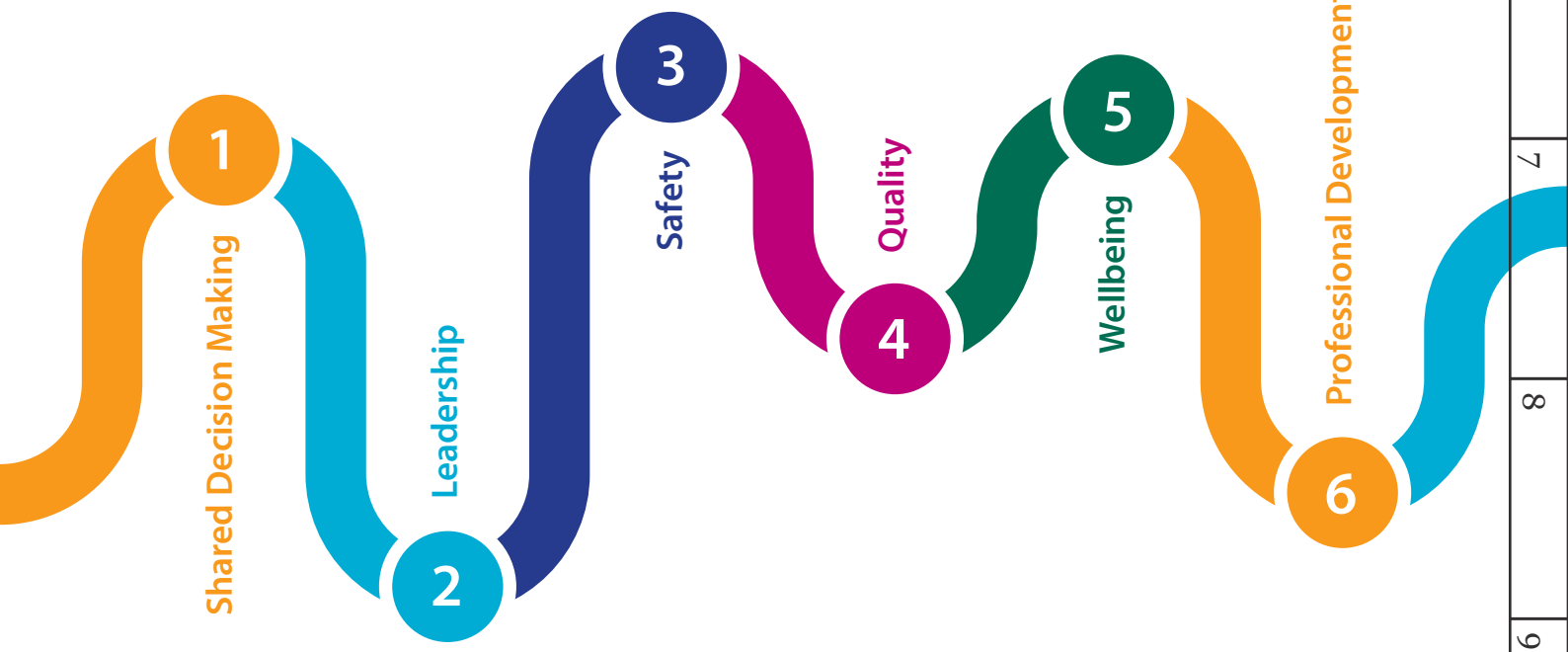
By 2029, our vision is to be the first Trust in STW to achieve Pathway to Excellence® designation.

In 2018, Northampton General Hospital became the first Trust in the UK to achieve Pathway to Excellence® Designation; a vision which is now shared across Kettering General Hospital. Pathway to Excellence® is a framework commissioned by the American Nurses Credentialing Center (ANCC) to accredit organisations which are 'Positive Practice Environments'. The CNO for England, Ruth May, also sees Pathway to Excellence® as an integral part of achieving her vision of Nursing & Midwifery Excellence.

Overview of the ANCC Pathway to Excellence Program | ANA (nursingworld.org)

Over the coming years we are committed to creating a positive working environment for our Nurses, and AHP's. This will enable them to flourish because they experience job satisfaction, professional growth and development, respect, and appreciation. Pathway to Excellence® has been shown internationally to improve recruitment and retention of staff, improve patient experience and reduce preventable harms. We see this as an integral part of enabling our Nurses, and Allied Health Professionals to lead on our commitment of being 'Dedicated to Excellence'. Pathway to Excellence® comprises of 6 Standards which must be embedded within organisations to achieve designation; Shared Decision Making, Leadership, Safety, Quality, Wellbeing, Professional Development.

The ANCC have now expanded their survey requirements to include Midwives and Nursing Associates. Across the Trust we recognise the importance of also hearing AHP voices and their valued contributions to our hospital, therefore, will be working to include these groups as part of our journey to achieve the **Pathway to Excellence®**.



Implementation, Monitoring and Evaluation

The strategy's commitments will be achieved through the delivery of a detailed overarching action plan, identified clear milestones and lines of accountability.

Progress against the actions will be monitored by the commitment leads.

To keep the strategy 'live', embedding the commitments and actions locally will be the responsibility of the senior Nursing and AHP team.

Overall progress on delivery of the strategy will be monitored by the Chief Nurse and Patient Safety Officer.

Progress will be presented regularly through the SNAHP meeting and onwards to People & Culture Committee and Trust Board.

In Conclusion

Our strategy aims to set the outline of what is needed to be the best and support our colleagues across the Trust.

This is a springboard to further our work as a strong multiprofessional clinical workforce,

empowering individuals and teams to respond and lead on the ambitions outlined for the future.

We have been ambitious in our vision for the future, recognising the challenges we may face, some of which are unknown. We are confident that we will rise to meet these with optimism, appreciation and kindness for each other.

Trust Board - People & Workforce
March 2024 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

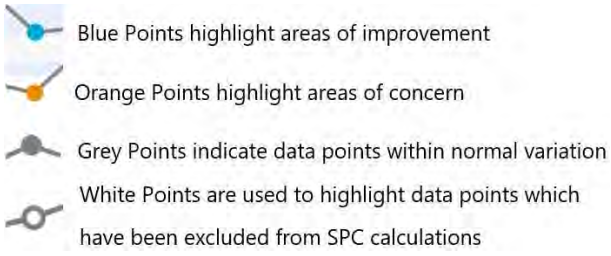
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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

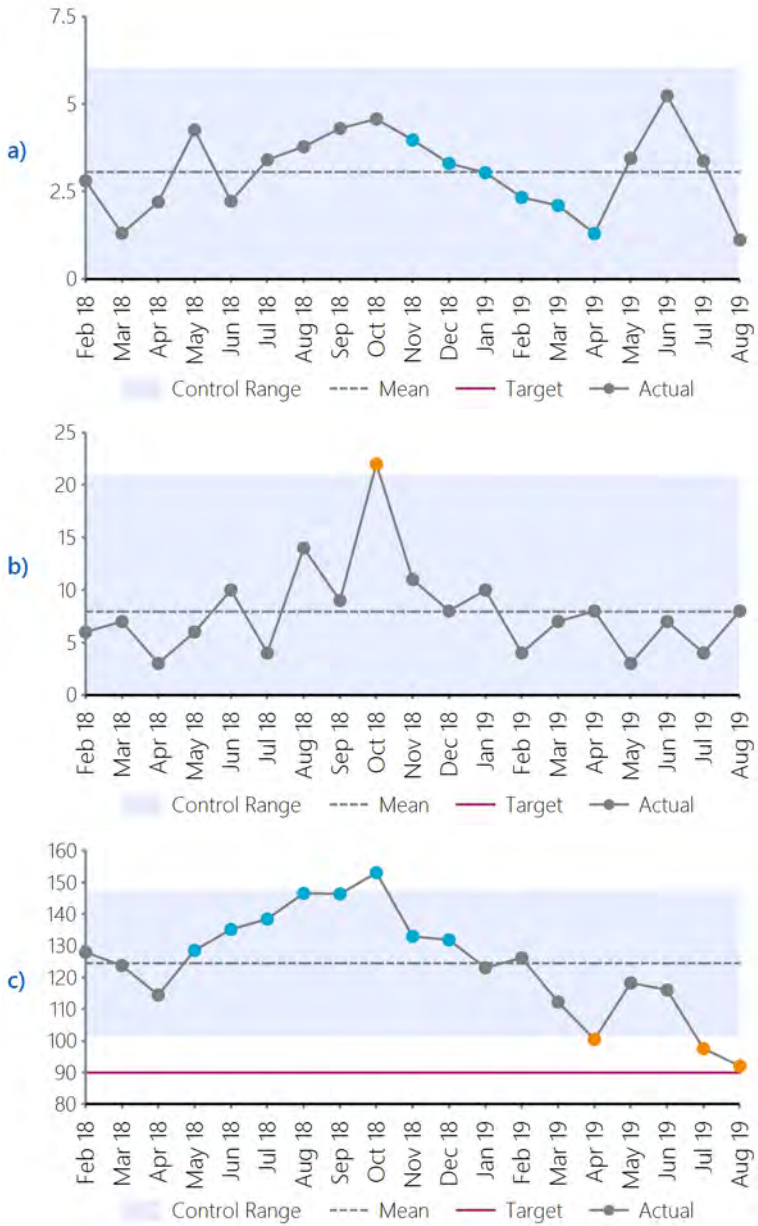


Some examples of these are shown in the images to the right:

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

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

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



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	4.92%	5.31%			Moving Target	+	05/12/23
Staff Turnover - Headcount	10.00%	7.65%			Moving Target	+	
In Month Leavers	10	15			Moving Target	+	15/04/24
Vacancy Rate	8.00%	3.25%				+	15/04/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Core - On Framework	258	255		N/A to SPC	Moving Target	+	
Agency Core - Off Framework	0	41		N/A to SPC	F	+	

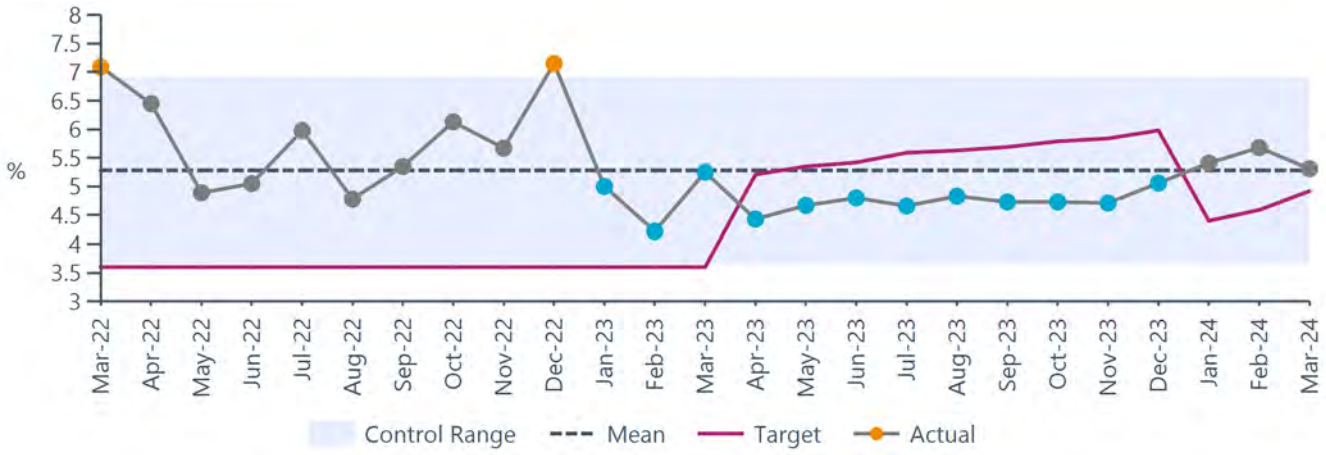
Sickness Absence

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

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
4.92%	5.31%		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The sickness absence rate for March is reported at 5.31%. This rate remains within our normal variation but does remain above target this month. The target forms part of the Trust's operational planning and was profiled in line with historical data.

'Anxiety/stress/depression/other psychiatric illnesses', 'Other musculoskeletal problems' and 'Back problems' remain the top three reasons for absence throughout the month. The hotspot areas for sickness this month were:
* DEXA 25.72%
*Powys Ward 15.36%
* Pre-Operative Assessment Unit 15.33%
* Ward Housekeepers 15.28%
* Therapies T&O Team 14.35%

Actions

Application of sickness absence policy remains a priority of the people team. Resources such as FAQ's and staff sickness leaflets are available on the intranet to support staff, as well as a robust sickness absence policy. Sickness Absence training is available and continues to be encouraged for all managers. Additional training available in April.

Instigation of sickness absence management is highlighted to managers by the People Team, supported by Workforce Information, with assurance being requested at key stages ,and where necessary, People Services Team intervention.

The wellbeing offer is under review as a system. There is emphasis to ensure anxiety/stress/depression is a priority within the offer. The People Services Team continue to support colleagues within the current system offer for anxiety/stress/depression. Focused communication on wellbeing to be issued to staff and managers in April.

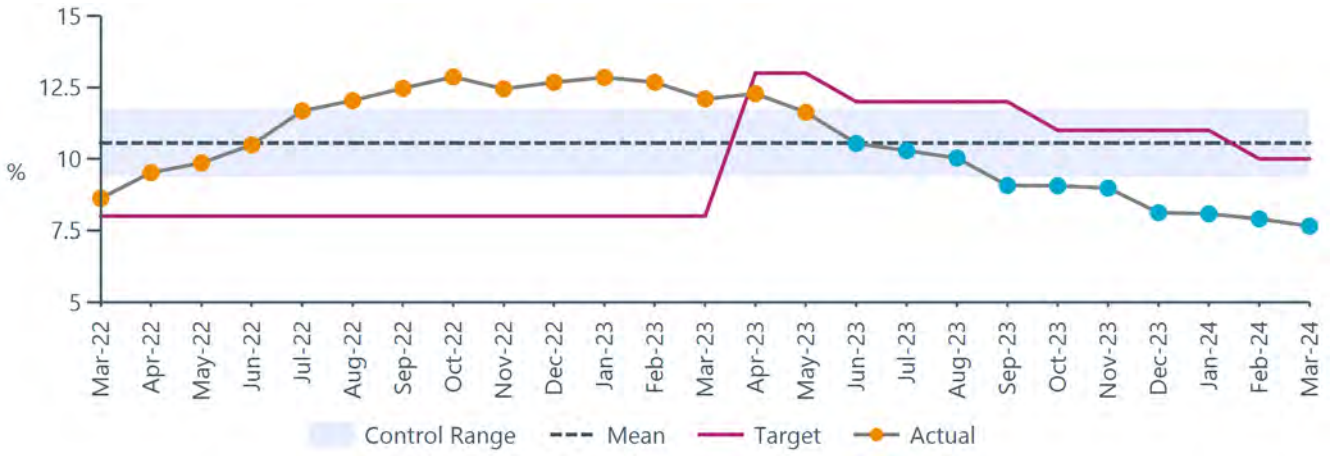
Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
5.25%	4.43%	4.67%	4.80%	4.66%	4.83%	4.73%	4.73%	4.71%	5.06%	5.41%	5.68%	5.31%

Staff Turnover - Headcount

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

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
10.00%	7.65%	L	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Staff Turnover is reported at 7.65% for March and included as special cause variation due to the sustained improvement. As demonstrated on the graph above, this is the lowest reported position over the last two years.

This metric relates to the leavers over the past twelve months. For the period of April-23 to March-24 there have been 138 leavers as a proportion of the month end headcount.

Actions

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
12.10%	12.28%	11.63%	10.54%	10.29%	10.03%	9.07%	9.06%	8.98%	8.12%	8.08%	7.90%	7.65%

In Month Leavers

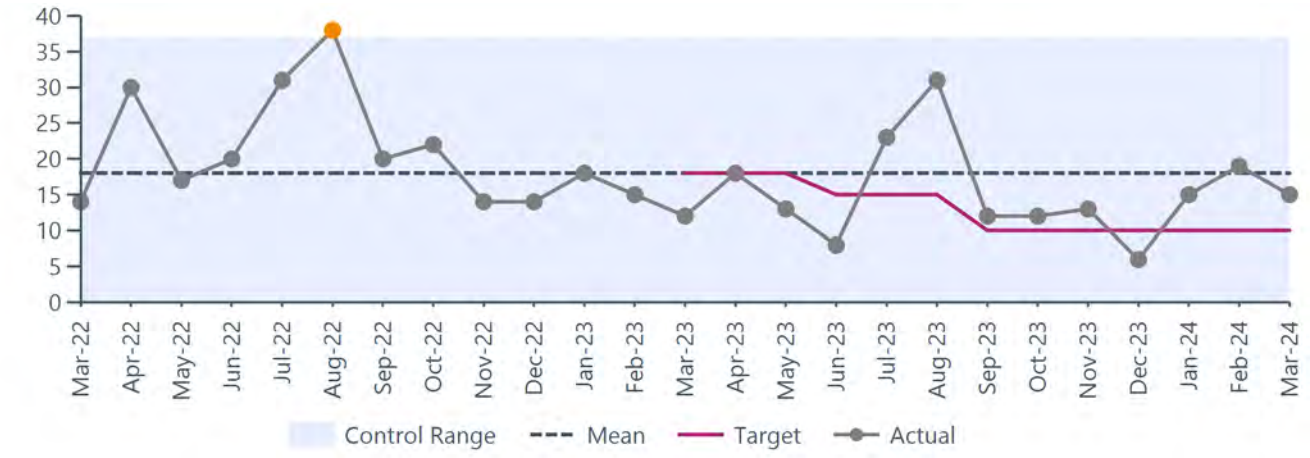
Number of leavers in month 217809

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
10	15		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

Fifteen staff left the Trust throughout March. This metric has been included as an exception as it's now been reported above the target for three consecutive months. The staff that left the Trust in March were from the following staff groups:
* Administrative & Clerical (6)
* Additional Clinical Services (3)
* Nursing and Midwifery Registered (2)
* Allied Health Professionals / Estates & Ancillary / Healthcare Scientists / Medical & Dental - 1 each

The reasons for leaving were recorded as:
* Voluntary Resignation - Other/Not Known (5)
* Retirement Age / Flexi Retirement (4)
* Voluntary Resignation - Relocation (2)
* Voluntary Resignation - Work Life Balance (2)
* End of Fixed Term Contract - Completion of Training Scheme / Voluntary Resignation - Lack of Opportunities - 1 each

Actions

* Trainee Nurse Associates; March-24 cohort compromised due to funding challenges. Revised Business Case to be formulated and presented in Quarter One; awaiting information from NHSE regarding government funding offer that supports this workforce. Risks to programme delivery from University Centre in Shrewsbury with initial resolution meeting taken place. Any risk associated with delivery can be mitigated through alternative providers.
* HCSW Retention; Begin plans for a focus on retention of this staff group within quarter one. This will align with roll out of career progression work (see following point).
* Pathway of career progression for AHP HCSW with competencies for band 2,3,4 posts commenced. Job descriptions to be reviewed. The project has continued to develop, aligning NHSE/HEE HCSW roadmap framework. Career roadmaps are in current discussions with a date of promotion to be confirmed.
* Cross site working, mutual aid and system rotations for Theatre Practitioners now in place. View to further expand as a strategy to support retention.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
12	18	13	8	23	31	12	12	13	6	15	19	15

Vacancy Rate

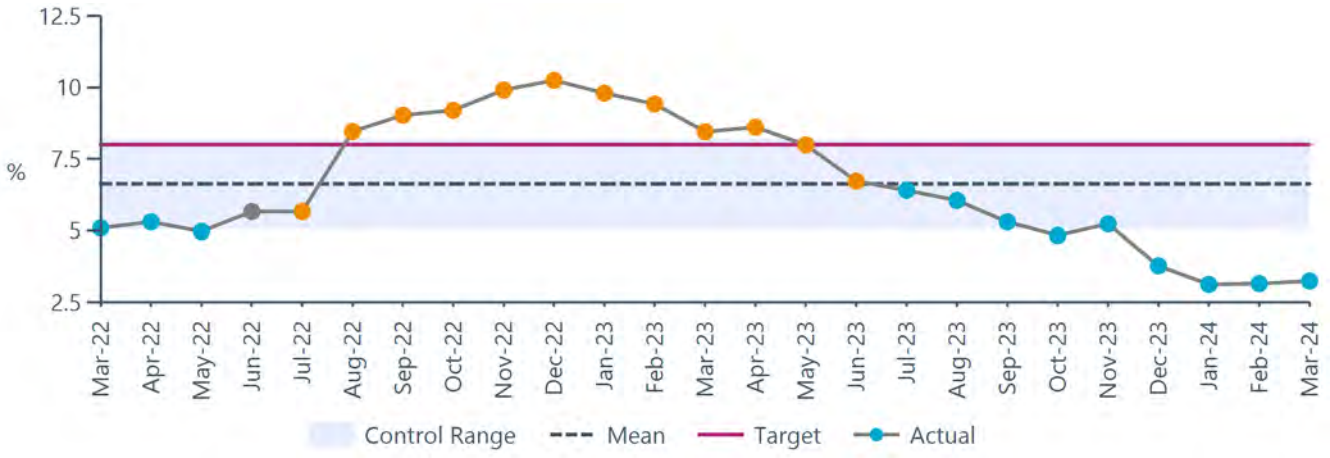
% of Posts Vacant at Month End 211183

Exec Lead
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	3.25%	L	?

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The Trust-wide vacancy rate for March month-end is reported at 3.25%. It is included as an IPR exception due to the graph displaying sustained special cause variation of an improving nature.

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

* MCSI Inpatients - 9.93 WTE vacant, equating to 10.96%
* Anaesthetic Medical Staff - 4.85 WTE vacant, equating to 16.30%
* Kenyon Ward - 4.36 WTE vacant, equating to 16.08%
* X Ray Department - 4.02 WTE vacant, equating to 8.39%
* Orthotics - 3.43 WTE vacant, equating to 10.25%

Actions

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
8.45%	8.61%	7.99%	6.72%	6.40%	6.05%	5.30%	4.83%	5.23%	3.78%	3.13%	3.16%	3.25%

Agency Core - On Framework

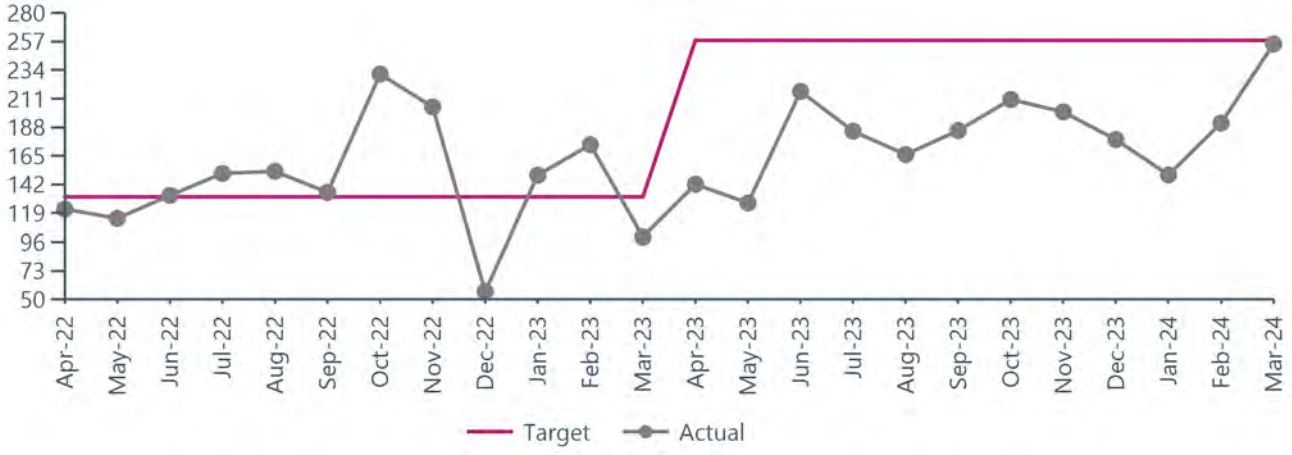
Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency On Framework 217816

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
258	255	N/A to SPC	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

Core agency spend adverse to cap by £38k in month. Increase of £83k from M11.

Actions

Agency deep dive through Financial Recovery Group looking forward to 24/25.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
100	142	127	216	184	166	185	210	200	178	149	191	255

Agency Core - Off Framework

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

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
0	41	N/A to SPC	F

Trajectory

What these graphs are telling us

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

Narrative

Off framework usage at 14%, 4% increase from M11

Actions

Agency deep dive through Financial Recovery Group looking forward to 24/25.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
208	202	122	156	44	64	64	34	29	27	26	21	41

Chair's Assurance Report
People and Culture Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	01 May 2024
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	23 March 2024
Paper Reviewed by:	Martin Evans, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

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

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

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

3. Assurance Report from People and Culture Committee

This report provides a summary of the items considered at the People and Culture Committee on 21 March 2024 and 18 April 2024. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

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

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

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

KPI Proposal

The KPI relating to the Committee were considered and endorsed following the presentation of the proposal for 2024/25. The KPI proposal (in its entirety) is scheduled to be presented for approval to the Board of Directors in May.

Freedom to Speak Up Q4 Report

The Committee were assured with the processes in place to support staff in raising concerns and

that there was a correlation between improvements in reporting routes and the increased numbers of incidents being reported. It was agreed that although there has been an increase in incidents its viewed as positive as staff are becoming more aware and confident to raising concerns, with solutions and improvement being identified. Ther Committee were reassured that there have been no common themes or trends identified. The report was supported for oversight by the Board.

Guardian of Safe Working Hours Q4 Report
The Committee were assured with the processes in place to support junior doctors within their role. It was noted there have been no exception reports within Q4 and only one exception report throughout 2023/2024. The one exception was aligned to a staff member working in North Wales. This remains a challenge for the team however, the Trust actively engages with other providers to prevent this. The report was supported for oversight by the Board.

Staff Survey and Staff Engagement
The Trust received the results in March 2024 and the Committee commended the Trust on the comparison data from 2022/23.

- 907 completed questionnaires (increase from 837 in 2022)
- 52% response rate (median response rate 54%)
- 75.63% recommend the Trust as a place to work *(2022 data – 65.89% increase of 9.74%)*
- Best Result nationally (in benchmark group of 13)
- Q25d Standard of care provided if a friend or relative needed treatment 94.02% *(2022 data – 91.18% increase of 2.84%)*

A staff focus group has been established to support improvement areas following the staff survey. The Committee were assured with the process in place to act upon the feedback including a roll out of a 'you said, we did' campaign. The presentation is scheduled to be presented at the Board meeting in May for oversight.

3.2 Areas of on-going monitoring with new developments

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

Corporate Risk Register
The Committee reviewed and approved the risk register ahead of presentation to the Board. It was noted that an emerging risk will be added to the register for the next meeting, this related to diabetic demand into the Orthotics services.

Development of the Operational Plan 2024/25
In both the March and April meetings the Committee received progress updates on the workforce element of the 24/25 Operational Plan which included carrying out an establishment review which is underway. The Committee were assured the plan progress will be developed within the IPR to allow the Committee to have continued oversight and assurance of the plan. Progress against the plan will be a key are of focus for the committee in May.

Workforce Performance Report
The Committee reviewed the February and March Workforce Performance reports. The following areas were highlighted:

- Long term sickness was reported above target for the fourth month – deep dives into the areas are to be completed. It was noted that the majority of long-term sickness was relating to staff awaiting overdue surgery (highlighting the waiting lists).
- Vacancy rate, staff turnover and professional development reviews remained below the tolerance rate. It was suggested the Trust review the vacancy rate target.
- Training compliance has been maintained since March 2023.
- Personal Development Reviews remain just under target at 90%
- A planned recruitment pipeline (per days) is to be presented to the Committee for oversight in relation to the Theatres department.
- The Committee requested supernumery shift allocation and costing to be included for future reports.

In relation to sickness levels, the Committee requested some benchmarking data to be obtained to provide further assurance.
The Committee also requested for some additional effort to be made to get the Personal Development Reviews to achieve target.
The Committee commended the Trust for their overall positive workforce performance.

Agency Update
The Committee were assured with the actions implemented to support the reduction in agency usage. The unexpected overspend of agency in March was highlighted, and the Committee were reassured that the forecasting tool is being reviewed and utilised to support in increased oversight of spend going forwards.

Theatre Approach Update
The Committee was informed the terms of reference for the review within theatres was completed in March and that some progress has been made. A verbal update was provided highlighting that some areas of improvement have been identified and work has already commenced to embed the changes. The committee have requested a more detailed progress report to include findings, recommendations and actions identified and anticipated performance outputs.

Continuing Professional Development (CPD)
The Committee received the report which offered an overview of the CPD, along with work being completed and recommendation identified to support improvements. The Trust received annual CPD funding to support learning and development of nurses and AHP workers. The Committee noted the report and the proposed next steps.

Committee Effectiveness Annual Report
The Committee received the draft self-assessment survey results and annual report. Although there were no areas of concern highlighted, the Chair of the Committee agreed to review the self-assessment findings and effectiveness questions in further detail prior to presentation to the Board. The Committee will present its annual report and terms of reference to the Board in June for approval.

3.3 Areas of assurance

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

Civility and Compassion Update
The Committee were provided a verbal update on the work being undertaken across the organisation, noting the breadth of training forums available for staff. The Committee requested a written report is presented to the next meeting (May).

EDI Update
The Committee were assured by the work ongoing to support the EDI agenda. Some of the key improvements embedded include, establishing staff network groups, the recruitment of the people promise manger and the 'this is me' event took place which was well received. The Committee asked for the People Promise plan to be presented at a future meeting (once benchmarking data has been completed).

Staffing Establishment Reviews
Following a request from the March meeting, the Committee received a verbal update on the establishment reviews and took assurance from the ongoing progress and work being undertaken. The Committee welcomed a report on the review once completed.

Safe Staffing
The Committee received an overview of safe staffing for February and were assured that the organisation has fulfilled its obligations in relation to nurse safer staffing.
The Committee requested a staff story from an international recruit in relation to experience and wrap around care at a future meeting.

Vacancy Approval Process
The Committee were assured with the robust internal process. In order to gain further assurance, the Committee asked for the detail on the vacancies which have not been approved by the Trust to be presented at a future meeting.

NHS leadership competency framework
The Committee noted the update which provided an overview of the revised framework which has been launched by NHSE earlier this year. The document was presented and noted by the Board members at the private meeting in March.

Case Management Summary
The Committee noted the verbal update on case management and a summary was circulated to the relevant members following the meeting. There were no concerns to raise to the Board.

Chair Reports

- Joint Consultancy Group (March and April) – the Committee noted the report, there were no items of escalation to the Committee.
- Equality, Diversity and Inclusion (March and April) – the Committee noted the report, there were no items of escalation to the Committee.
- Non-Medical Staffing Group (March and April) – the Committee noted the report, there were no items of escalation to the Committee.
- ICS People Committee (verbal update) – there were no items of escalation to the Committee. The structure of the ICB people team was shared to the Committee for information.

Policies
The Committee endorsed the family leave and family pay policy

4.0 Conclusion / Recommendation

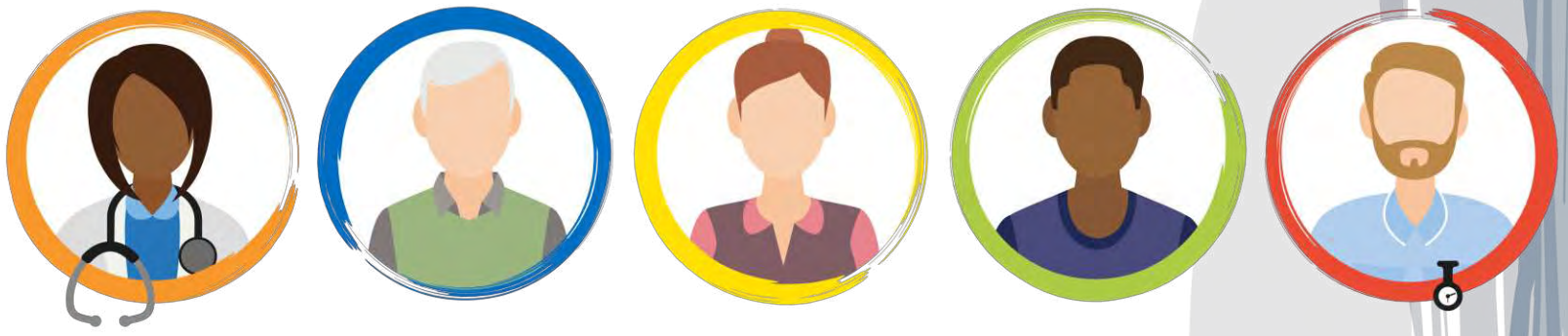
The Board is asked to:

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHS Staff Survey 2023

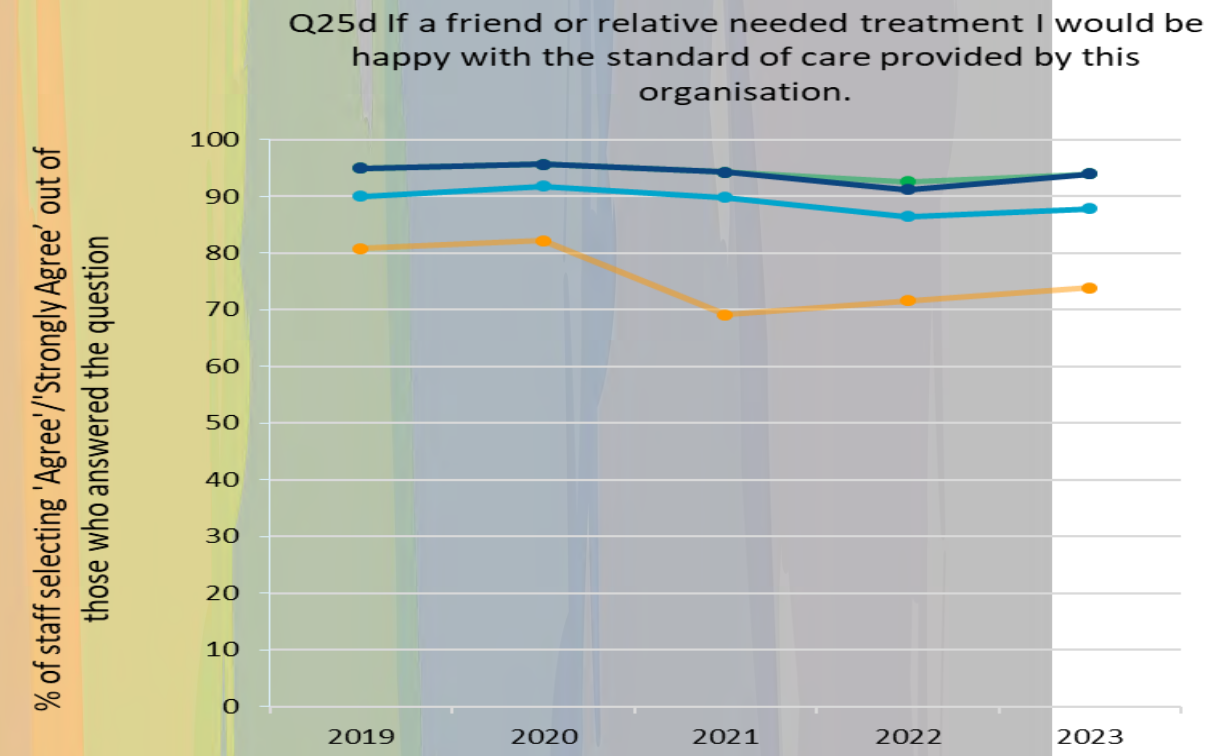
RJAH highlights



Aspiring to deliver world class patient care

Headlines

- Completed questionnaires: **907 (increase from 837 in 2022)**
- Response rate: **52%** (median response rate 54%)
- Recommend the Trust as a place to work: **75.63%**
  (2022 data – 65.89% increase of 9.74%)
- **Best Result nationally (in benchmark group of 13)**
- Q25d Standard of care provided if a friend or relative needed treatment **94.02%**
  (2022 data – 91.18% increase of 2.84%)



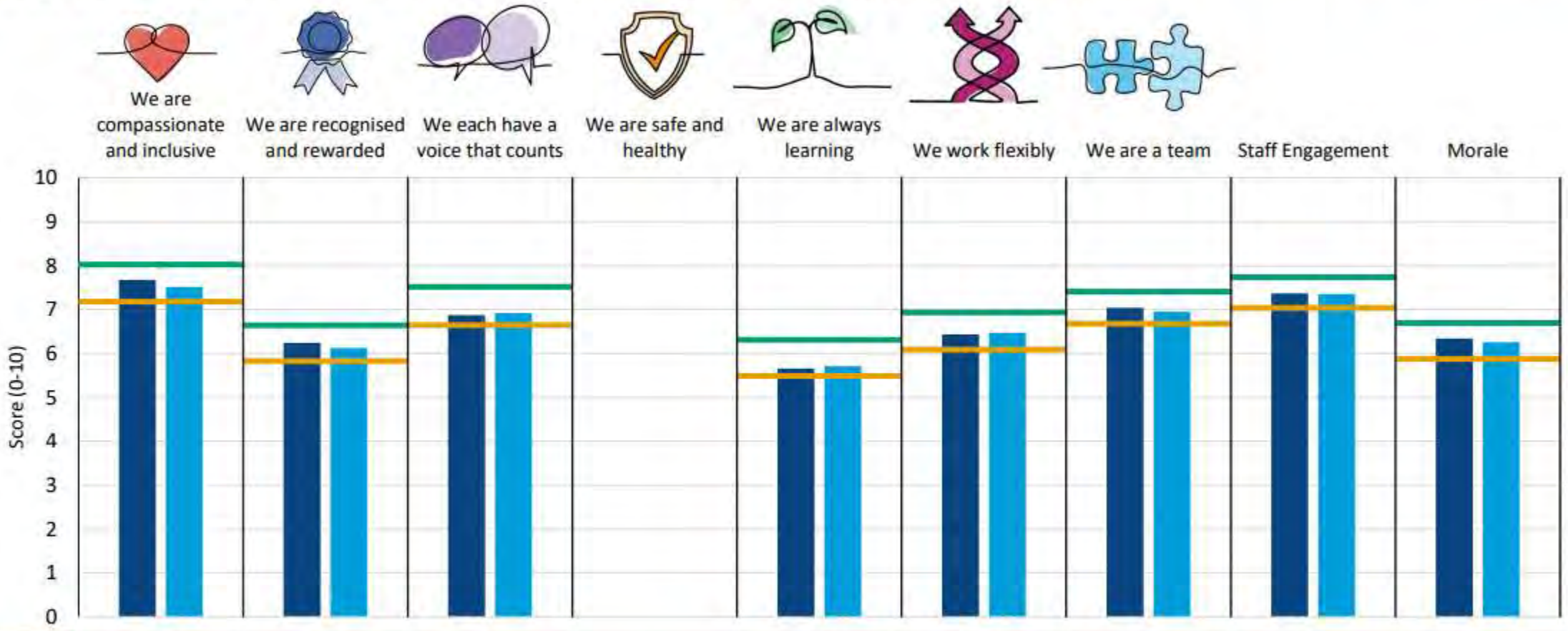
	2019	2020	2021	2022	2023
Your org	94.95%	95.67%	94.25%	91.18%	94.02%
Best result	94.95%	95.67%	94.25%	92.56%	94.02%
Average result	89.98%	91.82%	89.84%	86.42%	87.82%
Worst result	80.84%	82.15%	69.16%	71.58%	73.88%
Responses	929	893	838	833	901

People Promise elements and themes: Overview

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



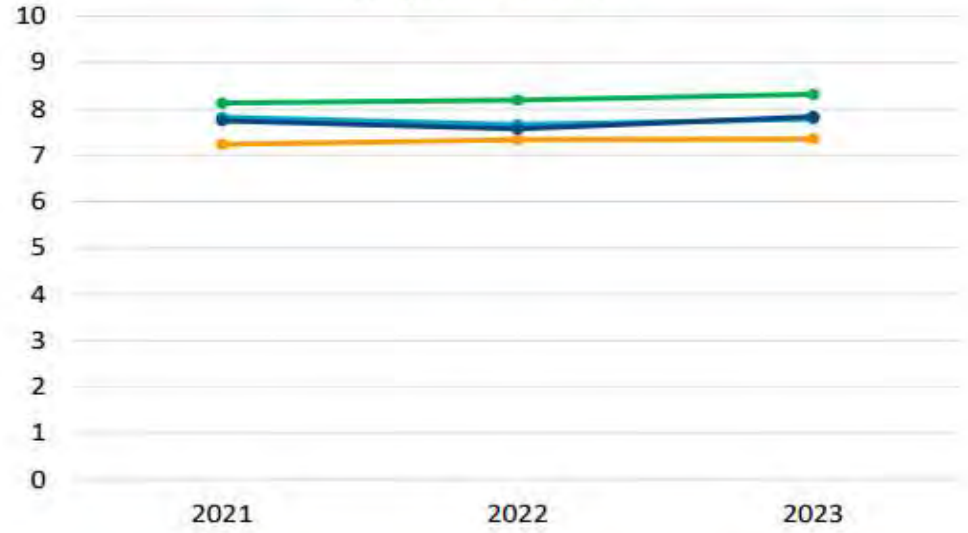
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.68	6.24	6.87	-	5.66	6.43	7.04	7.37	6.34
Best result	8.02	6.64	7.52	-	6.31	6.93	7.40	7.74	6.69
Average result	7.51	6.12	6.92	-	5.71	6.47	6.95	7.35	6.26
Worst result	7.17	5.82	6.65	-	5.48	6.09	6.68	7.04	5.87
Responses	904	904	894	-	872	893	902	904	905

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Compassionate Culture/Compassionate Leadership - 2023

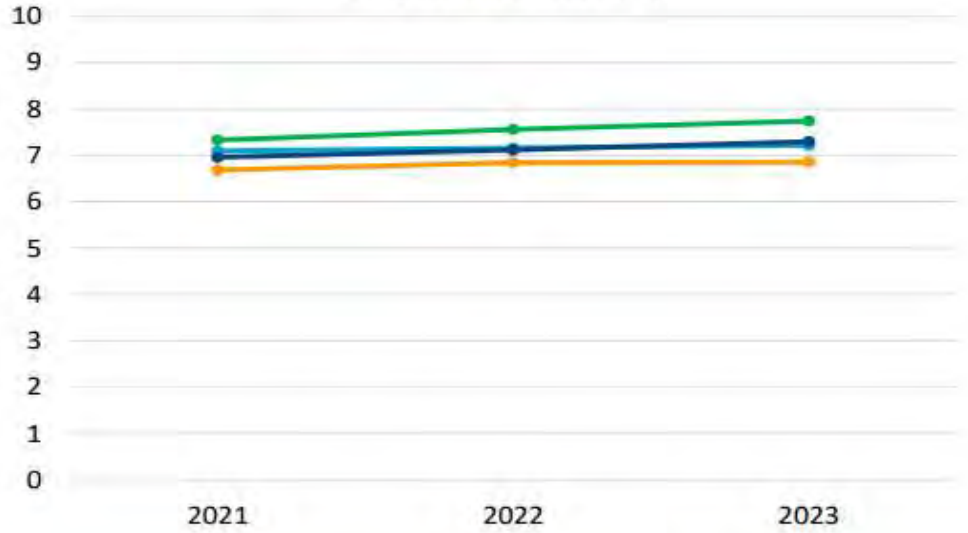
Promise element 1: We are compassionate and inclusive (1)

Compassionate culture



	2021	2022	2023
Your org	7.75	7.57	7.83
Best result	8.12	8.19	8.31
Average result	7.82	7.66	7.78
Worst result	7.23	7.34	7.35
Responses	840	834	902

Compassionate leadership



	2021	2022	2023
Your org	6.96	7.12	7.30
Best result	7.33	7.56	7.74
Average result	7.09	7.16	7.22
Worst result	6.68	6.84	6.86
Responses	839	836	901

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

People Promise Elements and Themes

Question/statement	RJAH result	Average Result
We are safe and healthy : Burnout	5.44%	5.32%
We are always Learning : Development	6.49%	6.61%
We are always Learning: Appraisals	4.79%	4.89%
We are Flexible: Support For Work-life Balance	6.48%	6.51%
We are a Team: Team Working	6.92%	6.81%

People Promise Elements and Themes – Morale

Question/statement	2022	2023	Change
I often think about leaving this organisation.	30.29%	23.52%	-6.77%
I am able to meet all the conflicting demands on my time at work.	41.50%	48.10%	+6.60%
There are enough staff at this organisation for me to do my job properly.	25.71%	37.89%	+12.18%
My immediate manager encourages me at work	73.98%	76.54%	+2.56%

People Promise Elements and Themes – Voice that Counts : Autonomy & Control

Question/statement	2022	2023	Change
I am involved in deciding on changes introduced that affect my work area / team / department.	53.47%	58.45%	+4.98%
I am able to make improvements happen in my area of work.	55.71%	59.03%	+3.32%
I have a choice in deciding how to do my work.	55.02%	57.39%	+2.37%
I would feel secure raising concerns about unsafe clinical practice.	70.65%	69.89%	-0.76%
I am confident that my organisation would address my concern	58.56%	59.10%	0.54%

Questions not linked to People Promise elements: Patient Care

Question/statement	2022	2023	Change
Care of patients / service users is my organisation's top priority	80.60%	82.87%	+2.27%
My organisation acts on concerns raised by patients / service users.	76.68%	77.83%	+1.15%

Areas for attention

➢ *Concerns*

Question/statement	2022	2023	Change
I have unrealistic time pressures.	25.31%	29.94%	+4.63%
Relationships at work are strained.	40.55%	50.53%	+9.98%
On what grounds have you experienced discrimination? - Ethnic background.	24.15%	41.57%	+27.40%
On what grounds have you experienced discrimination? – Disability	9.22%	11.17%	+1.95%
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	57.81%	59.33%	+1.52%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	2.50%	3.05%	+0.55

Significance Testing 2022 vs 2023

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.48	836	7.68	904	Significantly higher
We are recognised and rewarded	5.87	834	6.24	904	Significantly higher
We each have a voice that counts	6.71	827	6.87	894	Not significant
We are safe and healthy	6.15	828	-	-	-
We are always learning	5.38	806	5.66	872	Significantly higher
We work flexibly	6.14	831	6.43	893	Significantly higher
We are a team	6.81	834	7.04	902	Significantly higher
Themes					
Staff Engagement	7.10	836	7.37	904	Significantly higher
Morale	5.89	837	6.34	905	Significantly higher

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

‘Free text’ comments

we should have fewer meetings. Too much of my time is spent preparing for and attending meetings. There is often a duplication of information shared, and an overlap of staff attending the meetings, who were in other meetings. If we spent less time preparing for an attending meetings, we would have more time to do the actual work

I think learning from incidents is a big area the organisation could improve on, too often Datixes are seen as a tick box exercise with the investigation closed and only shared with a few people, rather than learning points being widely disseminated

I've only been here since [date removed], so far it is a lovely place to work, I work with a fabulous team of people who are always ready to help or advise if needed

I feel very lucky to work on our ward and my manager is extremely supportive

The Trust has too many ward closures. Staff are not informed until last minute and are not given a definite re-open date when ward does close, this is very unsettling for staff to keep being re-deployed to different areas

RJAH is a wonderful place to work. I am very happy here

Next Steps

- ***Task and Finish Group*** *– co-produce actions with our staff*
  - *3 Top Themes for Concern*
  - *3 Top Themes of best practice to share*
  - *Use ImproveWell App to capture real time information and feedback*
  - *Work with the focus group and Staff Network Groups, particularly on areas for concern*

Committee / Group / Meeting, Date

Board of Directors Meeting, 01 May 2024

Author: **Contributors:**

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

Report sign-off:

People Committee. 25th April 2024

Paul Kavanagh-Fields Chief Nurse and Executive Lead for FTSU
People and Culture Committee, 25th April 2024

Is the report suitable for publication?

Yes

Key issues and considerations:

This paper is provided as a summary of the Freedom to speak up (FTSU) activity for January – March 2024 quarter 4. The committee is asked to note the content and agree any subsequent recommendations / actions.

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

Key Points: -

This quarter there has been a total number of 24 cases received. Out of these, 8 required advice and 16 were classified as concerns and have been escalated.

2 concerns were anonymous, both referred to attitudes and behaviour. 11 patient safety issues, 8 worker safety concerns, 10 attitudes and behaviour concerns, 3 bullying and harassment concerns and 1 staff member who felt that she had suffered detriment because of speaking up about patient safety.
12 of the concerns were raised to the FTSU Champions and 12 concerns were directly raised to the FTSUG.

When concerns are raised, they may have several different elements. Therefore, the National Guardian Office (NGO) requires that the concerns are recorded across all categories which match the issue. For example, a concern may have elements of patient safety and worker safety.

All concerns were responded to within 48hrs, escalated or signposted as required.

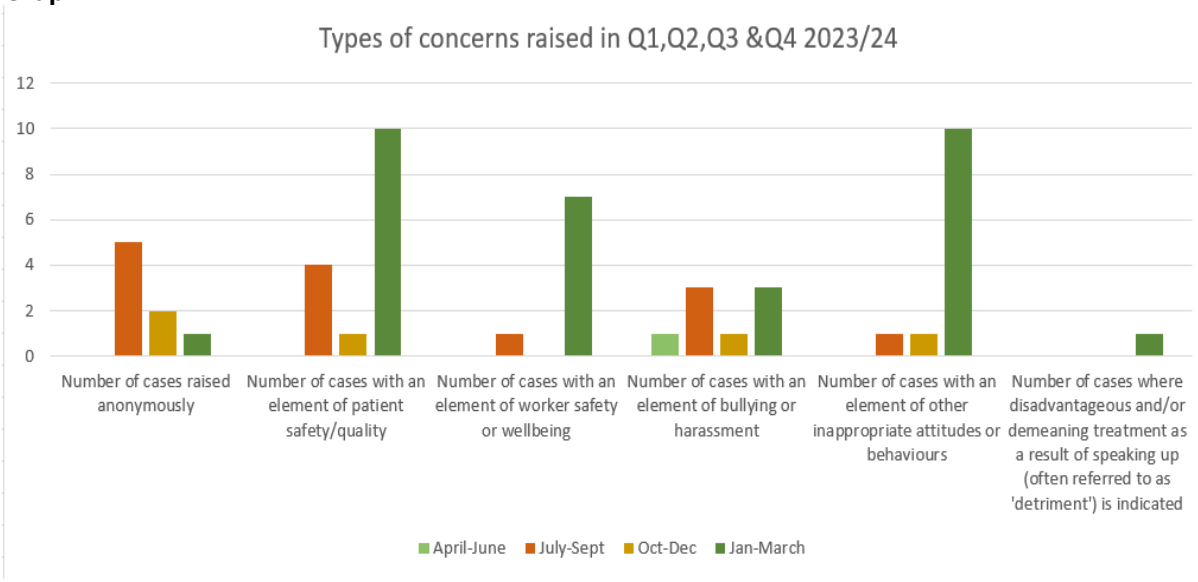
The FTSUG has attended the Regional Midlands FTSUG meetings and the NGO Conference in March 2024.

Assessment of cases

The number of cases raised this quarter is 24. This is the largest number of cases recorded to date at RJAH.

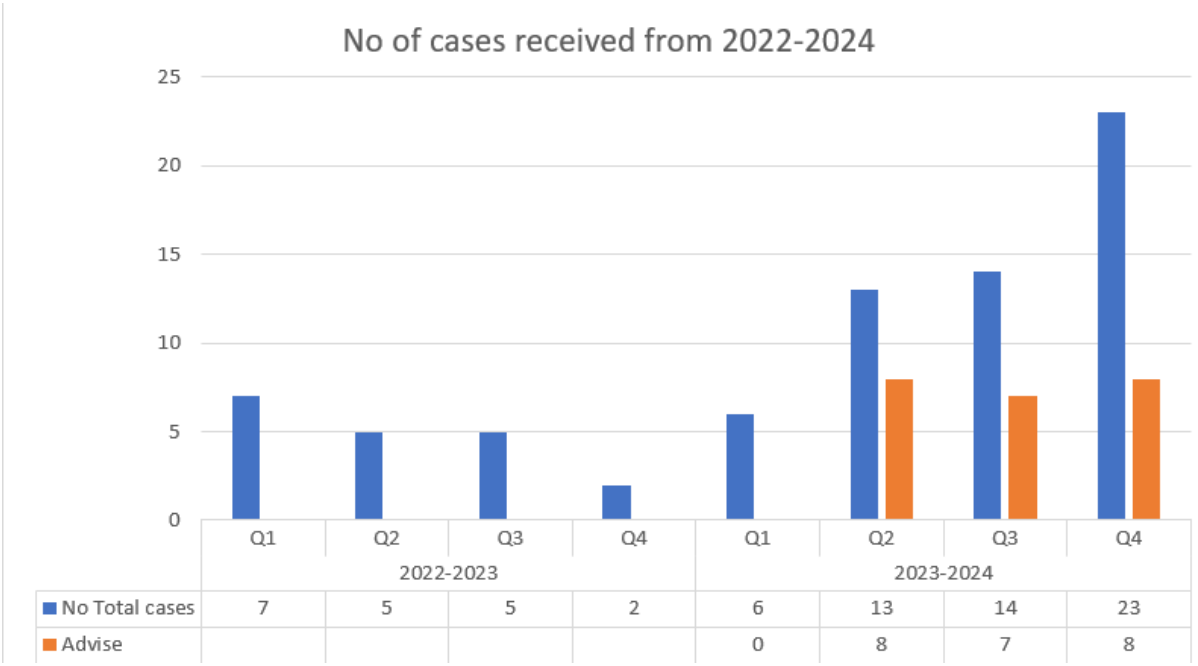
Below in Graph 1, is a chart which compares the types of concerns raised across each quarter of 2023/2024. Attitudes, behaviours, and bullying remain the main area of concerns raised by staff.

Graph 1



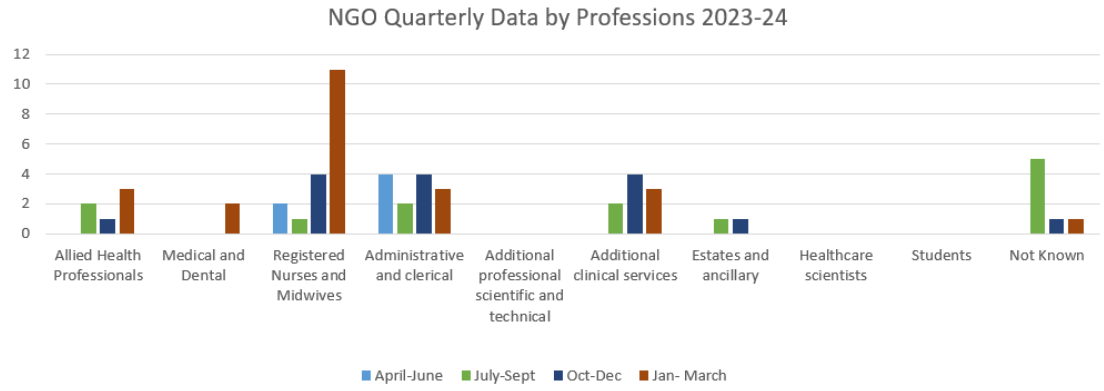
Graph 2 below shows the total number of cases received. The number of staff raising concerns has increased throughout 2023 -2024. From Q2 it now records how many required advice only.

Graph 2



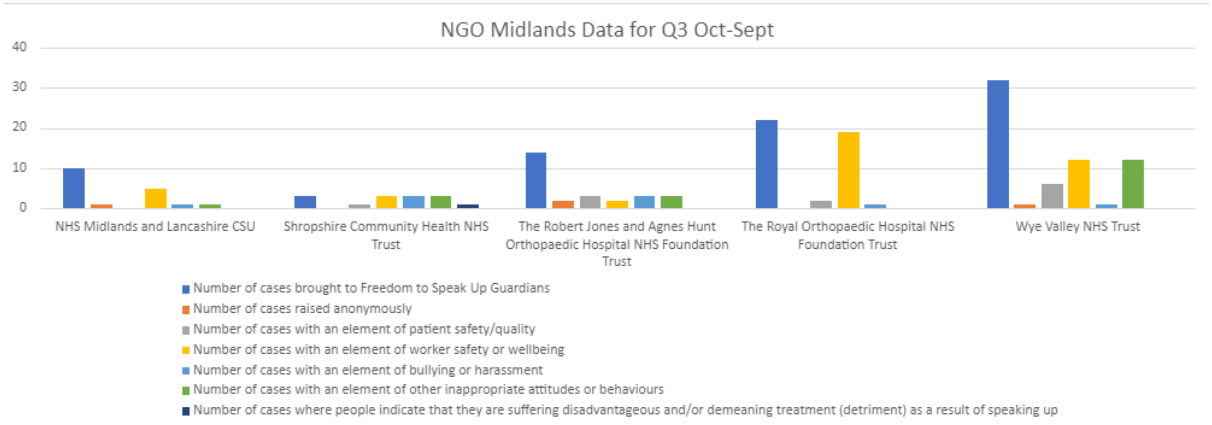
In Graph 3 we can see that in this quarter only one anonymous concern was raised out of the twenty-four cases. It also depicts the professional categories, stipulated by the NGO, who have raised concerns. This quarter most concerns raised came from registered nurses. Over the year administrative staff and HCA's have consistently raised concerns.

Graph 3



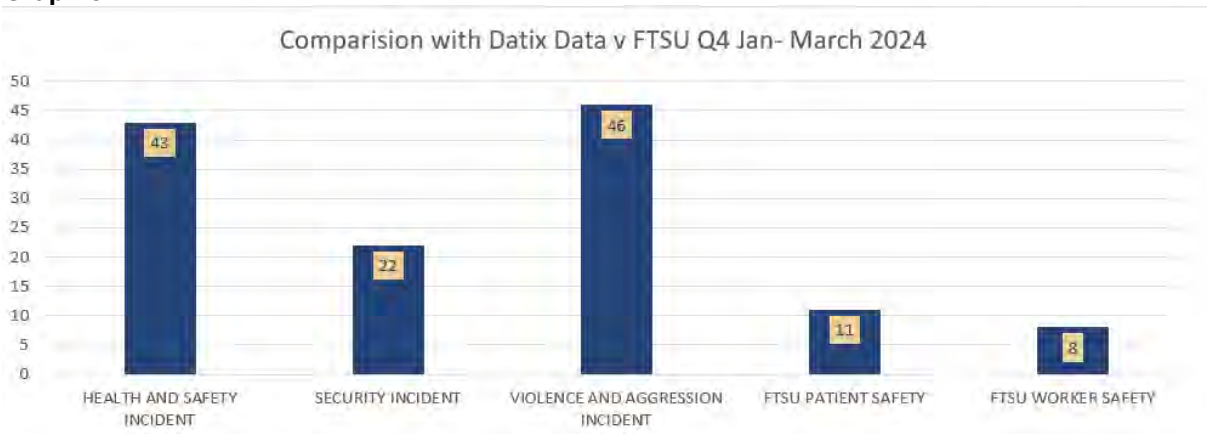
Graph 4 below compares small, midlands based, acute NHS Trusts to RJAH. The definition of small is under 5,000 staff. The most comparable Trust to Robert Jones and Agnes Hunt Orthopaedic Hospital is her sister Trust, The Royal Orthopaedic Hospital (ROH) in Birmingham. The data is taken from the NGO website for Q3 October – December 2023.

Graph 4



Graph 5 depicts the triangulation of datix data with the FTSU concerns. In quarter three the ROH had significantly more concerns raised over all but few issues around worker safety.

Graph 5



Learning and Improvement

With the completion of the NGO Reflection and Planning tool this has highlighted areas for improvement for FTSU.

An online anonymous form has been designed with a QR code which directly links to the form. The form is not traceable, staff can feel safe that they can submit concerns anonymously. However, if staff wish to fill in their details so that the Guardian can contact them then there are areas on the form, they can fill in.

It was highlighted that the Trust requires more diver FTSU Champions. Recruitment is taking place via links with the staff networks.

FTSU posters have been refreshed and enlarged.

The disadvantageous and demeaning treatment as a result of speaking up process has been launched and is active on the Trust intranet 'Percy'. This process is to help staff feel safe when they speak up and gives the managers a process to follow if a member of sufferer's detriment as a result of speaking up.

Actions

The Reflection and Planning tool has enabled the FTSUG to develop an annual plan for improvement for promoting FTSU and enabling staff the contact the Guardian in a variety of different ways.

A review of the current FTSU hours, due to the reduction of 7.5 hours in May 2024, which was assigned on a fixed tern contract.

Attendance at the National Guardian Conference, Regional FTSU meetings and ICB Shropshire FTSU meetings.

Monthly Comms around FTSU.

Strategic objectives

FTSU concerns, work towards the delivery of high-quality clinical services by ensuring that the concerns raised around patient care are escalated and improvements introduced where applicable.

FTSU empowers departments to encourage staff to Speak up about improvements and ensure that all staff are treated fairly, impartially and in confidence by the Guardian. This supports and contributes to the objectives of the RJAH strategic objectives.

Conclusion

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

Acronyms

FTSU = Freedom to Speak Up

NGO = National Guardian Office

NHS = National Health Service

HCA = Health Care Assistant

Safe Working Hours: Doctors in Training Q4 2023/24

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	01 May 2024
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee	Paper Ref:	N/A
Forum submitted to:	People and Culture Committee – 18th April	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the April 2024 annual summary report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

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

opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period October 2023 – Data not updated by HR – based on previous submission

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

3.2.2 Exception reports (regarding working hours)

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

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

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

During the year we have received an exception report from a trainee in a Welsh placement, on a centralised contract with RJAH. We have engaged with the trainee, responsible department and HR to ensure the issue raised is being addressed. TOIL was provided and a diary exercise instigated. We are still awaiting final reassurance on the outcome of the diary exercise to address this and prevent future reoccurrences.

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

3.2.3 Work schedule reviews

Please see above.

Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. There have been no formal work schedule reviews.

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies (28 posts)

April 23	1 sickness , 2 leavers
May 23	1 sickness , 2 leavers
June 23	1 sickness , 2 leavers
July 23	0
Aug 23	1 vacancy
Sept 23	1 sickness
Oct 23	1 sickness
Nov 23	0
Dec 23	0
Jan 24	0
Feb 24	0
Mar 24	0

Vacant shifts

April 23	13
May 23	14
June 23	4
July 23	6
Aug 23	5
Sept 23	4

Oct 23	7
Nov 23	3
Dec 23	8
Jan 24	4
Feb 24	10
Mar 24	0

Total cost - £55815

Medicine

Number of Vacancies (12 posts)

April 23	1
May 23	1
June 23	1
July 23	0
Aug 23	0
Sept 23	2
Oct 23	Unknown
Nov 23	Unknown
Dec 23	Unknown
Jan 24	Unknown
Feb 24	Unknown
Mar 24	Unknown

Vacant shifts

April 23	20
May 23	18
June 23	9
July 23	5
Aug 23	18

Safe Working Hours: Doctors in Training Q4 2023/24

Sept 23	15
Oct 23	25
Nov 23	10
Dec 23	44
Jan 24	24
Feb 24	30
Mar 24	29

Total Cost £114720

MCSI

Number of Vacancies (9 posts)

April 23	0
May 23	0
June 23	0
July 23	0
Aug 23	2
Sept 23	2
Oct 23	2
Nov 23	1
Dec 23	0
Jan 24	0
Feb 24	0
Mar 24	0

Vacant Shifts

April 23	0
May 23	0
June 23	0
July 23	8

Aug 23	8
Sept 23	8
Oct 23	14
Nov 23	4
Dec 23	6
Jan 24	2
Feb 24	8
Mar 24	0

Total cost - £ 14726.60

Long Term Vacant Shifts

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

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Trainees placed in North Wales

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

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

Impact of Junior Doctors Strikes

The financial impact of the industrial action is reflected in the costs detailed in the report. The report does not represent the full impact, including activity loss and many other factors. Currently, a pay agreement has not been reached. Further industrial action is likely, with a mandate for strike action achieved.

Software System

We still do not have a go live date.

Associated Risk

We need to establish an electronic reporting system.

Next Steps

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

3.4. Conclusion

The Trust has had no exception reports this quarter. There has been one for the annual period

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

Christopher Marquis

Guardian of Safe Working

Trust Board - Performance
March 2024 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

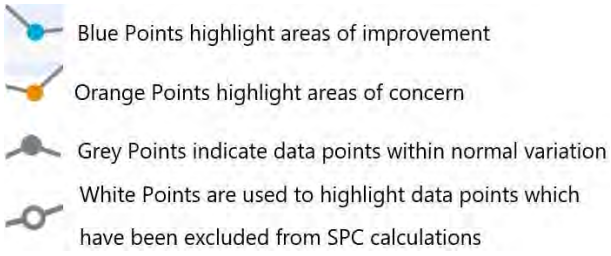
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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

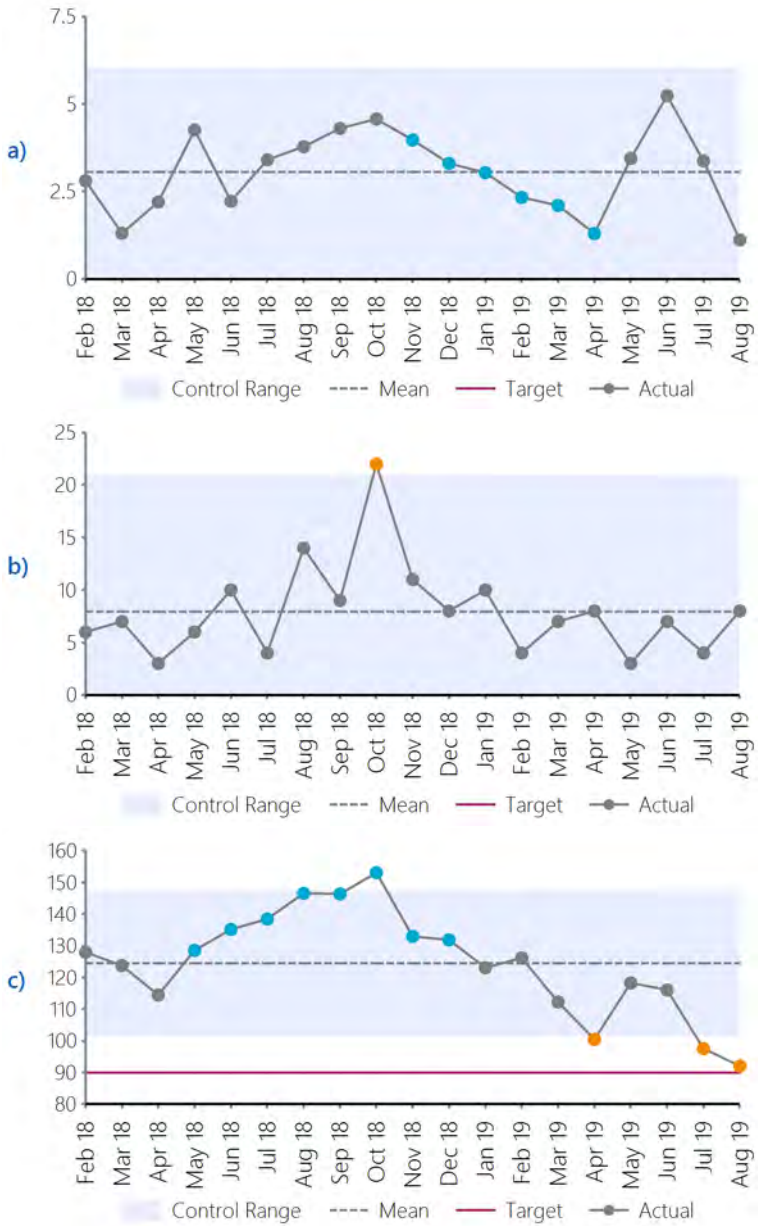


Some examples of these are shown in the images to the right:

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

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

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



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
31 Day General Treatment Standard*	96.00%	100.00%			P		
62 Day General Standard*	85.00%	75.00%			?	+	
28 Day Faster Diagnosis Standard*	75.00%	93.10%			?		12/09/23
18 Weeks RTT Open Pathways	92.00%	46.96%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,309	767	L	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,141		H	No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	3	0	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		309			No Target	+	
Patients Waiting Over 104 Weeks - English	0	0		L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		81		H	No Target	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Overdue Follow Up Backlog	5,000	10,186				+	
6 Week Wait for Diagnostics - English Patients	85.00%	82.09%				+	04/03/24
8 Week Wait for Diagnostics - Welsh Patients	100.00%	92.02%				+	04/03/24

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,197	1,100			Moving Target	+	24/06/21
Overall BADS %	85.00%	82.06%			?	+	
Total Outpatient Activity against Plan (volumes)	14,647	12,327			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	5.00%	2.88%		L	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,627	2,664			Moving Target		

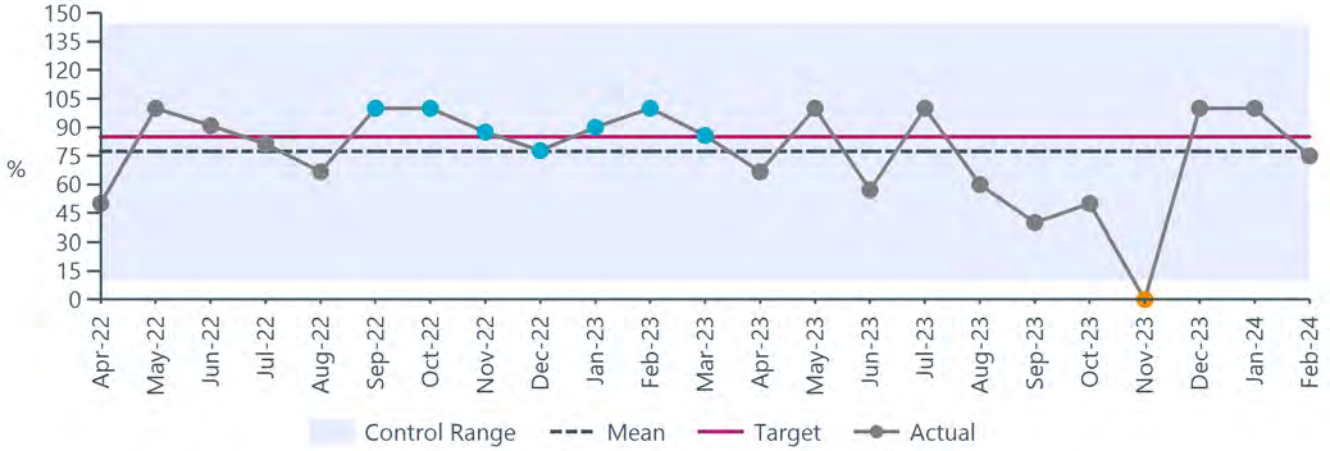
62 Day General Standard*

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85%	75%		

Trajectory



What these graphs are telling us

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

Narrative

The Cancer 62 Day General Standard was not met in February; this measure is reported in arrears. The February performance is reported at 75% against the 85% target. The standard is reporting 2 pathways (made up of shared pathways) where 0.5 is a shared breach with another Trust. The breach pathways was a complex pathway where the patient required multiple scans, biopsy and discussion at MDT.

Actions

There are no applicable actions.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
85.71%	66.67%	100.00%	57.14%	100.00%	60.00%	40.00%	50.00%	0.00%	100.00%	100.00%	75.00%	

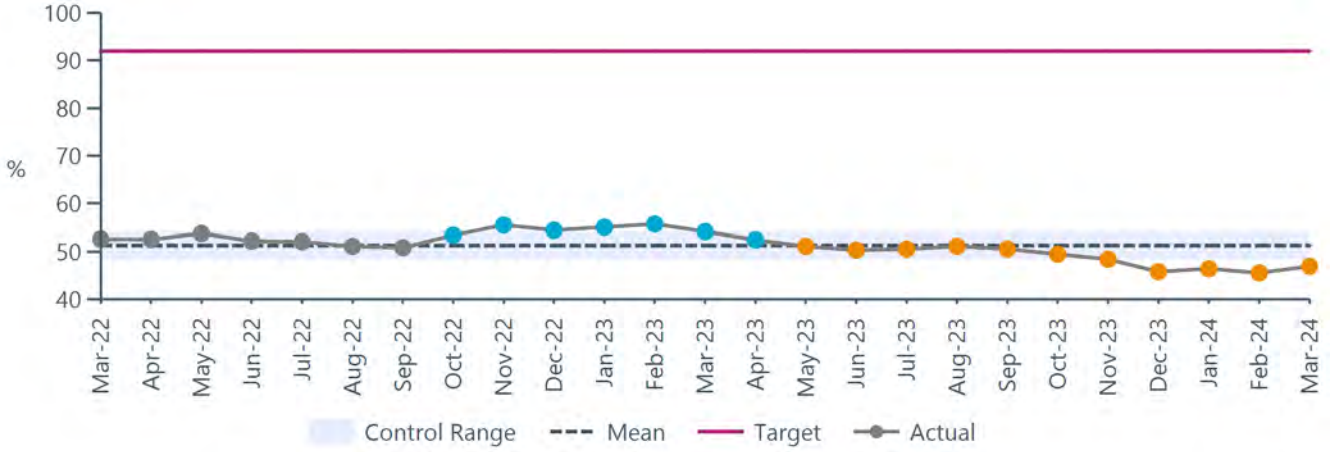
18 Weeks RTT Open Pathways

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	46.96%	L	F

Trajectory



What these graphs are telling us

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

Narrative

Our March performance was 46.96% 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 – 8194 patients waiting of which 3051 are breaches
* MS2 - 1638 patients waiting of which 1125 are breaches
* MS3 - 5474 patients waiting of which 3943 are breaches

For March reporting, the Trust is still working with 2023/24 operational planning guidance. Industrial Action, Operational pressures and ongoing Estates works have impacted original delivery plans. The original guidance stipulated:
* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025 .
Reporting against 24/25 operational plans will be reflected throughout the IPR next month.

Actions

Planning assumptions for 2023/24 included increases in capacity throughout the year aligned to productivity, workforce and estates programmes of work. Delivery of activity levels has continually been monitored within the Trust against these programmes of work. The Trust has been focusing on treatment of its longest waits. A continuous validation programme is in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. A digital solution to support with validation went live in early December. For patient initiated digital mutual aid, external deadlines have been met and patients have been contacted where applicable.

As part of system working, the Trust accepted 72 long wait patients from Shropshire Community during quarter three and is supporting Shrewsbury & Telford Hospitals by providing Elective Orthopaedic Theatre capacity. Discussions underway to assess future requirements.

Historical Industrial Action impacts continue to be monitored within the Trust, and any future planned action will be assessed. The Trust is reviewing its pre-operative pathways in place to support with health optimisation and ensuring patients wait well. Trial to begin in quarter one supporting improvements to pre-optimisation.

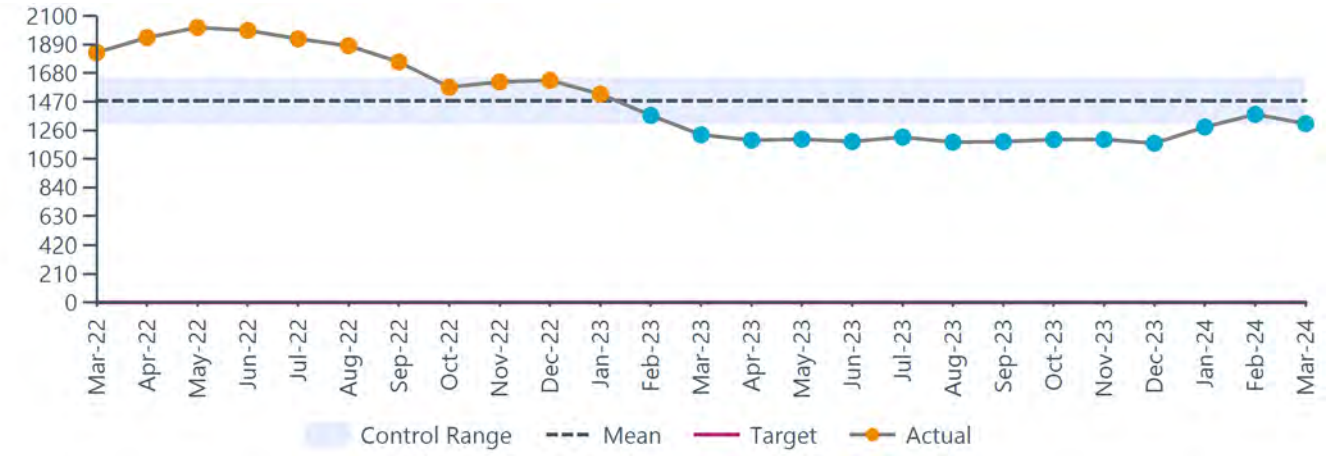
Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
54.18%	52.44%	51.12%	50.33%	50.55%	51.15%	50.57%	49.49%	48.43%	45.84%	46.45%	45.57%	46.96%

Patients Waiting Over 52 Weeks – English

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,309	L	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of March there were 1309 English patients waiting over 52 weeks; above our trajectory figure of 767 by 542. The patients are under the care of these sub-specialities; Arthroplasty (481), Spinal Disorders (254), Knee & Sports Injuries (189), Upper Limb (160), Foot & Ankle (111), Rheumatology (74), Metabolic Medicine (17), Physiotherapy (6), Paediatric Orthopaedics (4), ORLAU (4), Tumour (4), Orthotics (2), Neurology (2) and Paediatric Medicine (1).

Patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 1111 patients
* >65 to <=78 weeks - 195 patients
* >78 to <=95 weeks - 3 patients
* >95 to <=104 weeks - 0 patients

Actions

The national planning requirements for 2023/24 stipulate that Trusts should eliminate waits of over 65 weeks for elective care, by March-24 (except where patients choose to wait longer or in specific specialties). The Trust is currently putting plans in place to achieve during quarter two 2024/25. Harms reviews process and validation resource are in place. A digital solution to support with validation that went live in early December. Cohort one for Patient Initiated Digital Mutual Aid had very small volumes of patients who were transferred to other Providers, rollout of further cohorts within 2024/25.

Internal Operational meeting are in place to further monitor progress. Historical Industrial Action impacts continue to be monitored within the Trust, and any future planned action will be assessed. The Trust is reviewing its pre-operative pathways in place to support with health optimisation and ensuring patients wait well. Trial to begin in quarter one supporting improvements to pre-optimisation.

As part of system working, the Trust accepted 72 long wait patients from Shropshire Community during quarter three and is supporting Shrewsbury & Telford Hospitals by providing Elective Orthopaedic Theatre capacity. Discussions underway to assess future requirements.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
1227	1187	1195	1178	1210	1173	1177	1192	1193	1165	1284	1377	1309

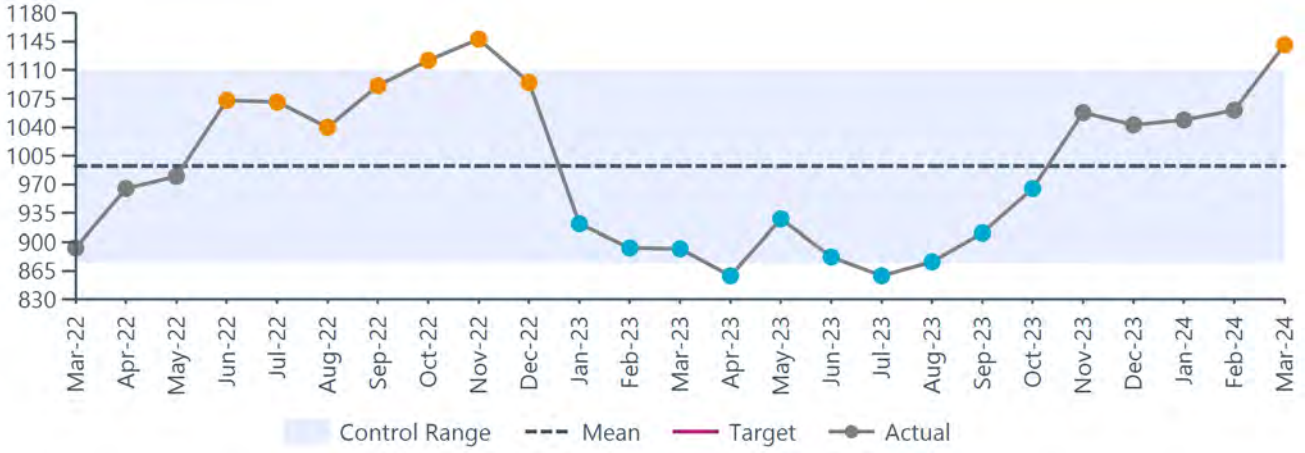
Patients Waiting Over 52 Weeks - Welsh (Total)

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	1,141	H	No Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of March there were 1141 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (439), Arthroplasty (283), Knee & Sports Injuries (197), Upper Limb (99), Foot & Ankle (88), Veterans (14), Paediatric Orthopaedics (13), Metabolic Medicine (3),Tumour (2), Neurology (2) and Spinal Injuries (1).
Patients are under the care of the following commissioners: BCU (614), Powys (498), Hywel Dda (25), Cardiff & Vale (2), Cwm Taf (1) and Aneurin Bevan (1). The number of patients waiting, by weeks brackets is:

* >52 to <=65 weeks - 564 patients
* >65 to <=78 weeks - 268 patients
* >78 to <=95 weeks - 180 patients
* >95 to <=104 weeks - 48 patients
* >104 weeks - 81 patients

As seen in the graph, this metric is above the upper control range and is reporting the highest number since November 2022, demonstrating special cause variation of a concerning nature. Analysis of historical referrals trends does demonstrate a peak in March-23.

Actions

The Welsh guidance differs from NHS England guidance. The Trust continues to monitor equity across our commissioners whilst recognising guidance and differences in pathway monitoring. The Trust has taken action to offer mutual aid for our most challenged speciality. The patients that have transferred have been low volumes to date.

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

Historical Industrial Action impacts continue to be monitored within the Trust, and any future planned action will be assessed.

The Trust is reviewing its pre-operative pathways in place to support with health optimisation and ensuring patients wait well. Trial to begin in quarter one supporting improvements to pre-optimisation.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
892	859	928	882	859	876	911	965	1058	1043	1049	1061	1141

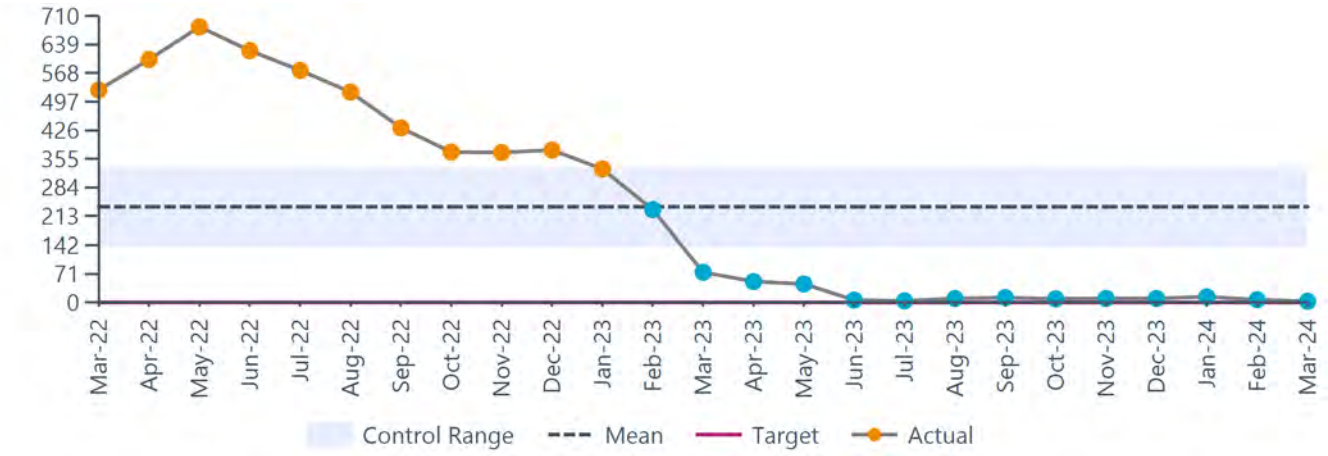
Patients Waiting Over 78 Weeks - English

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	3	L	F

Trajectory



What these graphs are telling us

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

Narrative

At the end of March there were 3 English patients waiting over 78 weeks; 3 above our trajectory of 0. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Spinal Disorders (1), Knee & Sports Injuries (1) and Foot & Ankle (1).

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

For March reporting, the Trust is still working with 2023/24 operational planning guidance. Industrial Action, Operational pressures and ongoing Estates works have impacted original delivery plans. The original guidance stipulated:
* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025 .
Reporting against 24/25 operational plans will be reflected throughout the IPR next month.

Actions

The Trust is now reporting against this standard by exception with the Trust making significant improvements during 23/24. In line with national planning expectations the Trust aims to further reduce long waits to less than 65 weeks. The Trust is putting plans in place, with the aim to achieve this during quarter two 2024/25.

Validation resource are in place. The Trust has put in place a digital solution to support with validation that went live in early December. Cohort one for Patient Initiated Digital Mutual Aid had very small volumes of patients who were transferred to other Providers and rollout of further cohorts expected during 2024/25.

Internal Operational meeting are in place to further monitor progress.

Historical Industrial Action impacts continue to be monitored within the Trust, and any future planned action will be assessed.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
75	52	46	6	4	10	12	9	10	10	14	7	3

Patients Waiting Over 78 Weeks - Welsh (Total)

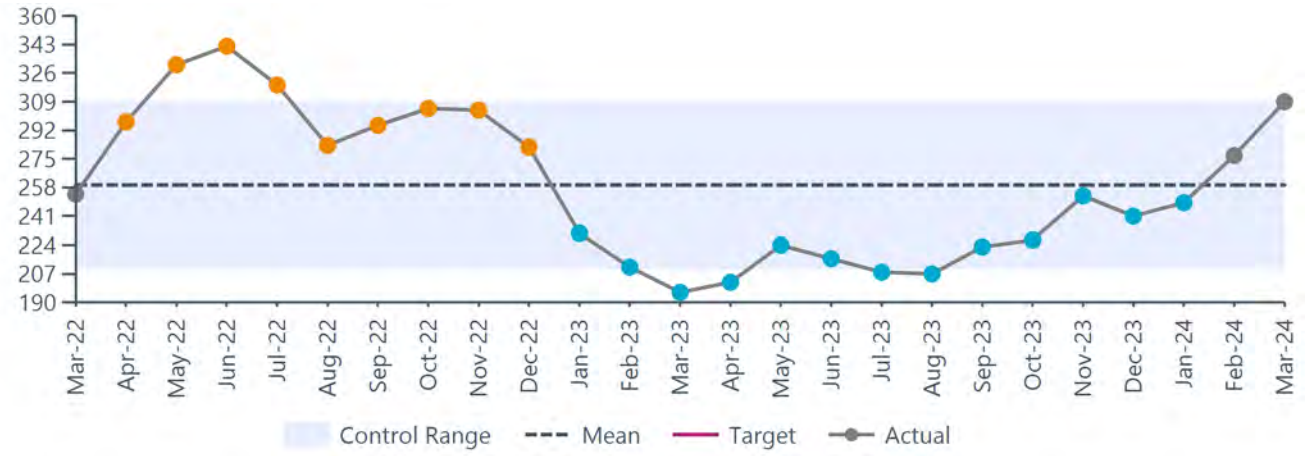
Number of Welsh RTT patients waiting 78 weeks or more at month end 217802

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	309		No Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of March there were 309 Welsh patients waiting over 78 weeks.

The patients are under the following sub-specialties; Spinal Disorders (121), Knee & Sports Injuries (80), Arthroplasty (74), Foot & Ankle (17), Upper Limb (12), Veterans (3), Neurology (1), and Paediatric Orthopaedics (1).

Although common cause variation, this metric is on the upper control range and is reporting the highest number since June 2022. Analysis of historical referrals trends does demonstrate a peak that supports this increase.

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients. The Trust continues to treat Welsh patients alongside English patients, balancing both long waits and clinical urgency. Actions taken to offer mutual aid for our most challenged speciality, however the patients that have transferred have been low volumes to date.

Validation resource are in place. The Trust has put in place a digital solution to support with validation that went live in early December. Cohort one for Patient Initiated Digital Mutual Aid had very small volumes of patients who were transferred to other Providers and rollout of further cohorts expected during 2024/25.

Internal Operational meeting are in place to further monitor progress.

Historical Industrial Action impacts continue to be monitored within the Trust, and any future planned action will be assessed.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
196	202	224	216	208	207	223	227	253	241	249	277	309

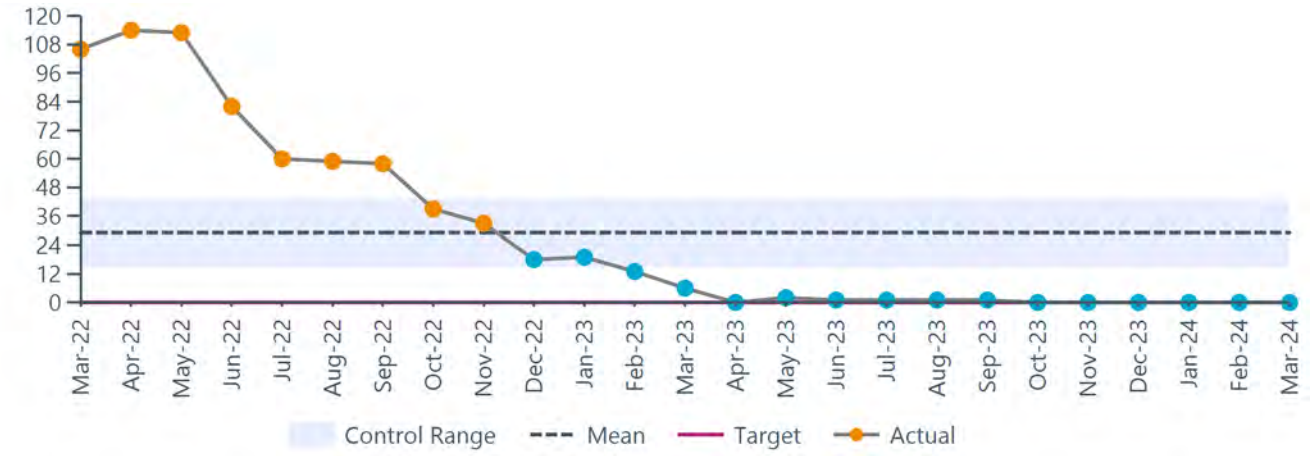
Patients Waiting Over 104 Weeks - English

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	0	L	F

Trajectory



What these graphs are telling us

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

Narrative

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

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

Actions

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

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

Patients Waiting Over 104 Weeks - Welsh (Total)

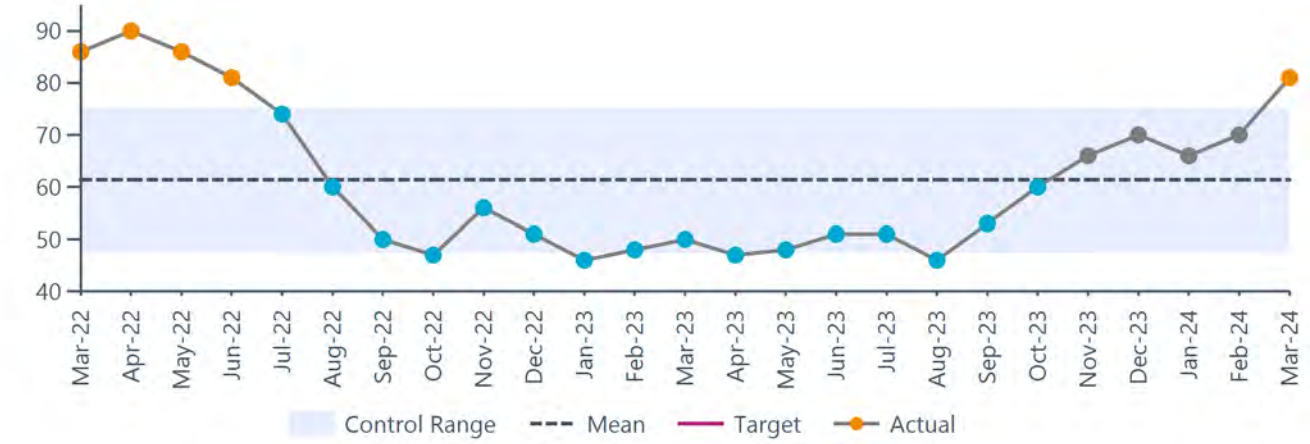
Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	81	H	No Target

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of March there were 81 Welsh patients waiting over 104 weeks. The patients are under the care of the following subspecialties:
* Spinal Disorders (54)
* Knee & Sports Injuries (20)
* Arthroplasty (3)
* Foot & Ankle (2)
* Upper Limb (1)
* Neurology (1)

As seen in the graph, this metric is above the upper control range and is reporting the highest number since June 2022, demonstrating special cause variation of a concerning nature.

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward. The majority of breaches are now attributable to our most challenged sub-specialty. The Trust has taken action to offer mutual aid for our most challenged speciality, however, the patients that have transferred have been low volumes to date. The Trust is continuing to progress further opportunities with regards to validation processes.

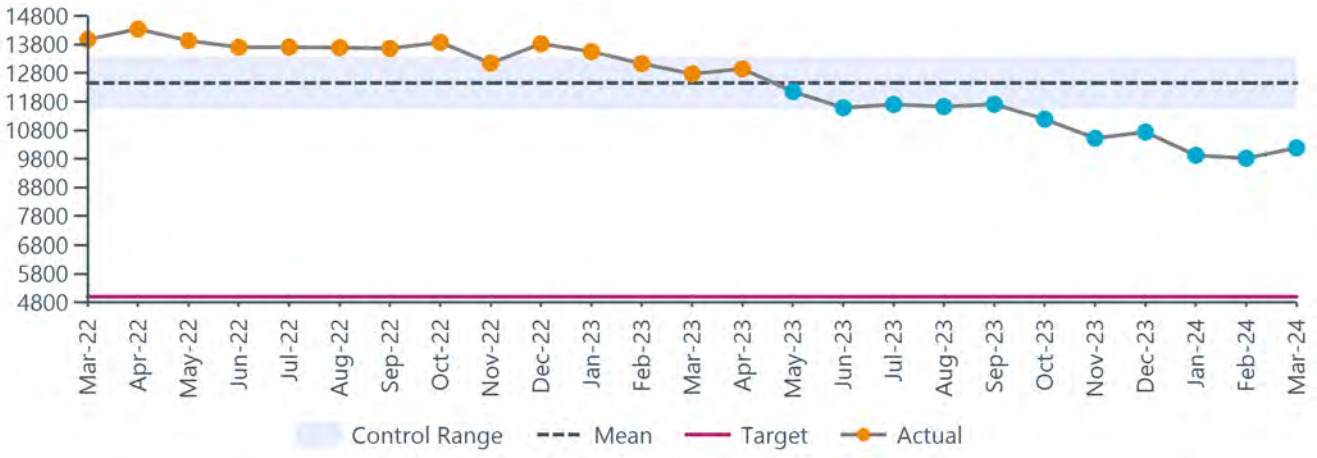
Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
50	47	48	51	51	46	53	60	66	70	66	70	81

Overdue Follow Up Backlog

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	10,186	L	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of March, there were 10,186 patients overdue their follow up appointment. This is broken down by:
- Priority 1 - 5924 with 888 dated (15%) (priority 1 is our more overdue follow-up cohort)
- Priority 2 - 4262 with 948 dated (22%);

* The backlog increased by 363 from last month. The priority 1 backlog decreased by 4.
* Of the 10,186 patients overdue, 36% are diagnostic follow ups.
* Of all the patients on a non-diagnostic follow up, 18% are overdue.
* Of all the patients on a diagnostic follow up, 53% are overdue.
* The sub-specialities with the highest volumes of overdue follow ups are: Rheumatology (2,390), Arthroplasty (1,435) and Spinal Disorders (1,144).

Rheumatology backlog increased by 450, however this was not due to a reduction in activity, this can be attributed to both trip-ins and TEMS Follow Up patients being added to the system.

Actions

Work on the follow up reduction plan remains ongoing:
* Technical validation continues in small streams due to resource limitations. This has also been limited further by increased absence within Teams.
* Service Managers are continuing to work with clinicians who have the largest volumes of overdue follow ups, balancing clinics within job plans.
* Good discussions took place during a benchmarking meeting with ROH. Another meeting has been scheduled in April.
* Further work to assess and understand our existing clinical protocols needs to take place.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
12777	12949	12158	11589	11707	11630	11710	11190	10522	10740	9925	9823	10186

6 Week Wait for Diagnostics - English Patients

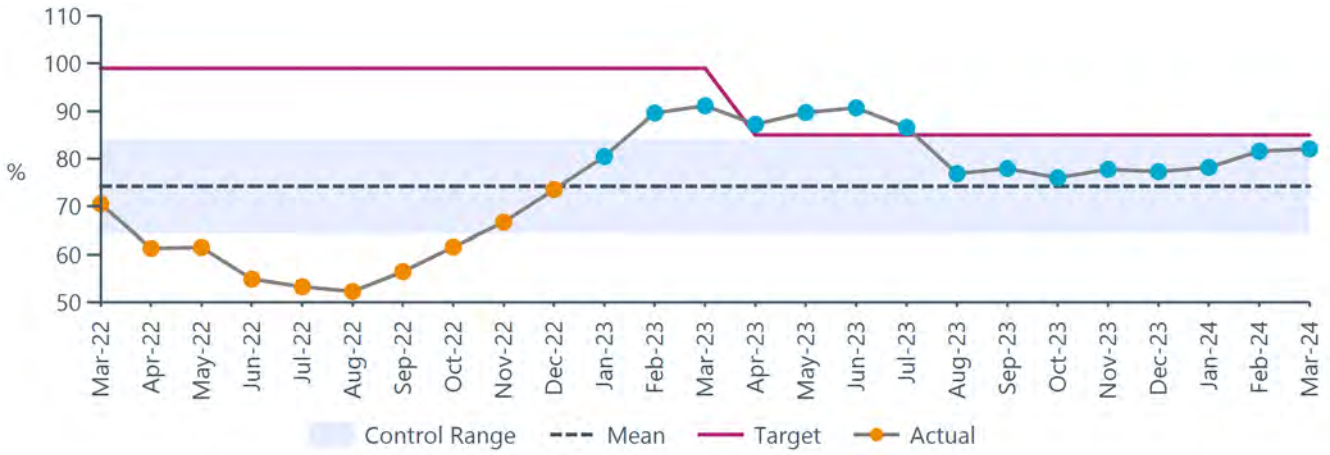
% of English patients currently waiting less than 6 weeks for diagnostics 211026

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	82.09%	H	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The March position is reported at 82.09%; below the 85% target. Reported performance equates to 231 patients who waited beyond 6 weeks. Of the 6-week breaches; 58 are over 13 weeks (all within Ultrasound). Breakdown below outlines performance and breaches by modality:

* MRI – 98.60% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine – 6-12 weeks) – 6 with 5 dated
* CT – 96.65% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine – 6-12 weeks) – 6 with 4 dated
* Ultrasound – 61.80% - D2 (Urgent - 0-2 weeks) - 1 undated, D3 (Routine - 4-6 weeks) – 1 dated, D4 (Routine - 6 -12 weeks) - 215 with 145 dated
* DEXA Scans - 100%

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

Actions

Plan in place for Ultrasound improvement in performance includes:
- Additional Saturday lists - this has already started
- Additional Radiologist
- Radiology Fellow
- Utilising existing Sonographers to carry out Ultrasounds (role expansion)
- Mutual Aid requested but this was not successful.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
91.15%	87.27%	89.74%	90.71%	86.61%	76.91%	77.97%	76.04%	77.80%	77.33%	78.22%	81.60%	82.09%

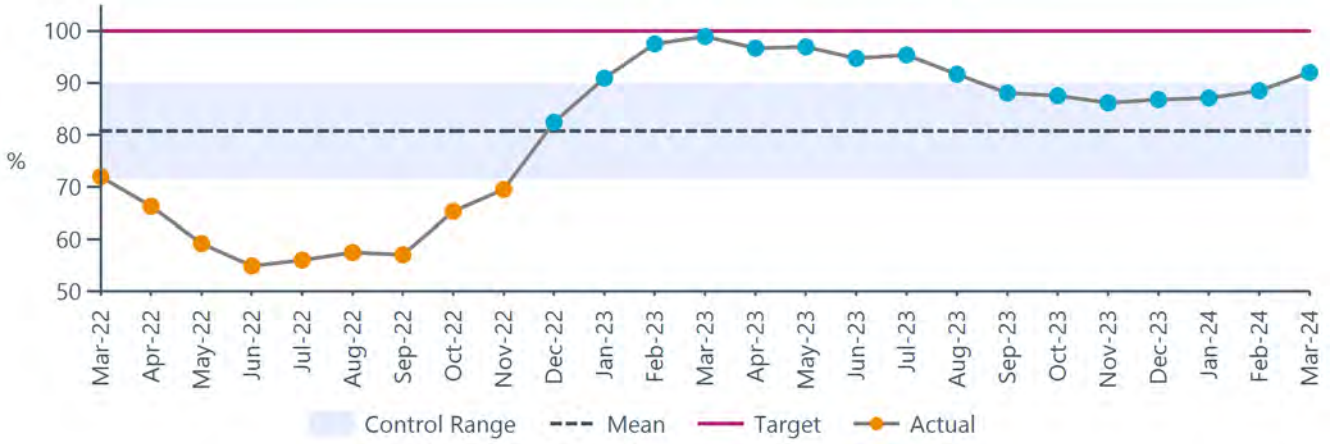
8 Week Wait for Diagnostics - Welsh Patients

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	92.02%	H	F

Trajectory



What these graphs are telling us

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

Narrative

The 8-week standard for diagnostics was not achieved this month and is reported at 92.02%. Reported performance equates to 36 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
* MRI – 99.25% - D2 (Urgent - 0-2 weeks) - 2 dated
* CT – 100%
* Ultrasound – 71.19% - (D4 (Routine - 6-12 weeks) - 34 with 31 dated
* DEXA Scans - 100%

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

Actions

Plan in place for Ultrasound improvement in performance includes:
- Additional Saturday lists - this has already started
- Additional Radiologist
- Radiology Fellow
- Utilising existing Sonographers to carry out Ultrasounds (role expansion)
- Mutual Aid requested but this was not successful.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
98.94%	96.69%	96.92%	94.74%	95.38%	91.67%	88.06%	87.54%	86.18%	86.80%	87.10%	88.50%	92.02%

Elective Activity Against Plan (volumes)

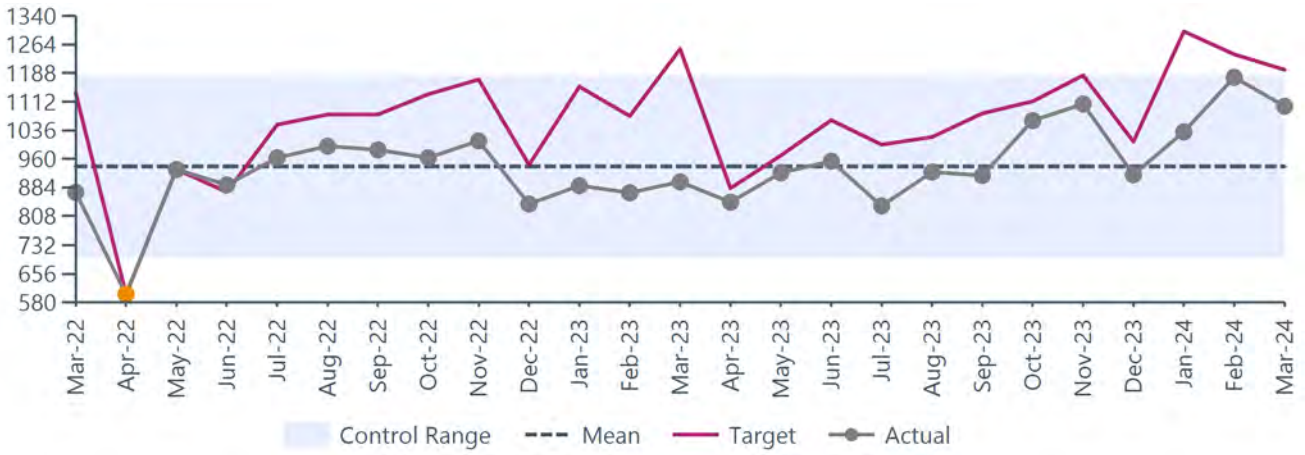
Total elective activity rated against plan. 217796

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
1,197	1,100		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

Total elective activity reported externally against 2023/24 plan of 1197 in March was 1100 shortfall of 97 (91.90%).
Elective spell activity is broken down as follows:
- Elective patients discharged in reporting month following operation - plan was 1015; 877 delivered (86.40%)
- Elective patients discharged in reporting month, no operation - plan was 182; 223 delivered (122.53%)
- Non-theatre activity accounted for 20.27% of elective spells this month; plan was 15.20%.

Against the revised forecast of 787 NHS theatre cases which is based on TIF2 theatre development delay and other performance impacts, NHS theatre activity achieved 883 equating to 112%.

It is worth noting that although common cause variation, March elective activity performance remains in the upper third of the control range.

Actions

* Focus on Theatre Improvement programme with key themes:
- Early session starts currently reporting two all day sessions across two Consultants in April.
- Weekend working equating to 41 theatre cases (NHS and PP) across four Sundays in March. April bookings indicate 26 patients across three Sundays at snapshot date.
- Standardisation of cases per session in accordance with GIRFT guidance with 4x arthroplasty joint lists continuing in April.
- Regular weekly use of Headley Court Day Case facility.
- Focus on reducing cancellations and opportunities for improvement identified and implemented.
- The Trust is continuing to support theatre capacity in the system where possible via 6-4-2 meetings.
- IJP theatre activity is maximised through theatre allocation, 6-4-2 process and Service Managers ensuring adherence to Trust policies such as annual leave and study leave.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
899	845	923	954	835	925	916	1062	1106	918	1032	1177	1100

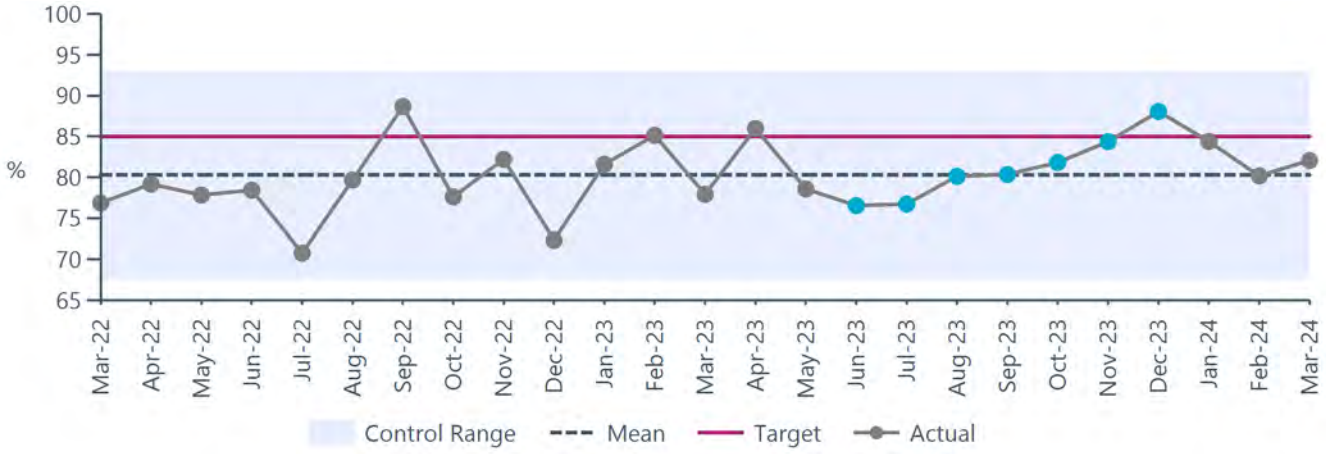
Overall BADS %

% of BADS procedures performed as a day case 217813

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	82.06%		

Trajectory



What these graphs are telling us

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

Narrative

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

In March the Trust is reporting 82.06% BADS day cases against a target of 85%. Following a period of sustained improvement, this metric has not achieved the target since December, however it is above the mean and reporting common cause variation.

Actions

Ongoing monitoring of performance via the Day Case Working Group; actions include:
* To improve day surgery success rates (against BADS).
* To extend range of procedures done as day cases.
* To meet process checklist set out in GIFRT day surgery delivery document.
* To improve the data quality of Day Case patients by:
- Working with Access Team to improve data quality of bookings and alignment between PAS and Bluespier. Focus on improving inpatient Physio bookings.
- Working with nursing and admin staff to improve timeliness of patient discharge from PAS.
- Working with Spinal Injuries Team to improve booking of day case patients.
- Exploring 'intelligent list planning' to maximise successful day case discharges.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
77.92%	85.98%	78.57%	76.54%	76.72%	80.12%	80.35%	81.82%	84.36%	88.06%	84.39%	80.18%	82.06%

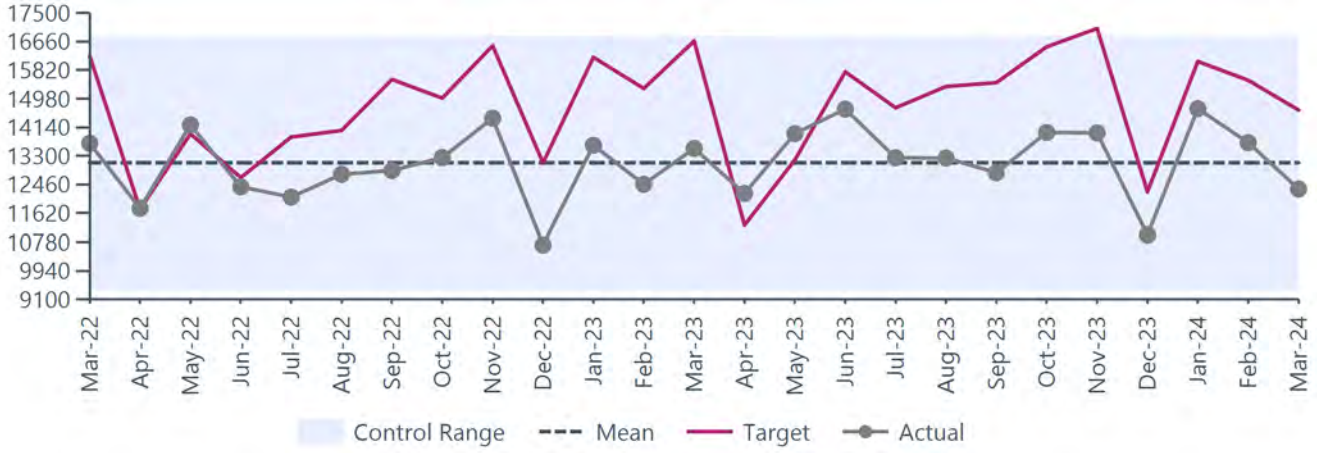
Total Outpatient Activity against Plan (volumes)

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

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
14,647	12,327		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

Total outpatient activity undertaken in March was 12,327 against the 2023/24 plan of 14,647; a shortfall of 2,320 that equates to 84.16% of plan.

Due to the transition of services for SOOS & Therapies, if we were to exclude SOOS & Therapies from both the Plan and Activity delivered, the Trust position for March would be at 99.03% (108 below plan).

The activity numbers are always taken on 5th working day to allow 4 working days for administrative transactions.

Actions

A new outpatient activity meeting commenced on the 8th of April led by the Managing Director of the Specialist Unit. The purpose of this weekly meeting will be to monitor, at sub-speciality level, the in-month and forecast position of total outpatient activity/bookings against plan, address any gaps and escalate any issues that could impact performance. There is an expectation that service managers will need to review their activity numbers prior to the meeting and explain the reason(s) for any shortfall and outline a plan of action on how activity will be caught up on.

As at 15th April, the forecast for April is 103% of plan, with the only area of concern being Rheumatology. This is due to RJAH taking the full plan for RJAH and TEMS activity even though RJAH does not have the full capacity. TEMS will still record some activity for April due to the phasing of the clinics.

The existing Outpatient Improvement Group and Outpatient Oversight Group continue to meet on a monthly basis to discuss performance and actions in relation to Overdue Follow Ups, DNAs, PIFU & Virtual KPI's.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
13521	12197	13956	14676	13244	13240	12805	13987	13976	10986	14688	13690	12327

Total Outpatient Activity - % Moved to PIFU Pathway

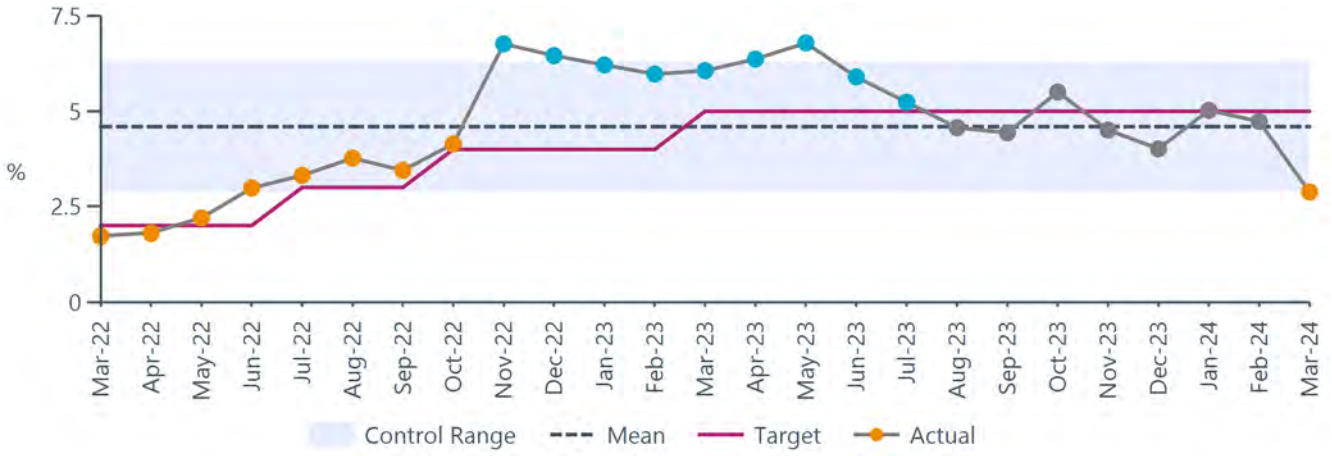
Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan 217715

Exec Lead
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5.00%	2.88%	L	Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The target for the number of episodes moved to a PIFU Pathway is 5% of all outpatient attendances. The % of patients moved to PIFU pathway for March was 2.88% equating to 355 patients.

The Teams with the highest achieving PIFU rate are:
Occupational Therapy (12.10%), Muscle (11.90%) & Paediatric Orthopaedics (9.95%).

Actions

* The PIFU letter that patients will receive has been shared with consultants and is awaiting feedback.
* Clinical engagement is now underway Rheumatology and MCSI to utilise continuous PIFU.
* An 'Opt out' model is being trialled with small cohort of Foot and Ankle patients, though no responses have been received yet.

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
6.06%	6.37%	6.79%	5.90%	5.24%	4.57%	4.44%	5.51%	4.51%	4.01%	5.02%	4.73%	2.88%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Long Waiters - 2023/24

Trust Board

1st May 2024

Aspiring to deliver world class patient care

2023/24 March and April** Performance

		Plan	Actual	Difference
March	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	81	
	English 78+ Weeks	0	3	3
	Welsh 78+ Weeks	-	309	
	English 65+ Weeks	305	198	-107
	Welsh 65+ Weeks	-	577	

		Plan	Forecast*	Difference
April**	English 104+ Weeks	0	0	0
	Welsh 104+ Weeks	-	87	
	English 78+ Weeks	0	1	1
	Welsh 78+ Weeks	-	317	
	English 65+ Weeks	319	303	-16
	Welsh 65+ Weeks	-	592	

**Forecast position.

NHS England Updates:

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

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

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

NHS Wales Updates:

2023/24 – Awaiting confirmation on targets. Discussions with Powys continue following meeting in April 2024.

2024/25 Planning:

2024/25 Planning is underway. NHS England plans for a route to 0 x 65+ week waits during quarter 2.

Committee / Group / Meeting, Date

- People & Culture Committee – 18/04/2024
- Quality & Safety Committee – 18/04/2024
- Finance, Planning & Digital Committee – 26/04/2024
- Board of Directors – 01/05/2024

Author:	Contributors:
Name: Mike Carr Role/Title: Chief Operating Officer	Claire Jones, Principal Analyst & Data Quality Lead

Report sign-off:

N/A

Is the report suitable for publication?:

YES

Key issues and considerations:

Discussion and agreement on proposed changed outlined in the paper are required.

Strategic objectives and associated risks:

The Integrated Performance Report provides overall performance oversight to support the delivery of all Trust objectives:

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

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. Throughout the 24/25 financial year, there will be enhancements to the content of the IPR to include data to support these objectives.

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

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

Recommendations:

The Board and it's sub-committees are asked to discuss and consider the proposals made in section 3 before implementation into IPR in 24/25.

Report development and engagement history:

Proposed changes that are outlined in this report are a result of discussions with key stakeholders in the Trust such as Unit Managing Directors and Assistant Chief Nurses, Executive Leads of reporting areas and Non-Executive Directors who Chair committees.

Acronyms

IPR	Integrated Performance Report

Appendices

Appendix A	Proposed Executive Summary/Icon Summary
Appendix B	KPIs Reported per Committee

1. Background / Context

This paper provides details on the changes that have taken place in the Integrated Performance Report (IPR) throughout the 2023/24 financial year and references future changes and proposals to be made for 2024/25.

This paper is submitted to all sub-committees, as well as Board of Directors, to ensure full oversight across metrics and committees.

The purpose of the Integrated Performance Report (IPR) is to provide the Board and sub-committees with the evidence of achievement against the national regulatory standards, identifications of key risks impacting our performance and the key initiatives and improvements in place that positively impact our performance.

2. Main Report

2.1 Introduction

The principles of the IPR are to ensure it contains the appropriate and focused metrics that allow the Board, and its sub-committees, to seek assurance and instigate actions where required. The metrics included reflect the following:

- Those outlined in the National Oversight Framework
- National planning stipulations
- National reporting requirements
- System reporting requirements
- Those determined appropriate to our organisation

As a result of both national and internal drivers, there have been many changes to the IPR throughout the 2023/24 financial year. These are all outlined in the paper below.

The Principal Analyst has carried out a review of the IPR to ensure it meets all the areas stipulated in the NHS Oversight Framework.

In addition to this, Principal Analyst has met with key stakeholders within the Trust and Executive Directors who lead on reporting areas. In addition, the Chief Operating Officer and Principal Analyst have met with the Sub-Committee Chairs to discuss and review each committee-version of the IPR.

2.2 Summary of Changes Made Throughout 2023/24

2.2.1 People & Workforce

The table below outlines the KPIs that have been added or removed, in relation to People & Workforce throughout this financial year:

KPIs Added	KPIs Removed
Time to Recruit	
Staff Retention	
Total Headcount in Post	

The following reporting changes have been made:

- Sickness & Staff Turnover – targets aligned to Trust's submitted operational plan

2.2.2 Quality & Safety

The table below outlines the KPIs that have been added or removed, in relation to Quality and Safety, throughout this financial year:

KPIs Added	KPIs Removed
Medication Errors	Patient Falls (With Moderate or Severe Harm)
RJAH Acquired Pressure Ulcers	Medication Errors with Harm
Patient Safety Incident Investigations	Patient Friends & Family - % Would Recommend (Inpatients)
Number of Deteriorating Patients	RJAH Acquired Pressure Ulcers - Grade 2
	RJAH Acquired Pressure Ulcers - Grades 3 or 4
	Complaints Rate Per 1000 WTE
	Never Events
	Serious Incidents

The following reporting changes have been made:

- Agency Non-Core – this was removed from the IPR for Q&S Committee, but remains within version for People Committee
- E-Rostering KPIs – these were removed from the IPR for Q&S Committee, but remain within the version for People Committee
- Medication Errors – Exec Lead changed from Chief Medical Officer to Chief Nurse & Patient Safety Officer

2.2.3 Performance

The table below outlines the KPIs that have been added or removed, in relation to Performance, throughout this financial year:

KPIs Added	KPIs Removed
Average Length of Stay - Elective & Non Elective	Advice & Guidance
31 Day General Treatment Standard	Independent Sector Activity Against Plan
62 Day General Standard	Volume of Sessions Against Plan
Referrals Received for Consultant Led Services	Average Length of Stay *(elective only)*
	31 Day First Treatment (Tumour)
	31 Day Subsequent Treatment - Surgery (Tumour)
	Cancer Plan 62 Day Standard (Tumour)
	Cancer 62 Day Consultant Upgrade
	Referrals Received for Consultant Led Services, Including SOOS

The changes made to reporting of Cancer Waits Standards was in response to updated guidance released in year. We are compliant with the reporting requirements.

2.2.4 Finances

The table below outlines the KPIs that have been added or removed throughout this financial year:

KPIs Added	KPIs Removed
Value Weighted Assessment	Big Ticket Item (BTI) Efficiency Delivered

3. Proposal of Changes for 2024/25

3.1 People & Workforce

The table below outlines the proposed New/To be Removed KPIs in IPR for 24/25:

New KPIs	KPIs Removed
'Recruitment - Vacancy Created to Conditional Offer'	'Time to Recruit' - where measure includes post approval part of process
In Future - when appropriate, impact of staff network groups	
In Future - utilise data from 'Improve Well' as it gets rolled out throughout the Trust. Currently being trialled in Theatres	

This table outlines some proposed changes to KPIs within the IPR:

KPI Changes
'Staff Availability' - explore alternative measure linked to job planning
'In Month Leavers' - Remove 'training grades' from the data reported
'In Month Leavers' - Target Change to 12 per month - based on 23/24 average
'% of E-Rosters Approved Six Weeks Before E-Roster Start Date' - addition of target at 90%
'% of System-Generated E-Roster (Auto Rostering)' - addition of target at 40%
Targets to be aligned with Trust's Operational Planning Submission

3.2 Quality & Safety

The table below outlines the proposed New/To be Removed KPIs in IPR for 24/25:

New KPIs	KPIs Removed
'Medication Errors with Harm' - with a target of 0 per month	'% Delayed Discharge Rate' - reported against available beds (in line with Operational Planning)
'Number of Compliments' per Month	
'Number of Patient Safety Reviews' - those commissioned internally per month	
'Percentage of Beds Occupied by Patients Not Meeting the Criteria to Reside' - reported against occupied beds	
In Future - may be some measures from Clinical Effectiveness	

This table outlines some proposed changes to KPIs within the IPR:

KPI Changes
'Medication Errors' - keep measure but remove target
Explore alternative measure to 'Number of Spinal Injury Patients Fit For Admission to RJAH'

3.3 Performance

The table below outlines the proposed New/To be Removed KPIs in IPR for 24/25:

New KPIs	KPIs Removed
'Patients Waiting Over 65 Weeks - English'	'English List Size'
'Patients Waiting Over 65 Weeks - Welsh'	'Welsh List Size'
' Diagnostics - Report Turnaround Times (Average Number of Days)'	'Patients Waiting Over 52 Weeks - Combined'
'Outpatient Clinic Utilisation' - data not yet available but should be following Apollo implementation	'Patients Waiting Over 78 Weeks - English'
	'Patients Waiting Over 78 Weeks - Welsh'
	'Patients Waiting Over 78 Weeks - Combined'
	'Patients Waiting Over 104 Weeks - English'
	'Patients Waiting Over 104 Weeks - Welsh'
	'Patients Waiting Over 104 Weeks - Combined'

This table outlines some proposed changes to KPIs within the IPR:

KPI Changes
'Volume of Theatre Cancellations' - target change to 5.5% of planned Theatre Activity -this equates to approx 20 per month reduction included in Planning assumptions
'Overdue Follow Up Backlog' - trajectory for 24/25 to be included in IPR - in line with submitted plans
'Touchtime Utilisation' - target change to 85% in line with GIRFT/Model Hospital
'Overall BADs' - include in IPR for F&P Committee
'Bed Occupancy' - look at alternative measure following Apollo implementation
Targets to be aligned with Trust's Operational Planning Submission

3.4 Overall IPR

The table below outlines the proposed changes for IPR in 24/25:

New throughout 2024/25
Executive Summary / Icon Summary - to highlight the exceptions within IPR - example can be found in Appendices
COD - changes to content with a specific section focusing on Theatres Productivity
Health Inequalities - covering paper for IPR to F&P and Q&S to contain supporting information looking at profiling of waiting lists and long waits initially. To be developed throughout financial year
Benchmarking - covering papers with IPR to contain supporting information looking at benchmarking of some measures. To be developed throughout financial year

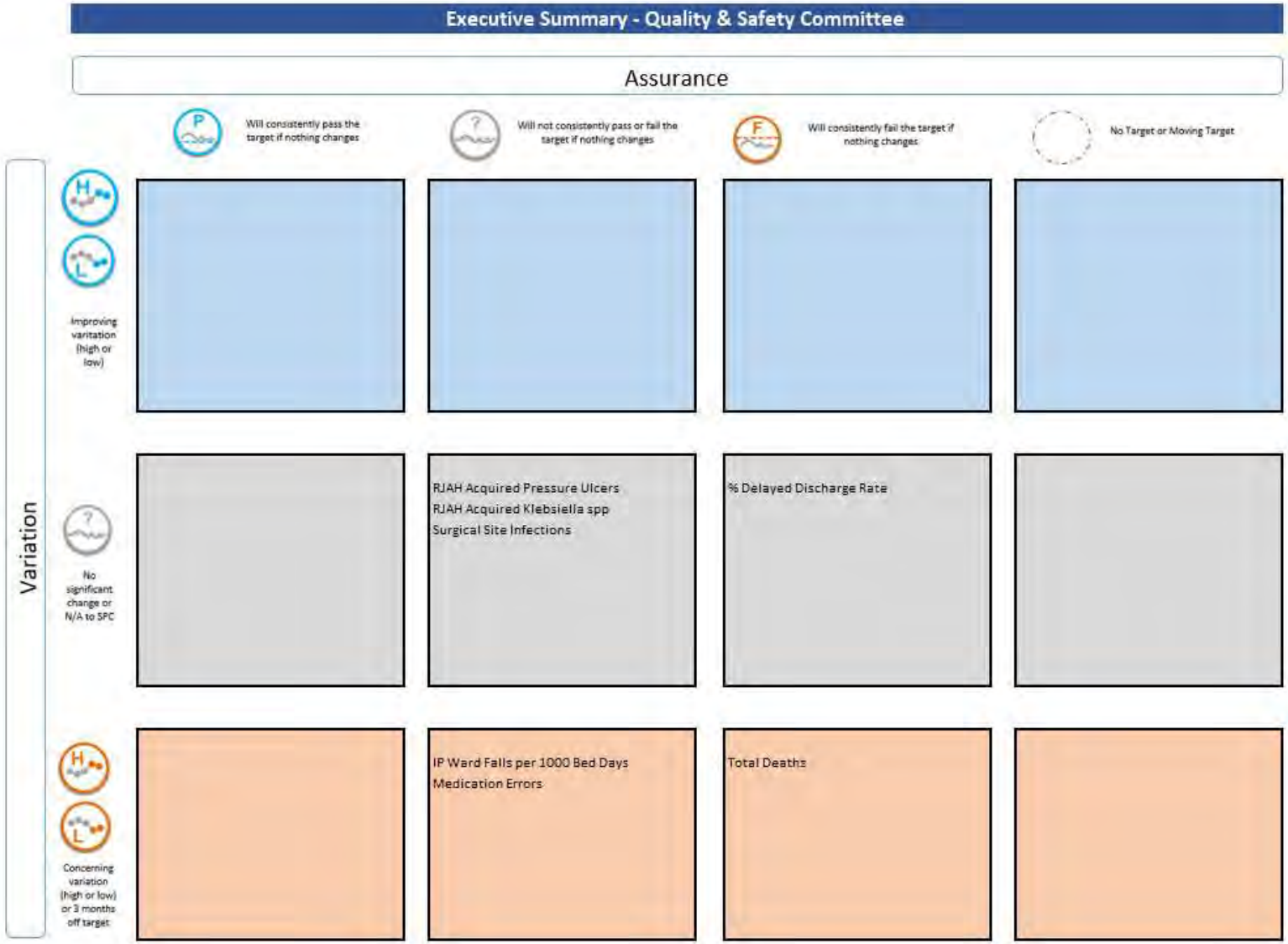
4. Recommendation

The Board and its sub-committees are asked to discuss and consider the proposals made in section 3 before implementation into IPR in 2024/25.

5. Appendices

Appendix A

There is a proposal to include an Executive Summary for each committee as demonstrated below. The summary allows easy identification of the exceptions within the IPR by variation and assurance.


Executive Summary - Quality & Safety Committee
Assurance
Will consistently pass the target if nothing changes
Will not consistently pass or fail the target if nothing changes
Will consistently fail the target if nothing changes
No Target or Moving Target
Variation
Improving variation (high or low)
No significant change or N/A to SPC
Concerning variation (high or low) or 3 months off target
RJAH Acquired Pressure Ulcers
RJAH Acquired Klebsiella spp
Surgical Site Infections
% Delayed Discharge Rate
IP Ward Falls per 1000 Bed Days
Medication Errors
Total Deaths

Executive Summary - Finance & Performance Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving variation (high or low)		Touchtime Utilisation Outpatient DNA Rate	Patients Waiting Over 52 Weeks - English Patients Waiting Over 78 Weeks - English Patients Waiting Over 104 Weeks - English Overdue Follow Up Backlog 8 Week Wait for Diagnostics - Welsh	6 Week Wait for Diagnostics - English Total Theatre Activity Against Plan PP Activity - Theatres - Against Plan Elective Activity Against Plan Total OP Activity Against Plan
No significant change or N/A to SPC				Patients Waiting Over 52 Weeks - Welsh Patients Waiting Over 78 Weeks - Welsh Patients Waiting Over 104 Weeks - Welsh Average Length of Stay Total OP Activity - % Moved to PIFU
Concerning variation (high or low) or 3 months off target		New to Follow Up Ratio	18 Weeks RTT Open Pathways English List Size	Volume of Theatre Cancellations Welsh List Size Total OP Activity - % Virtual

Appendix B – KPIs Reported to Committees

(As at 8th April 2024 – includes all changes made throughout 23/24 financial year but not those proposed for 24/25):

Section	Exec Lead	KPI Name	Trust Board	Quality & Safety	People	Finance & Performanc
Staff	Chief People Officer	Sickness Absence	✓		✓	
Staff	Chief People Officer	Sickness Absence - Short Term			✓	
Staff	Chief People Officer	Sickness Absence - Long Term			✓	
Staff	Chief People Officer	Staff Turnover - Headcount	✓		✓	
Staff	Chief People Officer	In Month Leavers	✓		✓	
Staff	Chief People Officer	Vacancy Rate	✓		✓	
Staff	Chief People Officer	Nursing Vacancy Rate (Trust)			✓	
Staff	Chief People Officer	Healthcare Support Worker Vacancy Rate			✓	
Staff	Chief People Officer	Allied Health Professionals Vacancy Rate			✓	
Staff	Chief People Officer	Total Headcount in Post			✓	
Staff	Chief People Officer	Time to Recruit			✓	
Staff	Chief People Officer	Staff Retention			✓	
Staff	Chief People Officer	% Staff Availability			✓	
Staff	Chief People Officer	Statutory & Mandatory Training			✓	
Staff	Chief People Officer	Personal Development Reviews			✓	
Staff	Chief Nurse & Patient Safety Officer	E-Rostering Level of Attainment			✓	
Staff	Chief Nurse & Patient Safety Officer	Percentage of Staff on the E-Rostering System			✓	
Staff	Chief Nurse & Patient Safety Officer	% of E-Rosters Approved Six Weeks Before E-Roster Start Date			✓	
Staff	Chief Nurse & Patient Safety Officer	% of System-Generated E-Roster (Auto-Rostering)			✓	
Staff	Chief Medical Officer	E-Job Planning Level of Attainment			✓	
Staff	Chief Medical Officer	Percentage of Staff with an Active E-Job Plan			✓	

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

IPR Review

Section	Exec Lead	KPI Name	Trust Board	Quality & Safety	People	Finance & Performanc
Patients	Chief Nurse & Patient Safety Officer	Patient Safety Incident Investigations	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	Total Patient Falls		✓		
Patients	Chief Nurse & Patient Safety Officer	Inpatient Ward Falls per 1,000 Bed Days		✓		
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired Pressure Ulcers		✓		
Patients	Chief Nurse & Patient Safety Officer	Pressure Ulcer Assessments		✓		
Patients	Chief Nurse & Patient Safety Officer	Patient Friends & Family - % Would Recommend (Inpatients &		✓		
Patients	Chief Nurse & Patient Safety Officer	Number of Complaints	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	Standard Complaints Response Rate Within 25 Days		✓		
Patients	Chief Nurse & Patient Safety Officer	Complex Complaints Response Rate Within 40 Days		✓		
Patients	Chief Nurse & Patient Safety Officer	Complaints Reopened		✓		
Patients	Chief Nurse & Patient Safety Officer	Safe Staffing		✓		
Patients	Chief Nurse & Patient Safety Officer	Mixed Sex Accommodation		✓		
Patients	Chief Nurse & Patient Safety Officer	% Delayed Discharge Rate		✓		
Patients	Chief Operating Officer	Number of Spinal Injury Patients Fit For Admission to RJAH		✓		✓
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired C.Difficile	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	C Diff Infection Rates Per 100,000 Bed Days		✓		
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired E. Coli Bacteraemia	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	E Coli Infection Rates Per 100,000 Bed Days		✓		
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired MRSA Bacteraemia	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired MSSA Bacteraemia	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired Klebsiella spp	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	RJAH Acquired Pseudomonas	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	Surgical Site Infections	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	Outbreaks	✓	✓		
Patients	Chief Nurse & Patient Safety Officer	Patient Safety Alerts Not Completed by Deadline		✓		
Patients	Chief Nurse & Patient Safety Officer	Medication Errors		✓		
Patients	Chief Medical Officer	Number of Deteriorating Patients	✓	✓		
Patients	Chief Medical Officer	Total Deaths	✓	✓		
Patients	Chief Medical Officer	RJAH Acquired VTE (DVT or PE)		✓		
Patients	Chief Medical Officer	VTE Assessments Undertaken		✓		
Patients	Chief Medical Officer	28 days Emergency Readmissions		✓		
Patients	Chief Medical Officer	WHO Quality Audit - % Compliance	✓	✓		
Patients	Chief Operating Officer	Volume of Theatre Cancellations		✓		✓
Patients	Chief Operating Officer	31 Day General Treatment Standard	✓	✓		
Patients	Chief Operating Officer	62 Day General Standard	✓	✓		
Patients	Chief Operating Officer	28 Day Faster Diagnosis Standard	✓	✓		

IPR Review

Patients	Chief Operating Officer	18 Weeks RTT Open Pathways	✓			✓
Patients	Chief Operating Officer	English List Size				✓
Patients	Chief Operating Officer	Welsh List Size				✓
Patients	Chief Operating Officer	Combined List Size				✓
Patients	Chief Operating Officer	Patients Waiting Over 52 Weeks – English	✓			✓
Patients	Chief Operating Officer	Patients Waiting Over 52 Weeks – Welsh (Total)	✓			✓
Patients	Chief Operating Officer	Patients Waiting Over 52 Weeks - Combined				
Patients	Chief Operating Officer	Patients Waiting Over 78 Weeks – English	✓			✓
Patients	Chief Operating Officer	Patients Waiting Over 78 Weeks – Welsh (Total)	✓			✓
Patients	Chief Operating Officer	Patients Waiting Over 78 Weeks - Combined				
Patients	Chief Operating Officer	Patients Waiting Over 104 Weeks - English	✓			✓
Patients	Chief Operating Officer	Patients Waiting Over 104 Weeks - Welsh (Total)	✓			✓
Patients	Chief Operating Officer	Patients Waiting Over 104 Weeks - (Combined)				
Patients	Clinical Services Unit	Overdue Follow Up Backlog	✓	✓		✓
Patients	Clinical Services Unit	6 Week Wait for Diagnostics - English Patients	✓			✓
Patients	Clinical Services Unit	8 Week Wait for Diagnostics - Welsh Patients	✓			✓

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

IPR Review

Section	Exec Lead	KPI Name	Trust Board	Quality & Safety	People	Finance & Performanc
Finances	Chief Operating Officer	Theatre Cases per Session against plan				✓
Finances	Chief Operating Officer	Touchtime Utilisation				✓
Finances	Chief Operating Officer	Total Theatre Activity Against Plan				✓
Finances	Chief Operating Officer	IJP Activity - Theatres - against Plan				✓
Finances	Chief Operating Officer	OJP Activity - Theatres - against Plan				✓
Finances	Chief Operating Officer	PP Activity - Theatres - against Plan				✓
Finances	Chief Operating Officer	Elective Activity Against Plan (volumes)	✓			✓
Finances	Chief Operating Officer	Overall BADS %	✓			
Finances	Chief Operating Officer	Average Length of Stay - Elective & Non Elective				✓
Finances	Chief Operating Officer	Bed Occupancy – All Wards – 2pm				✓
Finances	Clinical Services Unit	Total Outpatient Activity against Plan (volumes)	✓			✓
Finances	Clinical Services Unit	IJP Activity - Outpatients - against Plan				✓
Finances	Clinical Services Unit	OJP Activity - Outpatients - against Plan				✓
Finances	Clinical Services Unit	Total Outpatient Activity - % Virtual				✓
Finances	Clinical Services Unit	Total Outpatient Activity - % Moved to PIFU Pathway	✓			✓
Finances	Chief Operating Officer	Outpatient DNA Rate (Consultant Led and Non Consultant Led Activity)				✓
Finances	Clinical Services Unit	New to Follow Up Ratio (Consultant Led and Non Consultant Led Activity)				✓
Finances	Clinical Services Unit	Total Diagnostics Activity against Plan - Catchment Based	✓			✓
Finances	Chief Operating Officer	Data Quality Maturity Index Score				✓
Finances	Chief Operating Officer	Referrals Received for Consultant Led Services				✓
Finances	Chief Finance and Planning Officer	Financial Control Total	✓			✓
Finances	Chief Finance and Planning Officer	Income	✓			✓
Finances	Chief Finance and Planning Officer	Expenditure	✓			✓
Finances	Chief Finance and Planning Officer	Efficiency Delivered	✓			✓
Finances	Chief Finance and Planning Officer	Cash Balance	✓			✓
Finances	Chief Finance and Planning Officer	Capital Expenditure	✓			✓
Finances	Chief Finance and Planning Officer	Agency Core - On Framework	✓		✓	✓
Finances	Chief Finance and Planning Officer	Agency Core - Off Framework	✓		✓	✓
Finances	Chief Finance and Planning Officer	Insourcing Agency			✓	✓
Finances	Chief Finance and Planning Officer	Proportion of Temporary Staffing			✓	
Finances	Chief Finance and Planning Officer	Better Payment Practice Code (BPPC) % of Invoices paid within 30 days				✓
Finances	Chief Finance and Planning Officer	Value Weighted Assessment	✓			✓

Trust Board - Finance
March 2024 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

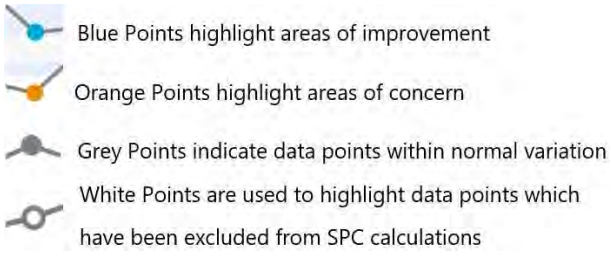
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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

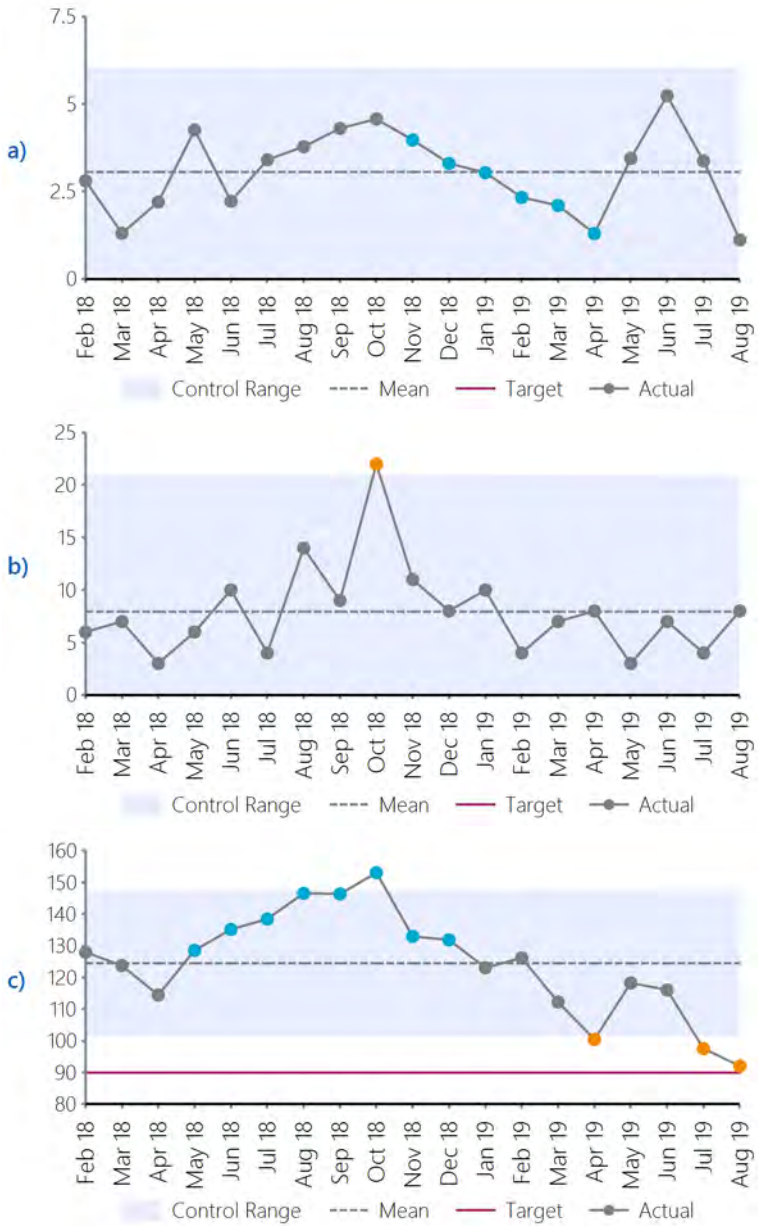


Some examples of these are shown in the images to the right:

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

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

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



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

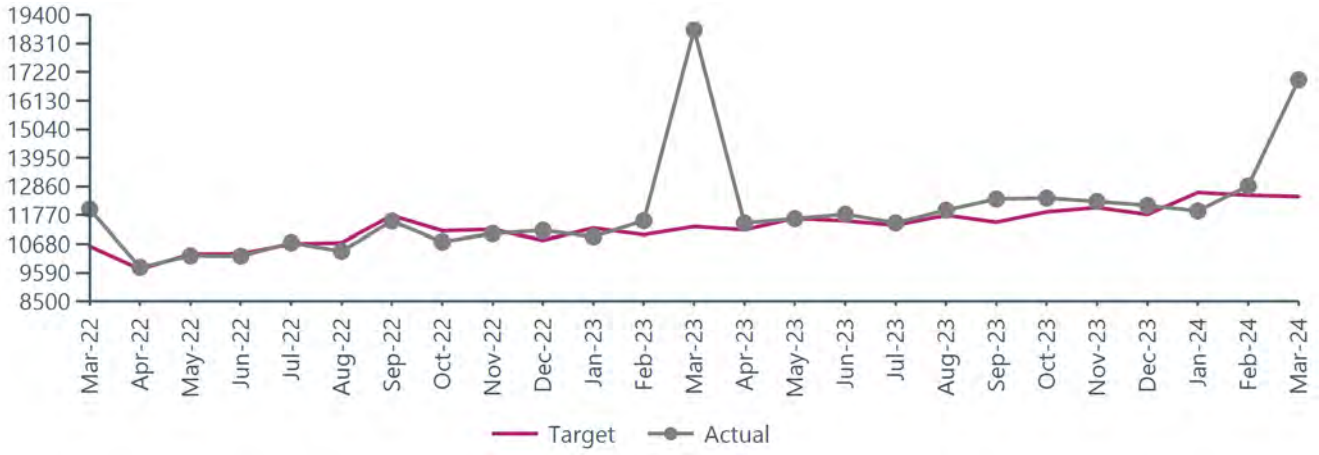
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	78	370.85		N/A to SPC	Moving Target		
Income	12,553.37	17,200.98		N/A to SPC	Moving Target		
Expenditure	12,475.80	16,929.27		N/A to SPC	Moving Target	+	
Efficiency Delivered	492	485		N/A to SPC	Moving Target		
Cash Balance	20,647	21,743		L	Moving Target		
Capital Expenditure	2,316	5,127		N/A to SPC	Moving Target		
Value Weighted Assessment	143.64%	112.40%		N/A to SPC	Moving Target	+	

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
12,475.80	16,929.27	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Expenditure – £384k adverse material cost pressures:

- Adverse wards pay MSK & Spec driven by bank & agency.
- Adverse theatres pay driven by bank & agency.

Actions

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

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
18833	11469	11634	11800	11472	11956	12383	12417	12288	12136	11929	12881	16929

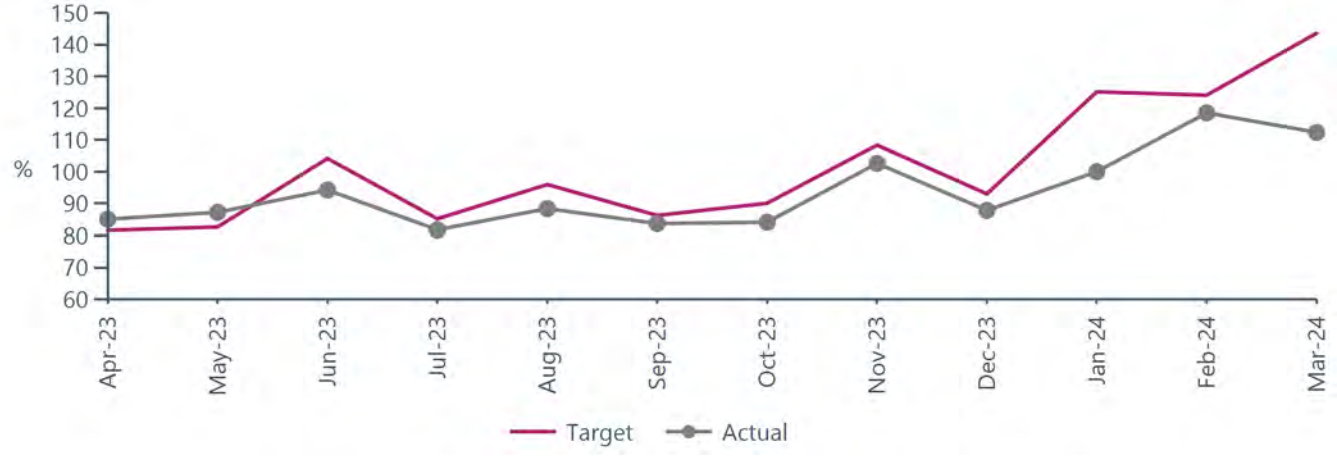
Value Weighted Assessment

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

Exec Lead
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
143.64%	112.40%	N/A to SPC	Moving Target

Trajectory



What these graphs are telling us

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

Narrative

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

Actions

Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	85.08%	87.24%	94.25%	81.76%	88.41%	83.71%	84.12%	102.65%	87.85%	100.04%	118.55%	112.40%

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

Operational and Financial Plan 2024/25

Aspiring to deliver world class patient care

Introduction and context

- We are required to submit a detailed Operational and Financial plan for 2024/25 in line with national planning guidance
- The draft plan was submitted in March and has been further refined following feedback and challenge for a final submission due to be made on 2nd May
- There is full buy in from across the organisation to the assumptions and plans have been socialised through sub committees of the Board (Finance and Performance and People Committee) throughout the planning process
- The risks to delivery have been identified and will be under continuous review through relevant Committee oversight
- Whilst the RJAH plan is largely compliant with national expectations the financial position of the STW ICB remains non compliant so the plan may not be accepted by NHSE
- Upon the recommendation of the Finance and Performance Committee the Board is required to approve the Operational and Financial Plan submission

Submission Headlines

Workforce

- Overall Establishment remains flat in line with NHSE requirements
  - Assumes EPR agreed Business case efficiencies delivered in full
  - Assumes a 26 wte reduction from ongoing Establishment review

- Continued reduction in temporary staffing requirements
  - Bank reduced by 30% by March 2025
  - Agency reduced by 70% by March 2025
  - Agency cap compliance (excluding LLP) but in breach when LLP included (alternative models being explored)

Submission Headlines

NHS Activity

- Value weighted activity metric shows 112% of 2019/20 activity with key delivery assumptions:
  - Productivity improvements of 9% over 23/24
  - LLP activity risk is fully mitigated
  - Reduced outpatient templates following Apollo go live
  - Commencement of TIF 2 capacity from Month 7
  - No Industrial Action impact
  - OJP reduction to 20% by March 2025 (24% OJP overall for the year).

- **PP activity** is planned to continue at 2024/25 levels - 8% of total activity.

Performance

- No patients waiting over 65 weeks by the end of September 2024
- Cancer standards and Diagnostic 6 week target achieved by March 2025
- New Outpatient attendance and procedures equate to 34% of total outpatient activity against target of 46%

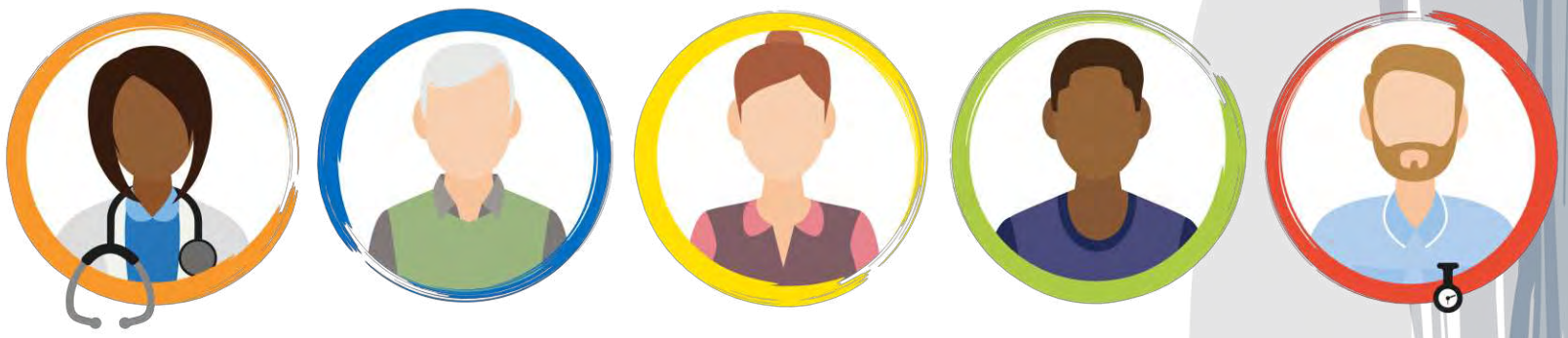
Submission Headlines

Finance

- Surplus of £2.1m
  - Financial risks identified of £13.5m – mostly activity delivery / LLP related
- Efficiency plan of 3.8% or £5.6m
  - 91% identified to date
  - Will be 100% assuming Establishment review identifies required post reduction
  - Aiming for 120% identification to provide mitigation against slippage
- Capital Plan of £8.1m
  - Plan constrained by NHSE imposed delegated limit
  - Almost half taken up by completion of new Theatre
  - Costs of EPR delayed implementation cannot be incorporated into plan – in discussion with NHSE regarding potential support
- Cash balances of £17.6m

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

Appendices
Supporting trajectories

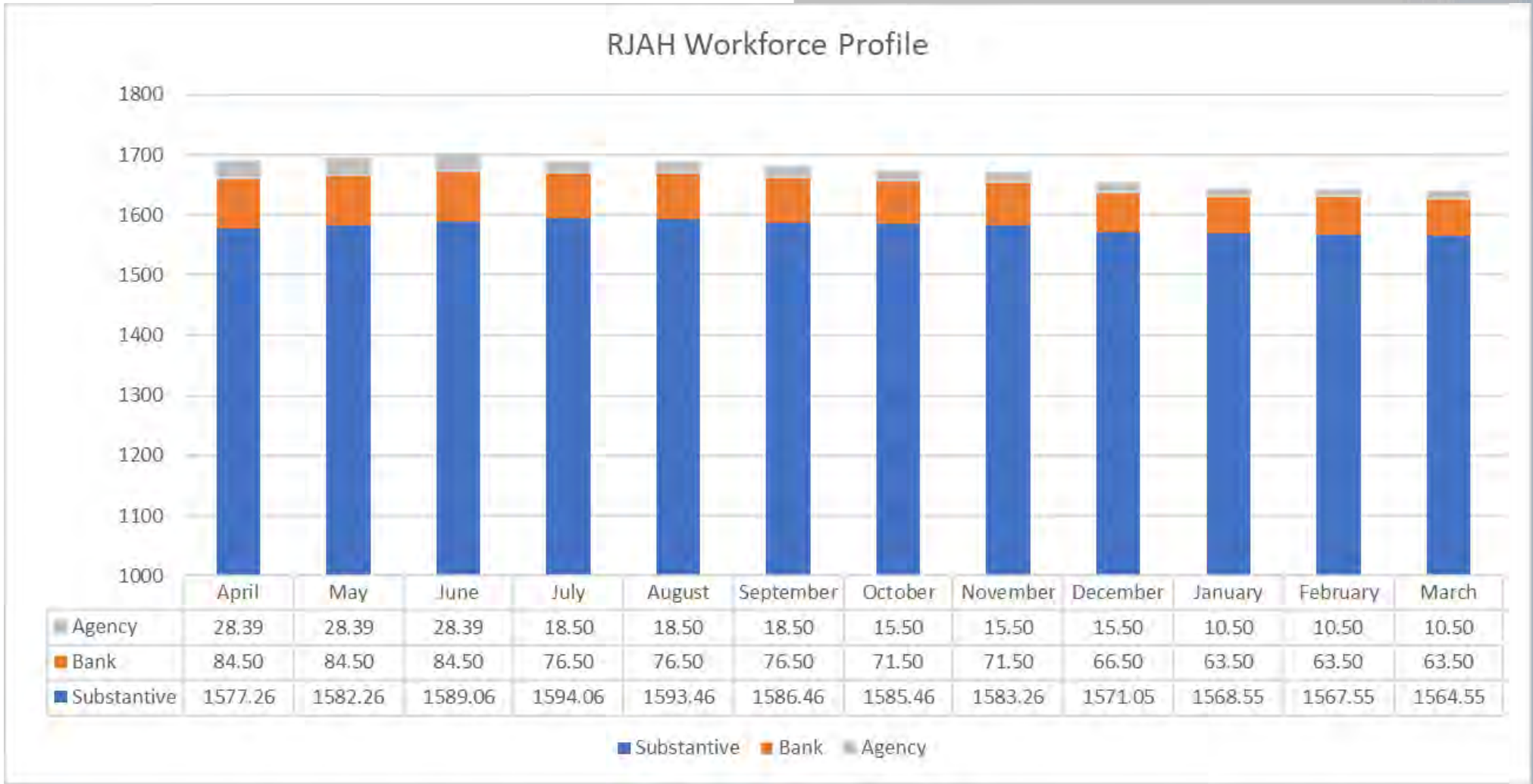


Aspiring to deliver world class patient care

Workforce

Aspiring to deliver world class patient care

RJAH workforce profile (combined staff in post, bank and agency)



	April	May	June	July	August	September	October	November	December	January	February	March
Agency	28.39	28.39	28.39	18.50	18.50	18.50	15.50	15.50	15.50	10.50	10.50	10.50
Bank	84.50	84.50	84.50	76.50	76.50	76.50	71.50	71.50	66.50	63.50	63.50	63.50
Substantive	1577.26	1582.26	1589.06	1594.06	1593.46	1586.46	1585.46	1583.26	1571.05	1568.55	1567.55	1564.55

Agency Summary

Agency wte	Actual	Agency WTE											
	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Registered Nursing, Midwifery and Health visiting staff	20.46	18.00	18.00	18.00	15.00	15.00	15.00	12.00	12.00	12.00	8.00	8.00	8.00
Scientific, Therapeutic, Technical staff	9.22	6.89	6.89	6.89	-	-	-	-	-	-	-	-	-
Support to clinical staff	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical and dental	-	-	-	-	-	-	-	-	-	-	-	-	-
NHS Infrastructure Support	3.15	4.50	4.50	4.50	3.50	3.50	3.50	3.50	3.50	3.50	2.50	2.50	2.50
	32.83	29.39	29.39	29.39	18.50	18.50	18.50	15.50	15.50	15.50	10.50	10.50	10.50

Agency £'000k	Agency £'000k												
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Registered Nursing, Midwifery and Health visiting staff	178	178	178	134	134	134	107	107	107	71	71	71	1,469
Scientific, Therapeutic, Technical staff	61	61	61	-	-	-	-	-	-	-	-	-	184
Support to clinical staff	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical and dental	221	208	234	193	199	212	228	210	196	178	175	170	2,425
NHS Infrastructure Support	-	-	-	-	-	-	-	-	-	-	-	-	-
	460	447	474	327	332	346	335	317	303	249	246	242	4,078

- The agency plan is set at £4.1m or 4.6% of pay bill
- Note this would be 2.7% excluding insourcing costs from OO LLP.
- The national target requirement is 3.2%.

Bank Summary

Bank wte	Actual	Bank WTE											
	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Registered Nursing, Midwifery and Health visiting staff	30.67	28.00	28.00	28.00	25.00	25.00	25.00	20.00	20.00	15.00	12.00	12.00	12.00
Scientific, Therapeutic, Technical staff	9.05	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00
Support to clinical staff	33.89	33.00	33.00	33.00	28.00	28.00	28.00	28.00	28.00	28.00	28.00	28.00	28.00
Medical and dental	20.27	15.50	15.50	15.50	15.50	15.50	15.50	15.50	15.50	15.50	15.50	15.50	15.50
NHS Infrastructure Support	-	-	-	-	-	-	-	-	-	-	-	-	-
	93.88	84.50	84.50	84.50	76.50	76.50	76.50	71.50	71.50	66.50	63.50	63.50	63.50

Bank £'000k	Bank £'000k												
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Registered Nursing, Midwifery and Health visiting staff	249	249	249	223	223	223	178	178	134	107	107	107	2,225
Scientific, Therapeutic, Technical staff	71	71	71	71	71	71	71	71	71	71	71	71	854
Support to clinical staff	232	232	232	193	193	193	155	155	130	97	97	97	2,004
Medical and dental	60	60	60	32	32	32	32	32	32	32	32	32	473
NHS Infrastructure Support	90	89	92	89	86	98	105	96	89	96	88	92	1,110
	703	701	704	608	606	618	541	532	456	403	395	399	6,666

- The bank plan is set at 7.5% of pay bill aligned to the workforce plan submission. This reflects the expected level of flexible resource required to support gaps in recruitment or unavailability during the year.

Activity and Performance

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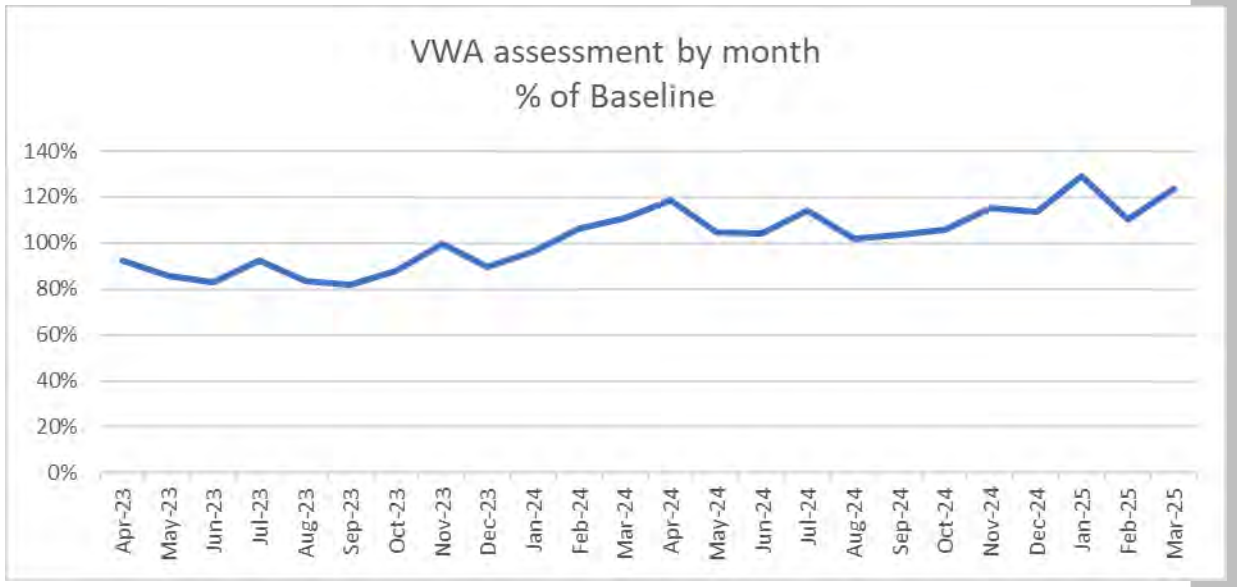
Value Weighted Activity trajectory

ERF/VWA Assessment by POD - 2024/25 Plan - with NHSE Baseline Adjustment	Inpatient £'000 Daycase		Inpatient £'000 Elective		Outpatient £'000 First Attendances		Outpatient £'000 Outpatient Procedures		Total £'000	%
STW	6,555,197	109%	18,699,254	129%	5,185,006	70%	616,871	72%	31,056,328	108%
Other English	1,374,809	102%	8,709,853	129%	871,351	108%	128,460	69%	11,084,472	122%
NHSE	933,609	111%	4,837,173	116%	520,623	95%	39,568	94%	6,330,973	113%
Total English (Exc LVA)	8,863,615	109%	32,246,280	125%	6,576,979	76%	784,899	73%	48,471,773	112%



- Assumes NHSE MSCI baseline error corrected – 1.6% impact
- Assumes inter system service changes for SOOS/MSST not adjusted as net neutral to system – 4% impact for RJAH
- Excludes LVA which is outside cope of methodology

Theatre Activity trajectory

24/25 Draft Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
NHS	887	903	919	891	865	992	1,076	1,022	932	1,043	888	997	11,415
PP	83	78	88	67	63	73	83	82	53	82	75	82	909
% of Activity	9%	9%	10%	8%	7%	7%	8%	8%	6%	8%	8%	8%	8%

Elective Spells Activity Trajectory

		Unit Plans												
		Total Elective Spells												Year
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
MSK Unit	Arthroplasty	314	322	356	345	308	378	425	354	324	373	303	338	**4140**
	Foot & Ankle	102	88	80	92	88	99	92	83	87	105	81	93	**1090**
	Knee & Sports Injuries	105	110	114	116	118	114	128	145	111	112	135	113	**1421**
	Upper Limb	220	224	195	197	199	245	244	259	235	269	202	281	**2770**
	Total	**741**	**744**	**745**	**750**	**713**	**836**	**889**	**841**	**757**	**859**	**721**	**825**	**9421**
Specialist	Geriatrics	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	Metabolic Medicine	91	91	86	99	91	91	99	91	86	95	86	91	**1097**
	Paediatric Medicine	2	3	2	3	3	3	3	3	2	3	2	3	**32**
	Paediatric Orthopaedics	93	97	80	90	97	100	104	107	94	100	92	96	**1150**
	Rheumatology	13	13	11	13	11	13	16	14	12	15	12	14	**157**
	Spinal Disorders	94	102	124	88	105	105	125	133	125	134	119	126	**1380**
	Spinal Injuries	28	28	28	33	28	28	33	28	28	30	28	28	**348**
	Tumour	32	35	28	28	22	26	25	24	24	25	24	25	**318**
	Total	**353**	**369**	**359**	**354**	**357**	**366**	**405**	**400**	**371**	**402**	**363**	**383**	**4482**
														0
	Grand Total	**1094**	**1113**	**1104**	**1104**	**1070**	**1202**	**1294**	**1241**	**1128**	**1261**	**1084**	**1208**	**13903**

- The planned elective spells has increased by increased by 107 cases as compared to the previous submission with additional Paediatric Medicine activity included (ORLAU GAIT)
- Phasing adjustments made to activity plan.

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Outpatient Activity Trajectory

Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
19/20 Baseline	15,935	15,164	14,342	15,869	14,299	15,687	16,700	15,535	13,149	17,003	14,880	15,187	183,750
Hydrotherapy	-225	-225	-225	-225	-225	-225	-225	-225	-225	-225	-225	-225	-2,702
MSST	-1,580	-1,635	-1,607	-1,906	-1,814	-1,888	-2,147	-2,030	-1,762	-2,226	-1,952	-2,035	-22,582
TeMS	394	392	410	431	443	428	488	465	414	440	413	459	5,177
Revised Technical Baseline	14,523	13,696	12,920	14,169	12,703	14,002	14,816	13,745	11,576	14,991	13,116	13,386	163,643
24/25 Plan - pre Apollo impact	13,227	13,366	12,841	13,454	12,759	13,211	14,056	13,734	12,574	14,604	13,436	13,910	161,172
Gap	-1,296	-330	-79	-715	56	-791	-760	-11	998	-387	320	524	-2,471
% Restoration 19/20 Baseline (unadjusted)	83%	88%	90%	85%	89%	84%	84%	88%	96%	86%	90%	92%	88%
% Restoration Adjusted Baseline	91%	98%	99%	95%	100%	94%	95%	100%	109%	97%	102%	104%	98%
Apollo Implementation	0	0	0	0	0	0	-7,066	-3,317	0	0	0	0	-10,383
24/25 Plan - adj re Apollo	13,227	13,366	12,841	13,454	12,759	13,211	6,990	10,417	12,574	14,604	13,436	13,910	150,789
% Restoration19/20 baseline (unadjusted)	83%	88%	90%	85%	89%	84%	42%	67%	96%	86%	90%	92%	82%
% Restoration Adjusted Baseline	91%	98%	99%	95%	100%	94%	47%	76%	109%	97%	102%	104%	92%

- The outpatient Plan includes Rheumatology TEMS transfers and excludes SOOS activity
- The trajectory shows the level of restoration against original baseline and MSST adjusted baseline. We will continue to seek NHSE approval for the necessary baseline adjustments.
- Apollo impact is noted separately and will be kept under review

English RTT Trajectories

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more	1,234	1,194	1,211	1,246	1,265	1,150	978	796	682	525	538	519
Number of 52+ week RTT waits, of which children under 18 years	60	59	59	61	62	56	48	39	33	26	26	25
Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	319	295	199	75	0	0	0	0	0	0	0	0
Referral to Treatment (RTT) pathways (patients yet to start treatment) of 78 weeks or more	0	0	0	0	0	0	0	0	0	0	0	0
Referral to Treatment (RTT) pathways (patients yet to start treatment) of 104 weeks or more	0	0	0	0	0	0	0	0	0	0	0	0

It is expected planning guidance will have a stronger focus on Children and Young People (CYP). Separate trajectories have been requested. RJAH long wait volumes are low with long wait risks predominantly in Spinal Disorders.

Diagnostics trajectories

2. %6wks performance by modiality

MRI	96.2%	96.2%	96.3%	96.1%	96.1%	96.2%	96.0%	96.1%	96.2%	96.1%	96.0%	96.1%
US	65.7%	68.3%	68.3%	73.3%	76.5%	78.2%	85.4%	91.2%	94.0%	88.2%	95.2%	95.2%
CT	95.1%	95.6%	95.3%	95.2%	95.0%	95.6%	95.4%	95.2%	95.0%	95.4%	95.1%	96.2%
Dexa	100.0%	100.0%	100.0%	96.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

3. %6wks performance all modialities

total 6w	217	200	199	168	144	129	91	59	45	68	38	35
total tls	1115	1081	1051	1058	1048	1038	1011	941	928	919	873	823
	80.5%	81.5%	81.1%	84.1%	86.3%	87.6%	91.0%	93.7%	95.2%	92.6%	95.6%	95.7%

- The Trust final submission reflects the performance recovery plan for ultrasound.
- The MRI mobile scanner is contained within the submission assuming 16 weeks utilisation per annum in order to maintain 95% compliance for MRI.

Cancer – 28 day Faster Diagnosis

Reporting Period	Total Patients	Treated in Target	% treated in target
April	23	20	86.96%
May	28	25	89.29%
June	43	40	93.02%
Quarter 1	**94**	**85**	**90.43%**
July	39	35	89.74%
August	38	34	89.47%
September	38	34	89.47%
Quarter 2	**111**	**96**	**86.49%**
October	40	36	90.00%
November	34	30	88.24%
December	38	34	89.47%
Quarter 3	**111**	**104**	**93.69%**
January	36	32	88.89%
February	34	30	88.24%
March	34	32	94.12%
Quarter 4	**104**	94	**90.38%**
Annual	**420**	**379**	**90.24%**

Performance trajectory for 2024/25 reflective of current performance in 23/24.

Cancer – 62 day target (combined referral to treatment) English

Provider Level					Nov-23	Plan Basis	Apr 2024-Mar 2025	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	E.B.35	Numerator	Number of patients seen within 62 days	0	In period activity	18	1	1	1	2	1	2	2	2	2	1	2	1
		E.B.35	Denominator	Total number of patients seen	0.5	In period activity	21	1	1	2	2	2	2	2	2	2	2	2	1
		E.B.35	Percentage	Percentage of patients seen within 62 days	0	In period activity	86	100	100	50	100	50	100	100	100	100	50	100	100

This trajectory has been updated due limitations in ability to show 0.5 patients in numerator and denominator in the National template for submission.

Improvement trajectory based on strengthening pathway coordinator role and administration processes. It is recognised that there remains a risk of a small number of breaches occurring due to pathway complexity which will impact on our performance percentage due to the small levels of activity reported.

Cancer – 31 day target (from decision to treat)

Reporting Period	Total Patients		% treated in
		JONES, Nia (THE ROBERT JONES AND AGNES HUNT	
April	1	1	100.00%
May	1	1	100.00%
June	1	1	100.00%
Quarter 1	**3**	**3**	**100.00%**
July	1	1	100.00%
August	1	1	100.00%
September	1	1	100.00%
Quarter 2	**3**	**3**	**100.00%**
October	1	1	100.00%
November	1	1	100.00%
December	1	1	100.00%
Quarter 3	**3**	**3**	**100.00%**
January	1	1	100.00%
February	1	1	100.00%
March	1	1	100.00%
Quarter 4	**3**	**3**	**100.00%**
Annual	**12**	**12**	**100.00%**

Performance trajectory for 2024/25 reflective of current performance in 23/24.

New Outpatient attendance and procedures as a percentage of total outpatient activity – target 46%

Trust performance against this target is 34%

Provider Level		Apr 2024 - Mar 2025	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Count	Outpatient procedures - ERF scope	6,172	402	428	475	475	480	460	566	538	520	624	560	644
Count	Outpatient first attendances without a procedure - ERF scope	31,951	2,621	2,719	2,738	2,624	2,660	2,502	2,786	2,554	2,396	2,974	2,519	2,858
Count	Outpatient follow up attendances without procedure - ERF scope	77,008	6,276	6,452	6,510	6,361	6,423	6,080	6,884	6,357	5,898	7,058	5,925	6,784
Percentage	Percentage outpatients follow-up without a procedure	66.9%	67.5%	67.2%	67.0%	67.2%	67.2%	67.2%	67.3%	67.3%	66.9%	66.2%	65.8%	66.0%

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Finance

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Movements from draft to final plan

Draft 2024/25 Plan	**1.7**	**Surplus**
EPR programme slippage	-0.4	EPR programme slipped 3 months, estimated revenue cost impact
Additional vacancy factor	0.4	Increase non recurrent vacancy factor aligned to workforce plans & vacancy controls
Remove Oliver Mcgowan training cost pressure	0.3	Removal of cost pressure agreed with ICS CNO's to review impact
Additional depreciation funding	0.1	Additional funding notified by NHSE to supprot depreciation cost pressures
Final 2024/25 Plan	**2.1**	**Surplus**

- Draft plan surplus of £1.7m, this has improved to a £2.1m surplus for the final submission, with the following movements :
  - EPR programme slippage – the programme has slipped 3 months to a Go Live date in September, this has a corresponding impact on system costs and benefits realisation.
  - Increase to the vacancy factor to 2.5% of pay bill aligned to workforce plans & enhanced vacancy controls
  - Cost pressure for mandatory Oliver McGowan training removed following system CNO discussions (training places are severely limited), review of approach to be undertaken
  - Additional depreciation funding notified by NHSE allocated to organisations pro rata

I&E Summary

Plan 24/25 £'000k	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
Clinical Income NHS	11,136	11,313	11,484	11,243	11,040	11,820	11,903	11,863	11,392	12,258	11,317	11,948	138,718
Clinical Income PP	751	709	795	622	609	697	786	777	521	777	715	777	8,536
Other Income	695	695	695	769	769	897	907	637	637	637	637	637	8,612
Pay	-7,529	-7,522	-7,532	-7,544	-7,529	-7,666	-7,862	-7,694	-7,675	-7,677	-7,681	-7,689	-91,599
Non Pay	-4,367	-4,354	-4,433	-4,368	-4,310	-4,564	-4,793	-4,720	-4,478	-4,723	-4,472	-4,667	-54,251
Finance Costs	-613	-610	-610	-615	-613	-648	-698	-698	-699	-700	-701	-701	-7,908
Total	73	231	398	-107	-33	537	242	-165	-302	571	-185	305	2,109

- The draft I&E position is £2.1m surplus:
  - Income plan is set at £138.7m clinical income, £8.5m Private Patient income and £8.6m non-clinical income
  - Expenditure plan totals £153.8m after efficiency
  - Phasing is largely linked to working days and is heavily influenced by theatre activity, months with higher working days and/or greater volumes of theatre activity tend to return a surplus

Final Capital Programme

Capital Plan	2024/25 £'m
Trust Funded Investments	
Business Continuity	
Backlog estates maintenance	0.40
IT investment & replacement	0.40
Capital project management	0.15
Equipment replacement programme	0.93
Diagnostic equipment replacement plan	0.10
Compliance (IPC, health & safety, quality)	0.30
Estates reconfiguration (utilisation, service optimisation)	0.30
Sub Total Business Continuity	**2.58**
Developments	
Invest to Save (Green developments and investment to benefit revenue)	0.30
Completion of TIF2 Theatre Development (contractually committed)	3.70
EPR Implementation Go Live Slippage (contractually committed)	0.30
IFRS16 Impact	0.20
Sub Total Developments	**4.50**
Total Operational Capital Requirement (CDEL)	**7.08**
External Operation CDEL Budget Estimate	7.06
Variance to CDEL	-0.02
Externally Funded	
EPR planning & implementation (contractually committed)	1.00
Donated equipment	0.10
Rehabilitation Facility (charitably funded)	
Total Externally Funded	**1.10**
Total Capital Programme	**8.18**

- The final capital programme totals £8.2m for 24/25
  - Trust funded capital (operational capital) is £7.1m
  - Externally funded capital is £1.1m (Apollo EPR)
- There is a significant roll forward commitments relating to the TIF2 theatre development £3.7m.
- Material changes since the draft plan include :
  - Radiology x-ray room spend slipped into 25/26 £0.9m (procurement can start in 24/25 for Q1 25/25 implementation)
  - EPR slippage cannot be afforded within the envelope £0.8m (discussions with NHSE on funding options)
- The Trust receives a capital budget (CDEL) limit through the ICS for operational capital, for 24/25 this is £7.1m, the final plan is therefore within this envelope.

Cash Projection

Projected Cash Balances 2024/25	£m
Opening cash balance	21.7
Impact of 24/25 plan	1.3
Loan repayment	-1.4
Cash investment in capital programme	-2.5
Working capital movements (estimate)	-1.5
Closing Cash Balances	17.6

- Opening cash balances £21.7m
- Cash reduction in 24/25 due to :
  - £1.3m surplus cash from plan, this is lower than surplus due to non-cash performance adjustments on the control total
  - -£1.4m loan repayment (final year)
  - -£2.5m investment in capital programme
  - -£1.5m working capital, this is outstanding cash payments in March for theatre development and Apollo EPR
- Minimum liquidity requirement for 30 days expenditure is c£6m so projected closing cash balances are sufficient.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance and Performance Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary / Craig Macbeth, Chief Finance and Planning Officer	Paper date:	01 May 2024
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	29 April 2024
Paper Reviewed by:	Sarfraz Nawaz, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors – Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Context

2.1 Context

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

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

3. Assurance Report from Finance and Performance Committee

This report provides a summary of the items considered at the Finance and Performance Committee on 25 March 2024 and 26 April 2024. It highlights the key areas the Finance and Performance Committee wishes to bring to the attention of the Board.

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

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

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

Update on LLP Plans

The Committee received an update regarding the future of the LLP contract following further discussion with NHSE and LLP leads. It is now almost certain that the capacity will end from July 2024 so mitigations to the 2024/25 plan are currently being worked up.

EPR Project Financial Forecast Update
The Committee received the report which outlined the financial forecast following the delay of the go live for EPR/Appollo Programme. It was noted that the programme is forecasting an overspend between £800k - £1.2m (capital) and £350k revenue impact. The revenue pressure has been added into the final plan submission but there is no headroom to accommodate the capital within the delegated capital spend limit. Discussions are therefore ongoing with NHSE to seek possible support. The Committee noted the current position, requesting support from DERIC Committee and EPR Implementation Assurance Committee to gain further assurance.

3.2 Areas of on-going monitoring with new developments

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

Operational and Financial Plan 2024/25
The Committee received the final operational and financial plan submission for 2024/25 and were assured that all of the further actions agreed following review of the draft submission had been completed or were progressing.
The Committee were advised of two significant areas that needed to be concluded for the plan to be achieved; completion of the workforce establishment review with around 25 posts required to be removed and alternative options for replacing capacity previously undertaken by LLP.
Additionally, an update regarding the system financial position was provided and it was highlighted that due to ongoing escalation with NHSE there was a push to continue to improve on the financials across all system partners. Further updates to the financial position were therefore likely and any further updates would be provided to Board ahead of final submission on the 2nd May.
Noting the areas of ongoing work, the Committee endorsed the 2024/25 plan which is to be presented to the Board of Directors for formal approval.
The Committee expressed thanks for all the effort that has gone into the planning and asked to extend thanks onto the teams involved.

KPI Proposal 2024/25
The Committee considered and supported the KPI proposal for 2024/25 which presented the indicators aligned to the Committee. The Committee recommends the Board approved the revised KPI's.

Financial Performance Report
The Committee were assured the Trust achieved the revised forecast position of £1.9m deficit. noting that the revised activity plans had been achieved and efficiency plans delivered in full. The Committee commended the work undertaken by the staff to overachieve in efficiency areas. It was also noted that the Trust had finally received support non recurrently from NHSE for the ERF baseline error, but a permanent fix was still awaited.
The Committee reflected upon the past 12 months and discussed lessons learnt expressing the effectiveness of the Financial Recovery Group as it offered protected time for proactive actions to be taken. There is much more positivity operationally around the delivery of plans and this will continue to be overseen through a re-branded Financial Improvement Group. On behalf of the Board, the Committee expressed gratitude for the collective approach to looking forward in identifying risks and mitigating them beforehand.

Corporate Risk Register
The Committee considered the register which reported the high risks aligned to the meeting. The following movements were noted:

- risk 3097 is reflected as it stood at the last Risk Management Group and will be altered following discussions at the Committee.
- risk 3027 is presented following a review of the wording requested by the Committee.
- risk 2934 is included in the summary, but this will be closed, reworked, and brought back in its new form.

The Committee approved the register ahead of presentation to the Board, subject to the following amendments:

- review risk 3097 in relation to the mitigating action
- review risk 3078 following discussion which took place at the last private Board meeting.

Committee Annual Report and Terms of Reference.
The Committee considered the annual report. Although there were no areas of concern raised, it was agreed that the Chair of the meeting would reflect upon the self-assessment and consider actions to support improvement of the Committee ahead of presentation to the Board in June.

NHSE Productivity Template
The Trust were presented with a tool of how productivity will potentially be monitored for 2024/2025. The tool triangulates the various elements of the plan to give a notional productivity value with key areas including expenditure and activity delivered. A requirement from NHSE was for the Trust to demonstrate a 6% improvement in productivity for 2024/2025. The adjusted figures alter the expenditure outturn to recognise the non-recurrent effects in year, making a fair comparison to the 24/25 plan. This decreases the expenditure growth to 1.3% and increases the activity growth to 10.4%, implying a 9% productivity gain. The Committee noted this was work in progress and welcomed an update at a future meeting once the further clarity was gained.

Productivity Dashboard
The purpose of the presentation is to undertake a stock take of 2023/2024 against several productivity metrics, how these have been progressed, and assurance that they have been considered in the 2024/2025 plans. It was noted that this is a work in progress as further metrics have been released by NHSE and a new portal is being developed in the Model Health System. The Committee requested the productivity dashboard being presented on a frequent basis and welcomed a deep dive presentation at a future private board development session given the importance to the Trust's future sustainability.

3.3 Areas of assurance

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

Performance Report
The Committee was assured with the performance report, noting the following positives in particular:

- Acknowledged the improving activity over the past year. Theatre activity shows a 35% increase within a 12-month period.
- Commended the Trust for sustaining similar levels of high activity for 5 months in a row.
- In job plan activity delivered at 99.6% for March.
- Noted an overall reduction in cancellations - staff are being redeployed into pre-op to aid in reducing cancellations.

Long Waiters Presentation
The Committee were assured with the processes in place to support long waiting patients. It was reported that there was 1 English patient at 78 weeks by the end of April and the Trust is on trajectory to achieve 0 for 65 weeks by the end of August. The Committee noted the increase in Welsh waiting list which is due to relevant referral period. The Trust are working to achieve NHSE target around 65 weeks by Q2 as this gives the Trust the remainder of the year to focus on equalising the waiting list between the English and Welsh patients.

Specialist Unit Efficiency Update (from March meeting)
The forecast position for the unit is between £10k - £64k over delivery and are reviewing the current short fall expected in 2024/25. The Committee were assured following the presentation of the report.

Veterans (Phrase 2) Update (from March meeting)
It was noted the Trust are not currently in a position to move forward with the Veterans Business case. The Rehabilitation Oversight Group will continue to develop the business case proposal with the scope adjusted to reflect the clinical and operational team findings. The Estates team and architects will work with the stakeholders to put forward a gym facilities proposal and the Trust will

engage with Headley Court Trust to provide an update on the current status of the proposal. An update will be shared with the Committee in due course.

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

- **MSK Transformation Board** – there were no concerns to raise. The Committee noted the MSST service waiting times and were reassured that regular meetings are overseen with the Director of Operations from Shropshire Community Trust to bring an improvement for the service. The Committee was notified of the contract's expiry date within the MSK Programme and will be taking this to the ICB to seek support and funding.
- **Trust Performance and Operation Improvement Group** – there were no concerns to escalate to the Committee. There is an increase to the demand in the pharmacy homecare service and a proposal is under development to make this a more sustainable service.
- **Procurement Working Group** – there were no concerns to raise. The Committee discussed the expiring implant contracts over the next 1-4 years with an expected 10-15% increase in inflation therefore alternative suppliers is being explored to mitigate this. This forward look has been built into the 24/25 financial plan.
- **Capital Management Group** – in relation to the new theatre, the contractor is now back working as expected and there are no current concerns regarding achieving the revised handover date of the 30th August. The slippage from 2023/24 will need to be prioritised against the 2024/25 capital limit and non-essential spend deferred to accommodate.
- **Theatre Development Group** – the future phases and requirements for further theatres within the extension was shared with the Committee. A review of utilisation and optimisation is currently underway. It was noted that for Menzies the lease expires at the end of 2026 therefore the Committee asked for further updates regarding the Theatre strategy.

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Financial Improvement Group - Terms of Reference

The Committee reviewed and approved the updated Terms of Reference for the Financial Improvement Group.

4.0 Conclusion / Recommendation

The Board is asked to:

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

Chair's Assurance Report
Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	01 May 2024
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1. Purpose of Paper

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

This is an assurance report from the Digital, Education, Research, Innovation and Commercialisation Committee. The Board is asked to consider the recommendations of the Digital, Education, Research and Innovation Committee.

2. Context

2.1 Context

The Trust Board has established a Digital, Education, Research, Innovation and Commercialisation Committee. According to its terms of reference: *"The Board of Directors has delegated responsibility for the oversight of the Trust's Digital, Education, Research performance to the Digital, Education, Research, Innovation and Commercialisation Committee. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board."*

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

3. Assurance Report from DERIC Committee

This report provides a summary of the items considered at the Digital, Education, Research, Innovation and Commercialisation (DERIC) Committee on 28 March 2024 and 24 April 2024. It highlights the key areas DERIC wishes to bring to the attention of the Board.

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

ALERT - The Digital, Education, Research and Innovation Committee wishes to bring the following issues to the Board's attention as they: • Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR • Require the approval of the Board for work to progress.
There were no areas to alert to the Board.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Digital, Education, Research and Innovation Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:
Corporate Risk Register The Committee received the relevant risks for consideration ahead of presentation the Board in May. It was noted there has been a rise in the radiology systems which has increases 16 to 20, the Committee asked for an update on the procurement process to be circulated for oversight.

It was noted EPR implementation risks are reported through the EPR Implementation Assurance Committee.

Chair Report for the EPR Implementation Assurance Committee
The Committee received the chair assurance report from the meeting in February. Overall, the Trust has greater confidence in the programme delivering.

- It was a well-attended meeting, and good discussions took place.
- Noted the risk for data migration has increased.
- Discussed the likelihood of harm to patients in relation to the EPMA module. The Trust confirmed the go live of the system will only take place with the EMPA module.
- Assurance was obtained on resources specifically relating to training and induction of the System.
- The Committee requested an update on the programme timeline at the next meeting.
- It was agreed a EPR task and finish group would be established to support the development of the training programme.

Digital/Cyber Security Report
The Committee were assured with the processes in place in relation to data security and patching programme which reported to have progressed.
The Committee queried the assurance regarding the MFA delivery deadline. The confidence in achieving the target was noted as internally the Trust is on track. The unknown element is the factors in the control of the internet provider and therefore, the Committee requested an update at the next meeting.
It was noted there is NHS digital guidance on the issue as all Trusts are encountering MFA implementation. It was agreed that the Trust must ensure it has done all it can to assist staff through this change.

ICS Digital Strategy Update
The draft strategy was shared with the Committee for information only. It was noted it is yet to be approved the ICB. Throughout the Committee discussions, there were areas of improvement highlighted and the greater need for collaboration across all providers. It was agreed the Trusts digital strategy will need to align with the Systems.

3.3 Areas of assurance

ASSURE - The Digital, Education, Research and Innovation Committee considered the following items and did not identify any issues that required escalation to the Board.

Chair Report – Research Meeting
There were no areas of concerns to raise, the following notes were highlighted**:**

- There has been a successful appointment for the post of Research Manager, DBS checks are currently in process, planning for an end of June start date.
- Assurance was given that the research departments finances are well managed.
- Assurance was given that the research governance processes continue.
- It was noted a report from the serious adverse events review meeting regarding Optetrak will go to Patient Safety Meeting and an update will be provided via the Chair Report for the DERIC Committee.

Education and Training Update
There were no areas of concern to highlight to the Board. The Committee agreed for the Nursing and AHP staff group to report into DERIC once the meeting has been established. The Trust are currently compiling the term of reference which will be presented to DERIC for approval in due course.

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

share ideas for improvement. There are currently 5 ongoing projects and 2 projects have been fully implemented. The Committee welcomed innovation stories to be added to the workplan.

Committee workplan
To support the direction of the meeting, the Committee agreed the following agenda item will be included within the work plan for 2024/25.

- Research Strategy
- Innovation Hub Business Case
- Innovation Stories

Chair Report – Non-Medical Staffing sub-group
The Committee agreed for the chair report to be removed from the workplan as this reports to the People and Culture Committee.

Commercialisation Update
The Trust are in the process of compiling a job description for a Commercialisation role and further information will be shared.

4.0 Conclusion / Recommendation

The Board is asked to:

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