The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 27.05.2021

MEETING
27 May 2021 11:00

PUBLISHED
25 May 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	27/05/21		11:00
1. Part Two - Public Meeting			
1.1. Minutes of the Previous Meeting		Chair	11:00
1.2. Matters Arising		Chair	
1.3. Declarations of Interest		Chair	
2. Presentations			
2.1. Patient Story		Chief Nurse	11:05
2.2. Staff Story - Running a Vaccination Hub		Chief Nurse	11:15
3. Chief Executive Update (verbal)		Chief Executive	11:25
3.1. 100 years of RJAH at Gobowen			11:35
3.2. Virtual Visits Feedback			11:40
4. Quality & Safety			
4.1. Chair Report: Quality and Safety Committee		Non Executive Director	11:45
4.2. Infection Control Board Assurance Framework		Chief Nurse	11:50
5. People Update			
5.1. The Life of a Trainee		Chief Medical Officer	11:55
5.2. Chair Report: People Committee		Non Executive Director	12:05

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams	27/05/21		11:00

6. Performance & Governance		
6.1. Chair Report: Audit Committee	Non Executive Director	12:10
6.2. Chair Report: Finance, Planning and Digital Committee	Non Executive Director	12:15
6.3. IPR Annual Review	Chief Performance, Improvement and OD Officer	12:20
6.4. Performance Report M1	Chief Performance, Improvement and OD Officer	12:25
6.5. Corporate Governance Statement	Trust Secretary	12:35
6.6. Governors Update (verbal)	Trust Secretary	12:40
7. To Note		
7.1. Headley Court Veterans Centre	Chief Finance and Planning Officer	
7.2. Chair Report: Quality and Safety Committee (April)	Non Executive Director	
7.3. Chair Report: Finance, Planning and Digital Committee (April)	Non Executive Director	
8. Any Other Business	All	12:45
8.1. Questions from the Public		
9. Next meeting: 29th July 2021		

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The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC BOARD
29 APRIL 2021
MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive	MB
Stacey-Lea Keegan	Chief Nurse	SLK
Harry Turner	Non-Executive Director	HT
Craig Macbeth	Chief of Finance	CM
Rachel Hopwood	Non-Executive Director	RH
Paul Kingston	Non-Executive Director	PK
Chris Beacock	Non-Executive Director	CB
Ruth Longfellow	Chief Medical Officer	RL
Kerry Robinson	Chief of Improvement, Performance and OD	KR
David Gilburt	Non-Executive Director	DG

In Attendance:

Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Chief of People	SS
Hilary Pepler	Board Adviser	HP
Nia Jones	Managing Director for Specialist Services	NJ
Alyson Jordan	Managing Director for Support Services	AJ
Jo Banks	Managing Director for MSK	JB
Dawn Forrest	Managing Director for Clinical Support Services	DF

FC welcomed everyone to the meeting.

MINUTE NO	TITLE
29/04/1.0	**APOLOGIES** David Gilburt, Non-Executive Director
29/04/2.0	**MINUTES OF PREVIOUS MEETING** The minutes of the previous meeting were accepted as an accurate record of the meeting held.
29/04/3.0	**MATTERS ARISING** None
29/04/4.0	**DECLARATIONS OF INTEREST** None
29/04/5.0	**DR SOPHIE SHAPTER, CONSULTANT ANAESTHETIST AND LEAD FOR HUMAN FACTORS FACULTY – CIVILITY AND BEHAVIOURS IN THEATRE** RL introduced Dr Shapter to talk about human factors and specifically civility and its impact on performance and safety. Dr Shapter's presentation highlighted the following: • Civil work environments matter because they reduce stress and reduce error and foster excellence • How this links to the work on the People Plan and NHS Long Term Plan • Incivility builds into bullying if left unchecked with an estimated cost to the NHS of

£2.3bn

- The 2020 NHS Staff Survey and the Trust's worse than average performance around harassment, bullying and abuse from managers and colleagues. The Trust does however perform slight above average for the receipt of respect from colleagues. This highlights the further work to be done in order to be the best.
- The work on behaviours in the theatre environment where the work undertaken by staff is complex and high stakes and involves large teams of multi specialties.
- Staff are being given the opportunity to share their thoughts about the environment with a survey launched to gather responses. This will provide a baseline to base any future work on. Happy and unhappy themes identified all related to feelings of value, team work and respect
- An overview of the behavioural makers that make up team skills and an emphasis that the gatekeeper to an effective team is interpersonal relationships and group climate.
- The impacts on all staff and impacts on patients
- A short clip from the 'Civility Saves Lives' campaign – Dr Chris Turner
- Statistics of the impact of incivility on staff performance and patient perception of the organisation. In particular how it reduces the quality of work, the likelihood of staff helping each other, increases errors and reduces patient confidence.
- Strategy to support staff – peer support and building resilience
- The risk that unacceptable behaviour left uncheck can become normalised
- The plan to trial the strategy in the Theatre Department and if successful will roll out further. This will introduce the concept of 'peer support second messenger'. Individuals identified to act as a peer support member who can then relay a message to someone who has demonstrated poor behaviour. Often behaviour is not malicious but comes from stresses and pressured workloads and as well as providing feedback it is important to check that person is alright.
- The Trust is aspiring to be world class and needs to demonstrate world class behaviours

FC thanked Dr Shapter for her presentation.

HT commented that the Trust's values should drive the behaviour and he asked what the connection is between the Trust's values and the behaviours described. Dr Shapter agreed that this ties in with the values and confirmed that the next step for theatres is to develop focus groups and get the staff to come up with the solutions. This work will be based on the Trust's values.

FC asked about the human factors workshops and Dr Shapter confirmed that the plan is for these to be rolled out across the whole organisation as everyone needs to share the same language and understand their impact on the team and organisation. Workshops have been delivered for three years but last year has been challenging due to Covid, the feedback has however always been very positive. Staff appreciate having the investment in them for training and the workshops provide an opportunity for staff to come together as multi-disciplinary groups and to network and understand how other people work.

CB commended Dr Shapter and her team for the work they are doing and asked if there is a uniform acceptance of the concepts across staff groups and what the measures it to understand if the programme has been successful. Dr Shapter advised that it is not embraced by everyone and this is part of the challenge but as the message gets across to those that are positive about it the negative voices will be in the minority. Dr Shapter advised that the survey baseline will assist with measuring improvement and one of the most powerful scores is on happiness. At the moment the responses are hitting a six and she would hope that this can be improved with work as more positive attitudes are already

	being seen. FC commented on how when the unacceptable behaviour becomes the minority it stops being tolerated. PK commented that this work fits with the wellbeing agenda being driven by the People Committee. He suggested that civility ambassadors to move around the organisation and Dr Shapter agreed and felt this could be the role of the peer support, second messenger role as it is about staff having someone they can go and talk to. Dr Shapter commented that she has a human factors faculty behind her that can help drive this and be champions. DF commented that she this exercise was undertaken in a different organisation the benefits were seen in improved sickness absence and productivity. The Board ***noted*** the presentation.
29/04/6.0	**PROFESSOR RICHARDSON MEMORIAL GARDEN** MB extended his thanks to the League of Friends and Victoria Sugden, Charity Director for their support and work on a memorial garden for Professor Richardson. The Board watched a short video which gave a tour of the garden and provided reflections from Professor Richardson's family and colleagues. It was noted that the garden was designed by 'Designs in Mind'. MB commented that the video will be made publicly available. The Board ***noted*** the presentation.
29/04/7.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • Thanks to the members of the Board and the Council of Governors for their support with the virtual visits programme that has taken place with feedback to be presented at the next Board meeting. • The Trust launched a new series of events for managers called 'In conversation with' and the first event was with Mike Barker, a senior and experienced NHS Manager. He spoke to staff about his work both before and during Covid and the pressures of working during a pandemic both professionally and personally. • The vaccine programme is continuing at pace and the Trust's own Vaccine Hub is very much a part of that. The vast majority of staff have now had their second dose and the Trust has been commended by region for the number of BAME staff that have been vaccinated, as it is known that these staff are vulnerable to Covid. MB thanked Sarah and her team, the process of personally ringing each member of staff and having a conversation has really helped. • Laura Peill has gone on maternity leave and MB wished her well and welcomed Alyson Jordan who has taken over in the role in the interim. • Planning permission for the Veterans Centre has progressed well as has finding a contractor and therefore he hopes to be in a position to make an announcement before the next Board. • Thanks to senior leadership team for the huge focus on the restart work which is trying to balance getting back to working in a new normal way. He went on to thank all colleagues who have worked hard on this over April. The Trust is now moving onto recovery planning and dealing with the backlog and the significant numbers of patients that are waiting. • Well done to this month's Health Hero, Katie Rogers, Catering Assistant, who was nominated as a good example of someone who lives the Trust's values. • There has been a significant amount of planning work and MB is grateful to colleagues working on two plans, the Trust's internal plan and the system plan.

	The Board ***noted*** the update.
29/04/8.0	**CHAIR'S REPORT QUALITY AND SAFETY COMMITTEE** CB presented a verbal Chair's Report due to the timing of the meeting and highlighted the following: • The meeting was well attended and quorate. • The agenda is presented due to meeting only taking place seven days earlier. • The Committee spent time discussing the harms review process and the assurance needed around this and it was agreed to have a further discussion around the metrics and this meeting is to take place shortly • The Specialist Services Quality Report was received and considered. The establishment of monthly governance meetings was noted and the Committee was keen to support the clinical engagement in that process. • The full chairs report will be presented at the next meeting. The Board ***noted*** the report.
29/04/9.0	**LEARNING FROM DEATHS** RL presented the Learning from Deaths Report which covered the period December 2020 to March 2021. RL confirmed that all deaths in the hospital are reviewed using a structured judgment review to inform learning. During the reporting period there were three deaths in the hospital with no concerns identified. The Trust's Learning from Death's Lead is now attending system learning from deaths meetings which is helping to enhance learning. CB commented on the low number of deaths at the Trust and the fact that there is no learning from a clinical perspective but we queried whether there is learning from the management of the death itself and whether this could inform part of the report. RL confirmed that this is already being looked into in terms of feedback from bereaved families. The Board ***noted*** the report.
29/04/10.0	**INFECTION CONTROL REPORT** SLK presented the Infection Control Report and confirmed that this had not been presented to the Quality and Safety Committee due to timing issues. The report highlighted the following: • Evidence of really good collaborative working across the organisation and the actions being taken • The Trust has implemented PLACE light, a tool for organisations to conduct a self-assessment instead of the annual PLACE inspections that have been paused due to Covid. The Trust undertook the first assessment in Q4 • A good summary of the work on Covid that has taken place over Q4 and feedback on the Covid audits is included in the report. SLK highlighted that the areas of non-submission related to ward closures. • The Trust reported two outbreaks in January • Restricted visiting has been re-introduced and the feedback is that this is going well • A third version of the Infection Prevention and Control Board Assurance Framework was released in February and the team is working through the Trust's compliance against this. CB asked about the compliance of clinical staff completing infection control training and SLK confirmed that since writing the report compliance has improved. There were some issues identified with the e-learning platform but these have been resolved. The Board ***noted*** the report.
29/04/11.0	**CHAIR'S REPORT FOR PEOPLE COMMITTEE** PK presented the Chair's Report for People Committee and highlighted the following:

	• The meeting was well attended. • There was full assurance obtained across all areas of the agenda other than two which are outlined in the report. • The Committee noted that absence levels remained below target. • The vaccination programme was considered a success at 94% of staff having received their first dose with considerable numbers receiving the second dose and risk assessments in place. • The review of workforce policies continues at pace with an extraordinary meeting held last week to ratify a number of policies. • A sub-committee is being established for training as this has lost momentum during the Covid period. • The Committee received the Recruitment Plan for medical staff and this provided partial assurance as remains in draft and will be further considered by the People Committee next week. FC commented that the Committee has established itself as a key driver of a significant agenda for the organisation. The Board ***noted*** the report.
29/04/12.0	**GUARDING OF SAFE WORKING REPORT** RL presented the Guardian of Safe Working Report and highlighted the following: • The Trust currently has twenty trainees working within the Trust • No exception reports were received during the reporting period and this represents a high level of satisfaction. • No work schedule reviews have been required FC thanked Chris Marquis, Guardian of Safe Working Hours for his work on this. The Board ***noted*** the report.
29/04/13.0	**CHAIR'S REPORT FOR RISK MANAGEMENT COMMITTEE** HT presented the Chair's Report for Risk Management Committee and highlighted the following: • The meeting was well attended • All outstanding actions had been completed • The Committee received a deep dive reports from the Clinical Support Unit and the Support Services Unit with no significant issues raised. The overall feeling was that the Trust is in a better place with both risks and incidents being managed well. • The Committee reviewed the work plan • It was noted that good progress had been made on safer sharps with the Trust now fully compliant • There was partial assurance received from the Health and Safety Committee with training noted to not be up to date and also delays with referrals to Occupational Health. The Committee asked for these matters to be referred to the People Committee for scrutiny and action. • The Committee met yesterday to discuss the Board Assurance Framework and noted the potential for risks to emerge as the Trust moves out of Covid, as well as opportunities. The Board ***noted*** the report.
29/04/14.0	**CHAIRS REPORT FOR FINANCE PLANNING AND DIGITAL COMMITTEE** RH presented the Chair's Report for Finance Planning and Digital Committee and highlighted the following: • The meeting was well attended • The Committee received and reviewed the Electronic Patient Record Outlines

	Business Case. RH congratulated Simon Adams, Digital Director for the extensive document. The Committee approved moving to the next stage which is procurement costings. The Committee is aware of the System requirements in terms of payback when at a business case stage and is grateful to CM for steering Simon on this • The Committee received and reviewed the 2020-21 finance performance and thanks was extended to the Finance Team for dealing with some late changes that were needed • The Committee reviewed the Financial Plan for 2021-22 along with the Capital Programme. The Committee asked for the Capital Programme to be shared with the Quality and Safety Committee due to the linkage with quality. The Board ***noted*** the report.
29/04/15.0	**PERFORMANCE REPORT MONTH 12** KR presented the Performance Report for the final month of 2020-21. KR highlighted that this was an extraordinary year with significant environmental shift resulting in a number of targets not being met. KR reminded the Board that plans and targets were suspended for first six months and last three months of the year. KR also highlighted that this the last time the report will be presented in this format as going forward the RAG ratings will be removed with a focus on variation and improvement. KR confirmed that 80% of targets not met were due to actions required for Covid. JB highlighted the following forward look and key points: • The Trust undertook few operations in March as staff were still redeployed to SaTH. In terms of April there was a recognition that the focus needed to be on the health and wellbeing of the staff returning to the Trust and for the first two weeks staff were encouraged to rest, take annual leave and get up to date with study and training. A significant number of staff were also still supporting the vaccination programme. • The planning guidance is taking a half year approach in H1 with a 5% incremental increase month on month. The Trust is still in the restoring phase and measures remain in place to manage Covid. However, the Trust remains focused on seeing as many patients as it can. • For Outpatient the Trust had completed and booked -34 of those planned and therefore there was confidence that this would be a positive position by the end of the month. • For elective spells there were 548 patients planned (calculated to discharge) this was at 59% for April and May was looking positive • In Theatres there was 557 planned for April and 594 booked • For Diagnostics and imaging the April plan stood at 83% for MRI, 83% for CT and 73% for USS • Overall this is a positive picture and staff are working hard to get people seen. FC asked for clarification around the percentages and JB confirmed these were comparisons to 2019-20 activity. JB highlighted that March last year was an odd month due to the pandemic. FC commented on comparing the post Covid with the early stage Covid activity and KR confirmed that adjusted comparisons are being used which take into account working days. FC commented on the encouraging indices. *Caring for Staff* SS highlighted the following: • The Trust's absence figures have been below target for 7 of the last 12 months and the overall annual figure is below target. SS reminded the Board that the approach to absence management was changed approximately 18 months ago and SS thanked the Trade Unions, Managers and HR Team for embracing these changes. The Trust continues to promote wellbeing is she is looking forward to continuing to

	improve in this area. *Caring for Patients* SLK highlighted the following: • No exceptions to report for March • The Trust reported a Never Event in April under the category of wrong site surgery the patient was a SaTH patient operated on by SaTH surgeon. There is meeting next week with the Regional Medical Director and National Patient Safety Director to look at these scenarios going forward. MB confirmed that the patient is fine and the Surgeon is being well supported and thoughtful in his response. The investigation is in its early stages but it is complex because both the patient and Surgeon are from another Trust. RL highlighted the following: • No unexpected deaths for the reporting period FC invited any further comments on the Caring for Patients aspect of the report before he moved to Caring for Finances and AJ advised that the DNA rate is reducing which is helping the flow of patients through the hospital. This has reduced from 6% to 5%. *Caring for Finances* CM highlighted the following: • The M12 review of risk provisions. There were no underlying issues but as a result of the risk assessment expenditure has been built into the end of year accounts. • The Trust was aiming for a break even position and assuming it needed to replay all of the system support. • The distribution of unused national funding meant the Trust received support for untaken annual leave and recognition of losses on non NHS sources of income and received an extra £4.5m in total. CM confirmed this strengthens the Trust's overall cash balances and provides more of a cushion as it enters a more challenging financial year. • A £4.5m surplus is being delivered as a result of the additional funding with adjustments from the Welsh commissioners and payback to the System to be taken into account in April FC commented on the great performance on the overachievement on the cost improvement programme. DG confirmed that an extraordinary meeting of members of the Audit Committee had taken place to review the accounts and he complimented the Finance Team on the comprehensive accounts. The Committee was joined by a representative of the Governors who gave positive feedback. The accounts are now with Deloitte for audit and an opinion. MB commented that the financial movements seen in M12 created a lot of work and he extended his thanks to Diana Owen and the team who take great pride in the accounts are presented. The Board ***noted*** the report.
29/04/16.0	**BOARD ASSURANCE FRAMEWORK (BAF)** SR presented the BAF and advised that has been aligned to the new objectives for 2021-22. SR apologised for the late circulation and explained that the Joint Audit and Risk Committee had only met the day before to review this. SR highlighted the new risks that had been added and the risks that would now be removed from the BAF as they no longer impacted on the delivery of the Trust's objectives.

	SR explained that these risks would remain on the register and would be managed through the Trust's usual risk management processes. SR advised that the Joint Audit and Risk Committee identified a number of additional risks that it felt should be considered for inclusion and these will now be worked up with the Executive Team. There are place markers within the document to highlight these. SR highlighted that there needs to be recognition that the Trust's risk appetite and tolerance will need to be aligned to the ICS as it develops and therefore risks may emerge or decrease accordingly. HT commented on the need to keep the objectives under review and to be flexible in response to the changing landscape. The Board ***noted*** the Board Assurance Framework.
29/04/17.0	**GOVERNORS UPDATE** SR provided an update on the work of the Governors and highlighted the following: • The Governors took part in the virtual visits held recently • One of the Governor's attended and observed a recent Committee meeting • The Governors are involved in the Non-Executive Director recruitment process • The process for the Lead Governor is due to commence as per the agreement at the Council of Governors. SR invited HT to provide any further update from his recent meeting with the Governors. HT commented on the challenges for the Governors of operating in the virtual world and SR acknowledged that a particular difficulty is the running of governor surgeries and that this had previously been an important interface for the Governors with the public. MB added that the Trust is looking to hold some sessions with the Governors on the ICS and what this means for the role of the Governor. The Board ***noted*** the update.
29/04/18.0	**ITEMS TO NOTE** The Board was presented with written reports of the Quality and Safety Committee, People Committee and the Finance, Planning and Digital Committee for meetings held in February as there had not been opportunity to present these since the meetings had taken place. PK also highlighted that a second extra-ordinary meeting of the People Committee was planned to bring the policy work up to date. DG commented that the Policy Committee has now served its purpose and the policies have been aligned to the appropriate Committees. FC confirmed that he, MB and SR are looking at this with a view to now standing the Committee down. SR confirmed that a position statement and proposal is due to come to the Committee in July. The Board ***noted*** the reports.
	AOB FC advised that Board that the Trust has commenced its work on the replacement of David Gilburt, Non-Executive Director. The work is at a very early stage and a Recruitment Consultancy has been enlisted to support the process.
25/03/23.0	**QUESTIONS FROM THE PUBLIC** None
	DATE OF NEXT MEETING IN PUBLIC: Thursday 27 May 2021 11.00 via Teams
	CHAIRMAN'S CLOSING REMARKS

	FC thanked everyone for their contribution and closed the meeting.

29 APRIL 2021

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
28/01/13.0 GUARDIAN OF SAFE WORKING HOURS Invite Rob Banerjee and a Registrar to a future Board	Trust Secretary	On the agenda
25/03/6.0 CHIEF EXECUTIVE UPDATE Vaccination Centre staff to be invited to share their experience with the Board	Trust Secretary	On the agenda
25/03/11.0 CHAIR'S REPORT FOR POLICY COMMITTEE Review of Policy Committee in 3 months' time	Trust Secretary	Scheduled for July 2021
Actions from Last Meeting	**Lead Responsibility**	**Progress**

0. Reference Information

Author:	Victoria Sugden	Paper date:	27th May 2021
Executive Sponsor:	Mark Brandreth	Paper Category:	
Paper Reviewed by:		Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper is provided to the Board to outline the proposed activities planned to celebrate the hospitals centenary at the Gobowen site.

The Board is asked to note and support the celebrations.

2. Executive Summary

2.1. Context

In 1919, the facilities at Baschurch were deemed unsafe due to the condition of the drains. A successful approach was made to The Red Cross Society, £25,000 was granted, along with £9000 from the Shropshire War Memorial Fund which provided sufficient funds to convert The Park Hall Military Hospital at the Gobowen site to the hospital as it is today. On 5th August 1921 the Marchioness of Cambridge officially opened 'The Shropshire Orthopaedic Hospital' on this site.

Whilst Covid-19 restrictions and priorities have reduced the planned calendar of events this year to celebrate the centenary we still wish to mark the occasion. This document outlines proposed plans.

The Board will also wish to note that The League of Friends was formalised in 1961 and The Orthopaedic Institute in 1981 therefore celebrating 60 and 50 years' service respectively.

3. Main Report

3.1 Planned celebrations

It is proposed that the following events and activities are undertaken:

Date	Activity	Description
Thursday, 5th August 2021	**Time Capsule** Committal on Hospital Field	Staff will be asked to donate items reflecting the history of the hospital and experience of the present time. This might include stories, photographs, books or items such as crutches or dressings. Marie Carter (Archivist) and The League of Friends will manage and curate this in order to present an engaging narrative of RJAH in 2021 and a legacy for future staff to discover.
Thursday, 5th August	**Celebration Lunch**, Denbigh's	A themed lunch made available to all on site staff to celebrate 100 years.
Friday, 30th July	**Presentation**: 100 years of RJAH, through the decades	Compiled and presented by Marie Carter, Trust Archives Officer. Pre-recorded film to be made available for social media and internal communications.
Saturday, 7th August 2021	**Festival on the Field**	An all staff, family and stakeholders event of food, music and fun to be held on the field.
Saturday, 9th October 2021	A multi-faith church **Service of Celebration and Thanksgiving**, Baschurch	To include readings, music and contributions from across the hospital community.

3.2 Promotional items

To support events Medical Illustration are designing a logo to reflect the Centenary that may be transferred for use on items such as stationery and commemorative merchandise including pin, t-towel and mugs these will be made available for sale in the League of Friends shop and on-line.

4. Considerations

The League of Friends are working closely with hospital teams including Estates & Facilities, Clinical Staff, Communications, Improvement and Organisational Development to deliver a positive and uplifting celebrations that are available to everyone.

Events will be fully risk assessed where appropriate.

All events are subject to cancellation should Government guidance relating to the pandemic materially alter what is permissible.

In addition to the celebrations the opening of Captain Sir Tom's Moore's Path of Positivity and the turf cutting ceremony for the Headley Court Veterans' Orthopaedic Centre will take place in June.

5. Conclusion

The Board is asked to support the proposed celebrations.

0. Reference Information

Author:	Gayle Murphy Trust Office PA	Paper date:	27 May 2021
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Strategy
Paper Reviewed by:		Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is to receive a report on the recent Virtual Visit event for information only.

2. Executive Summary

2.1. Context

A Virtual Visit event was held on 10th May 2021, where Trust Board members were invited to 'visit' areas across the organisation using virtual technology.

2.2. Summary

The report highlights the findings from the event and includes a copy of the Thank You letters which attendees sent to those areas they visited.

2.3. Conclusion

The Board of Directors is asked to note the Virtual Visit report.

3. The Main Report

3.1. Introduction

The Trust held the first Virtual Visit event on 3rd November 2020, where members of the Trust Board were invited to 'visit' departments within the Trust. The exercise is designed to improve the 'Ward to Board' relationship and offers a platform for the senior leaders to have a better understanding of issues which staff have faced during recent times.

3.2. Thank You Letters

Following the visits, those involved in the event were asked to write a thank you letter (appendix 1) to their areas about their discussions.

3.3. Next Steps

The Board of Directors is asked to:

- Note the Virtual Visit event report

3.4. Conclusion

Overall the Virtual Visit event is a positive experience for the Trust. The organisation continues to investigate ways to enhance the 'ward to board' relationship and improve the culture as a whole.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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17th May 2021

RE: Virtual Visit

To Sue Sayles and the Infection Prevention and Control Team – RJAH,

Dear Sue,

Firstly, may I thank you and your colleagues for hosting the virtual department tour on Monday 10th May. Dr Ruth Longfellow (Chief Medical Officer) and Nia Jones (Managing Director for The Specialist Services Unit) and I really enjoyed our time with you. Please extend our thanks to Amanda, Mary and Hayley for their time and contributions.

Not surprisingly, much of the discussion centred around the impact of the last 12 months, both on your department and on you as individuals. You spoke about the challenges of the early months of 2020 as the pandemic took hold and the pressure you felt as you endeavoured to respond to questions, concerns and demands from staff across the Trust. Very often, the advice you offered was based upon ever-changing and evolving national and regional guidelines and this led to concerns in your mind that you might be giving inaccurate advice or instruction to fellow clinicians which might, in turn, expose them to risk or harm.

The three of us all acknowledged this pressure and endeavoured to assure you and your whole team were at the front line in dealing with a major global pandemic when there was much uncertainty about how best to treat the virus. We know that you responded with determination, commitment and care and you should all take great personal and professional pride from the way in which you handled those early weeks of uncertainty.

It was interesting to listen to Hayley talk about her experiences having only joined the department in February 2020 and then finding herself as one of just a handful of administrative staff working on site. She spoke movingly about the personal concerns and fears she felt at the time. These are all extremely understandable and it was good to hear her say that she now feels much better.

Mary provided a real-life insight into some of the challenges of the time. The distressing but important task of ensuring the Trust had sufficient body-bags in store and having to offer re-assurance to staff who were presenting for PPE or FIT testing.

Amanda, working from home for much of the year, reminded us that Covid was an additional burden. The day-to-day routine work still needed to be undertaken with the demands of risk management relating to Covid-19 being an added pressure.

So, a challenging and tough period and we thank you all, not only for your honesty during our virtual visit but also for the work you and your colleagues have undertaken since the pandemic hit.

It was also good to hear you speak of some of the positives. Your department is much better known and it's role better understood by Trust colleagues and you commented that you are now consulted on decisions to do with Estates or clinical pathways before changes are implemented. This is a good outcome.

You felt that some IPC behaviours, started in 2020, will continue and cited the habit of hand cleansing and hygiene.

It was pleasing to see that following the business case approval you found benefit from the new IPC Apprentice. In terms of issues which we might help you with, you highlighted the valuable work undertaken by Dr Graham Harvey, Microbiologist. Graham's input rose to 4 days a week during the height of the pandemic and this was an essential part of the IPC response to the demands of the last year. Graham is due to retire in the coming months and you asked for the senior team in the Trust to consider the provision of on-site microbiological support both in the lead up to Graham's departure and thereafter. Ruth will investigate this matter for you.

Lastly, you took the opportunity of our visit to thank the Trust's leadership for their support to your department including the addition of a recruit with dedicated operating theatre experience.

In summary, thank you all for your time last Monday. Whilst a virtual tour will never take the place of a face-to-face discussion, you all presented well and with clarity and honesty. The last 12 months or so have been like no other for you all, be it on a personal or professional level and the way in which you dealt with the challenges, fears, anxieties and pressures of 2020 is a credit to you all. Well done.

Yours sincerely,

Frank Collins
Chairman

Also sent on behalf of Dr Ruth Longfellow, Chief Medical Officer and Nia Jones, Managing Director for Specialist Services Unit

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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17th May 2021

RE: Virtual Visit

To Joanne Richards and Kate Evans on behalf of The Therapy team and other staff on Sheldon Ward – RJAH,

Dear Joanne and Kate,

Firstly, may I thank you and your colleagues for hosting the virtual ward tour on Monday 10th May. Dr Ruth Longfellow (Chief Medical Officer) and Nia Jones (Managing Director for The Specialist Services Unit) and I really enjoyed our time with you. Please extend our thanks to Ruth and Gemma for their time and contributions.

It was also good of you to organise the visit as an actual "tour" with us being taken around the ward via a laptop aboard a trolley. Whilst not quite as interactive as a genuine visit, it was a great idea and one we shall recommend to other departments hosting similar visits.

Sheldon Ward is a very busy unit caring for patients requiring rehabilitation and rheumatology care and very often your patients present with complex co-morbidities. It is a demanding environment in which to work under normal circumstances but the added pressures of Coronavirus placed significant stress and pressure on many aspects of the ward's work.

Kate, talked about the personal fear and anxiety in the early weeks of the pandemic when there was uncertainty about the best and most effective practices and procedure to follow, including the use of PPE. We commented that this was a feeling being raised by staff from other departments across the Trust. The lack of consistent and reliable guidance was a major challenge for the national response to the virus and hospital ward staff from across the country deserve congratulating on their efforts and commitment during this period. Thank you all.

You made the point that the Trust deployed additional staff to help and whilst these eventually settled to become effective and valued team members, in the early days their presence was an added pressure and demand.

Many of you highlighted the challenges presented by the 12-hour shift pattern which is in place on Sheldon and how this can lead to a lack of continuity in the delivery of care as well as resulting in staff becoming exhausted. This is compounded by the current absence on long term sick leave of a senior nurse and the feedback you gave us was that an additional band 6 nurse would be an important addition to the team. Nia will discuss this with Nicky Bellinger and Stacey-Lea Keegan.

Ruth mentioned that a Discharge Planning role had been proposed by the team and the view that it would be a great addition to the Sheldon team because significant nursing time is currently devoted to the process of planning the safe discharge of your complex patients. Nia will investigate further.

Nia also raised the Trust's Improvement Project which is underway looking into reducing delayed transfers of care and will see if Ruth or another colleague can be invited to join the project team.

You advised us that the patient discharge issues are compounded by the absence of a social worker on the ward and whilst we all acknowledged that this was unlikely to be rectified, we all recognised that the absence of a social worker on site was not helpful to the discharge planning process.

It was good to meet Gemma Sweetman. Only recently qualified and just 12 months in post, she spoke about some of the pressures and challenges that working on Sheldon presents but also spoke more positively about the way in which the team pulled together during the last year.

Gemma felt that communication from her managers to front line staff could, on occasion, be improved. This is something which all of us can learn from - wherever we work and at whatever level - and it was useful to be reminded of the importance of effective communication particularly during a challenging period.

You took the opportunity to raise a specific concern over the requirement of the Vaccination Centre to expect patients receiving a "jab" to go to the Centre, rather than staff from the Vaccination Centre pay a visit to the ward. This presents particular challenges for some of your patients.

Nia advised that the policies and procedures for the Centre at RJAH are determined by colleagues from the Vaccination Hub at SaTH but she would look into this matter for you.

In terms of positives, all the staff we met spoke of the pride they feel in working on Sheldon and at RJAH. The pandemic year has seen better collaboration with external agencies such as Social Care and patient care packages are received much more speedily than in the past. Despite the tough year, teaching has continued throughout 2020 and the multi-disciplinary team approach is as strong as it has ever been.

So, in. summary, lots of positives to support the continuation of the great care you provide but also an acknowledgment of the pressures Sheldon is under and the effect this is having on staff morale and effectiveness.

Thank you to each member of the team for your hard work, commitment and professionalism throughout the last year. Your efforts are very much appreciated.

Yours sincerely,

Frank Collins
Chairman

Also sent on behalf of Dr Ruth Longfellow, Chief Medical Officer and Nia Jones, Managing Director for Specialist Services Unit

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Thursday 13th May 2021

Dear Jo, Kirsty, Lisa, Chris,

RE: Pre-Op Virtual Visit May 2021

To all the pre-op team we wanted to say thank you for the care you give our patients, how hard you've all worked over the last period and the insight you gave us on Monday, it left all three of us with many thoughts and learning that we wanted to take a little time to digest before writing to you.

The time we spent with you all was greatly appreciated recognising you made time to speak to us in what is a very busy period. We were humbled by your openness and personal stories of sacrifice you have made over the last period to care for our patients.

It was apparent how well you are all working together, recognising each other's pressures both personally and through work but ensuring everyone felt supported. Hearing you describe both your personal journeys aligned to the changes in our work caring for patients was so vivid and truly inspiring.

You described how the team had been split into two with both parts dealing with significant changes, with pathways re-created for pre-op in relation to IPC and new protocols and the other dealing with swabbing patients for potential covid.

As a small team this pressure was added to with the teams manager required to work in one team due to the constraints of staffing resource, which you all worked together to handle and deliver the services. Something as a Trust in future we should reflect upon, particularly your point regarding our manager "supported us brilliantly, but who was supporting our manager?" Together we'd explore how the team can become more closely linked with Theatres.

We heard how the covid swabbing team operated in outside conditions without a shelter for some time, as the investment to resolve within the Trust had been slow. You are also having similar experiences currently in regards to the continued staffing for covid swabbing, which we are looking to resolve with you.

We discussed how taking the time to reflect is so important to everyone within the team and that as a team you had not met as a whole for some time.

You were going to look how you could do this virtually in the near future. We were also going to explore with you your department being included within rolling half days to provide time to do some of this.
Thanks again to all the team, the care that you provide to our patients is heart-warming and you should be so proud of what you do each and every day, the strength of your team and how hard you work comes across.

Yours sincerely

Hilary Pepler Russell Luckock

Kerry Robinson	Hilary Pepler	Russell Luckock
Director of Performance	**Board Advisor**	**Public Governor**

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Thursday 13th May 2021

Dear Amanda, Gilly, Leonie, Liv, Nick, Beth & Ali

RE: Theatres Virtual Visit May 2021

To everyone in Theatres, across all teams, we just wanted to say thank you for the care you give our patients, how hard you've all worked over the last period and the insight you gave us on Monday, it left all three of us with many thoughts and learning that we wanted to take a little time to digest before writing to you.

The time we spent with you all was greatly appreciated. We were particularly impressed how you had come together over the last period across the multiple teams within theatres, demonstrating to us a really visible one team theatres ethos. It was apparent how well you are all working together, recognising each other's pressures but ensuring everyone felt supported. It was impressive how you had built upon this one team ethos to build greater relationship and collaborative working with our partner hospitals in the system.

Hearing you describe the journey of stopping elective, moving to trauma and then the return of elective patient care of the changing expectations with initially particularly IPC policies and procedures changing driving up anxieties. You described to us the learning and improvement cycle you have gone through using wave one experiences as the grounding for wave 2.

How the experience had left you all so positively through the learning acquired through caring for patients with different co-morbidities and how rightly proud you all are for the care delivered, the experience gained and most importantly the learning and improvement that you are now building upon.

Some examples you provided were how much leaner both processes and equipment within the theatres had become, utilising kit that was totally new to the teams and now advising on this kit. You also described how you'd found different ways of working through this last period which you plan to keep in place, some of which included with our partners in the system having now got the benefit of virtual meetings through Microsoft Teams e.g. PPE and procurement meetings. How all of these improvements had assisted in restarting elective care in the 'right' way and hope and enthusiasm to build upon this by embracing change in our pathways of care. This was added to by the proudness we felt of the feedback you'd received both from our partners and staff alike on your teams work ethic was heart-warming.

You described how the last year has blended home and work life, that it had been tough and the team had lots of varied experiences, including a feeling of gratitude related to the purpose of the work carried out and the connection with each other.

We discussed how taking the time to reflect is so important to everyone within the team and you were going to explore utilising the rolling half day to do some of this.

You highlighted the slope in theatres as an area of continued focus for improvement and where exploring the funding of battery assisted trolleys.

Thanks again to all the team, the care that you provide to our patients is heart-warming and you should be so proud of what you do each and every day, the strength of your team and how hard you work comes across.

Yours sincerely

Hilary Pepler Russell Luckock

Kerry Robinson	Hilary Pepler	Russell Luckock
Director of Performance	**Board Advisor**	**Public Governor**

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11th May 2021

Dear Becky and Team Awesome,

Firstly, we would like to thank you for taking the time to meet with us today for the virtual visit. We very much enjoyed the visit and the greater insight that you gave us into the amazing work that you have undertaken during the Covid pandemic in the Vaccination Centre.

What absolutely shone out throughout the visit was the utter pride that you and the team felt about the sterling work that you have achieved. The fact that you have undertaken 50,000 vaccines in such a small area is a fantastic achievement in itself. Evidence shows that you are the lead for the region and offer a Gold standard service.

Good strong leadership makes a team and it is very clear that all of the team felt that Becky had been the driving force behind this success story. Your efforts will have undoubtedly saved lives.

We note and recognise the model that the team have developed which is efficient and effective. It means that the qualified staff from different disciplines carry out the whole job of Consent and Vaccinating therefore making the patients feel very secure whilst having their vaccine and the staff satisfied that they are building relationships with the patients.

During the visit we asked if there was anything the organisation could do to further support your team or was there anything that you wanted to share with ourselves. Below is a summary of our discussions:

- You requested that the Trust keeps the team together until September so they can remain "Team Awesome".
- Asked that everyone continues to value the team and the work they undertake as this is important to the team.
- Recognise the staff that have given their time to the vaccination hub working on their days off etc.

We could not agree more that you are indeed Team Awesome and thank you for all of your hard work over this very difficult time in the NHS.

Kindest regards

David Gilburt

Non-Executive Director

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11th May 2021

Dear Teresa and Team,

Firstly, we would like to thank you for taking the time to meet with us today for the virtual visit. We very much enjoyed the visit and the greater insight that you gave us into the Research department here at the Trust.

During the visit we asked if there was anything the organisation could do to further support your team or was there anything that you wanted to share with ourselves. Below is a summary of our discussions:

- You asked would it be possible to have an electronic data capture solution in order to facilitate an on-line questionnaire? Simon advised that you should connect with the EPR team whilst the new EPR is still in the development phase.
- You raised the issue that post covid you had difficulty finding a clinic room to see the patients involved in research trials – Dawn advised you to link in with Nick Huband with reference to the Movement Centre or other available area.
- On your wish list was the fact that you would like to see an increase in the number of Academics being employed by the Trust who have research sessions in their job plan.
- We had a discussion about how your Research Strategy, developed just before Covid may need to have some adaptations to the 5 year plan for research post covid and you agreed to look at this.

- You were concerned that research might be “squeezed out” and de-prioritised as the Trust re-starts the elective program and the teams step up to over-achieve on the 19/20 activity plan.

We would once again like to thank you for all of the hard work undertaken by the team and as we are all aware the learning from research here at Robert Jones and Agnes Hunt will continue to support surgical orthopaedic advances for years to come.

Kindest regards

David Gilburt

Non-Executive Director

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18 May 2021

Dear Penny and the Pharmacy Team,

Re: Virtual Visit

Thank you for taking the time to host the virtual visit with Stacey, Craig and myself, we found it very interesting.

It was clear that the team have worked really hard to adapt to the changes during the pandemic, especially around the issue of staff being redeployed to Shrewsbury.

We noted the issues you raised regarding the limited space in the department especially around the difficulties of social distancing.

We noted your expression of interest to support the ambassador scheme at the Trust to help promote Pharmacy at career events in schools and colleges

You should be very proud of the work you do in Pharmacy and thank you once again for your time on what was a most enjoyable and interesting visit.

Kind Regards
Allen

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18 May 2021

Dear Liz and the Outpatients Team,

Re: Virtual Visit

Thank you for taking the time to host the virtual visit with Stacey, Craig and myself, we found it very interesting.

It was clear that the team have worked really hard to adapt to the changes during the pandemic and it was great that you felt the Trust overall had pulled together during this time.

We noted the issues raised regarding the limited space in the department especially with the increased footfall and the need for flexibility around the dates and times for training for clinical staff.

You should be very proud of the work you do in Outpatients and thank you once again for your time on what was a most enjoyable and interesting visit.

Kind Regards
Allen

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12th May 2021

Dear Soma and Dexa Team,

Re: Virtual Visit

Thank you for taking the time to host the virtual visit with Jan, Shelley and myself, we found it very interesting.

The facts you updated on regarding the 10k scans per year pre-Covid on one scanner and following the close down of a few month along with the detail of getting back up to speed with IPC guidelines was refreshing. It must be a great achievement to be conducting 32 scans per day now compared to 25-40 pre Covid, so well done.

We particularly enjoyed the clinical update regarding the home kits and bone markers that have been undertaken to provide flexibility to managing patients during this difficult time and how in some cases it has benefitted patients not to be on site.

We also noted the issues raised regarding hoisting of patients and booking of clinical rooms which I will ensure is managed through the estates and outpatient meetings.

Thank you once again for your time on what was a most enjoyable and interesting visit.

Kind regards

Alyson

Alyson Jordan
Managing Director of Support Services

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12th May 2021

Dear Nina and the SOOS Team,

Re: Virtual Visit

Thank you for taking the time to meet with Jan, Shelley and myself and talk through with your team all the good work you have been undertaking within SOOS. We particularly enjoyed the newsletter that you produced it was very informative and the layout was excellent.

The clinical team have worked really hard to adapt to the changes and the togetherness and bonding of the team was evident in how some big obstacles have been overcome. Taking the week out to plan and change your service to virtual and have flexible working was an enormous task and you all succeeded and made it look easy.

We understand the issues of cancelling patients and managing with less staff due to shielding but the lovely story of the admin support worker, who had been such a rock to the team in providing support and going the extra mile to ensure the clinicians and patients were booked in the right place was very heart warming. It is always good to see excellent team work and how people have taken on extra responsibility and delivered an incredible service in the face of adversity.

The refugee support service that you updated on is evident of the good work you and the team do and thinking outside the box.

We had good discussion on the communication of the alliance and the perception and grapevine element which we know has caused concern amongst staff and lets all work together to improve this area.

The development of the quality agenda, team meetings and daily debrief shows how far the team have come in a short space of time.

We thoroughly enjoyed the visit and took away a lot of key learns to share with other areas. You must be very proud of having such a good time of clinical and admin staff that work so well together and deliver results. Keep up the good work.

Kind Regards,

Alyson Jordan
Managing Director of Support Services

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Victoria Brownrigg
Finance Team
RJAH

Date: 25th May 2021

Dear Victoria and Team,

RE: Virtual Visit

Firstly, I thank you and your colleagues for joining us and hosting the virtual tour of Finance on Monday 10th May. Paul Kingston (NED), Karina Wright (Governor) and I really valued our time with you and the insight it gave. Please accept our thanks and extend it to all the team.

As anticipated, much of our discussion focussed on the challenges of the last 12 months and the impact it has had on you all. Particularly, the effect of home working whereby the team have been separated and the valued support you experienced when in work has been disturbed. We also discussed the benefits and challenges of digital support such as Microsoft Teams in linking with colleagues working from home.

During the visit we asked if there was anything the organisation could do to further support your team or was there anything that you wanted to share with ourselves. You all advised us of the value and efficiency gained in working together in the office in small numbers. You informed us that a rota had been developed to balance home and office working to support team working and effective working.

Finally, thank you to each member of the team for your hard work, commitment and professionalism throughout the last year. We acknowledge all of your efforts and very much appreciate it.

With kindest regards,

Yours sincerely,

J. Banks

Jo Banks
MD MSK Delivery Unit

CC: Paul Kingston (NED) and Karina Wright (Governor)

Chair Report
Quality and Safety Committee
20th May 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27th May 2021
Director Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Quality and Safety Committee Agenda for the meeting of 20th May 2021. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the Audit Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It is responsible for seeking assurance regarding the Trust's internal and external audit programme, the local counter fraud service and compliance with the law and regulations governing the Trust's activities. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

Due to the timing of the committee it is not possible to provide a paper Chair's Report. The Non-Executive Director Chair of the committee will provide a verbal report covering the attached agenda from the committee.

2.3. Conclusion

The Board is asked to note the agenda and that a verbal report will be provided during the meeting.

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	20/05/21		14:00

1. Introduction		14:00
1.1. Apologies	All	14:01
1.2. Minutes from the previous meeting	Chris Beacock	14:02
1.3. Action Log / Matters Arising	Chris Beacock	14:04
1.4. Declaration of Interests	All	14:06
2. Caring for Patients		
2.1. Serious Incidents, Never Events & Learning from Incidents	Shelley Ramtuhul	14:07
2.2. Harms Reviews	Sara Ellis	14:12
2.3. Infection Prevention Control BAF	Sue Sayles	14:17
3. Committee Management		
3.1. Clinical Services Unit Quality Report	Dawn Forrest	14:22
3.2. Board Assurance Framework & Corporate Objectives	Shelley Ramtuhul	14:32
3.3. Integrated Performance Report	Stacey Keegan	14:37
3.4. Items to Review/Approve:		
3.4.1. Terms of Reference	Shelley Ramtuhul	14:42
3.4.2. Quality Priorities 2021/22	Stacey Keegan	14:47

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	20/05/21		14:00

4. Items to Note:

4.1. Chair Report from Patient Safety Committee	Stacey Keegan	14:52
4.2. Chair Report from Patient Experience Committee	Stacey Keegan	14:53
4.3. Chair Report from Clinical Effectiveness Committee	Ruth Longfellow	14:54
4.4. Chair Report from Infection, Prevention and Control Committee	Stacey Keegan	14:55
4.5. Capital Plan 2021/22	Mark Salisbury	14:56
4.6. ICS Q&S Strategy	Stacey Keegan/Chris Beacock	14:57
4.7. Infection Prevention Control Q4 Report	Stacey Keegan	14:58
4.8. IPR Annual Review		14:59
4.9. Review of the Workplan	Chris Beacock	15:00
4.10. Attendance Matrix	Chris Beacock	15:02
4.11. Top Risks	All	15:03

5. Any Other Business 15:04

5.1. Next Meeting: Joint Audit and Quality and Safety Committee - Thursday 10th June 2021 at 2pm

0. Reference Information

Author:	Sue Sayles, Hayley Gingell, Amanda Roberts	Paper date:	27th May 2021
Executive Sponsor:	Stacey Lea Keegan, Chief Nurse	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. To provide an update of the Infection Prevention and Control COVID-19 Board Assurance Framework highlighting gaps in compliance to the Key Lines of Enquires (KLOES) and provide assurance purposes.

2. Executive Summary

2.1. Summary

- There are no actions carried over from the original action plan.
- 9 new KLOES have been introduced and require evidence to support compliance and provide assurance.
- Action plan in place to monitor progress on action completion

Infection Prevention and Control board assurance framework-Updates May 2021

1. **Systems are in place to manage and monitor the prevention and co assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**

Key Lines of enquiry	Evidence	Gaps in Assurance	RAG
1.1: There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	Lessons learned from Sheldon outbreak and shared with IPC committee and Link Nurse meeting Patients are transferred into an isolation room within the ward if suspected of COVID-19.		
1.2: That on occasions when it is necessary to cohort COVID or non COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	In line with the Trusts cleaning schedules evidenced by signoff sheets available on request. Enhanced Touch Point cleaning is in place and recorded which will mitigate and identify risks Example of cleaning records for Gladstone ward Feb 2021 Example of Bed space and Weekly deep cleaning charts from Clwyd Ward		

1.3 : Monitoring of IPC practices, resources are in place to enable compliance with IPC practice. **Staff adherence to hand hygiene?** **Staff social distancing across the workplace** **Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in a clinical and non-clinical setting**	COVID-19 Checklist, PPE Audits and Social Distance Tool kit are now included in the ward/departmental IPC audits. All data is collected and analysed by the IPC team and processed in line with Hand Hygiene, Bare Below Elbow and Environmental audits. Audit results are disseminated monthly to all ward/departmental managers and matrons to highlight areas that require immediate attention/support. Graphical information is provided in the IPC Quarterly reports and presented to the Infection Control & Cleanliness Committee on a quarterly basis.		
1.4: Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting	Link nurses for the clinical and non-clinical areas highlights the role SOP of the role Sign off the agreed 'contact' PPE champions redeployed to IPC team to support fresher PPE training across all staff groups. PPE Champions have provided face to face training workshops on :- Hand hygiene PPE/FFP3 Fit Testing Donning/Doffing PPE		
1.5: Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organizational systems in place to monitor results and staff test and trace	Staff have access to twice weekly lateral flow testing. Results are uploaded to the RJAH website. There are two submissions that are completed by the information team regarding lateral flow testing: 1. NHS Staff Lateral Flow test collection – This details the number of LFT kits distributed to staff. It also asks how many staff have tested positive through a lateral flow test and those that have tested positive via lateral flow but are negative via a PCR test. This is a weekly submission. NHS Lateral Flow test Results – This is submitted on a Monday for the results submitted in the previous 7 day period. It includes personal identifiable data for employees.		
1.6: Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team	Staff and patients are swabbed via PCR test in areas where outbreaks have occurred. Excel spreadsheet 'timeline' maintained as part of outbreak process.		

1.7: There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace.	There is a variety of visual reminders for patients, staff and visitors highlighting the importance of mask wearing, hand hygiene and social distancing. Face mask wearing video created to show the correct use of a fluid resistant surgical mask (FRSM) Trust wide social distancing posters displayed Rest room poster displayed to show how to take a break safely Regular audits undertaken by IPC team and people are challenged at point of contact if necessary		
1.8: That trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	The Trust has introduced weekly Manager Briefings to update from a national and local perspective, and the focus for the organisation. Chief Nurse attends all outbreak meetings where she approves the reporting/sitrep. RJAH submissions are weekly on a Monday.		
1.9: This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust Board.	IPC COVID-19 BAF is discussed at IPC Committee, IPC Working Group, Quality and Safety Committee and Trust Board Committee.		
1.10: There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	Executive Team undertake walk-arounds which monitor compliance with social distancing, PPE and BBE and have challenged where necessary. Information has been fed back to the IPC team in an email format SK to remind all senior leadership colleagues to continue to check and challenge with compliance measures		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in Assurance	RAG
2.1: Monitor adherence environmental decontamination with actions in place to mitigate any identified risk	In line with the Trusts cleaning schedules evidenced by signoff sheets available on request. Enhanced Touch Point cleaning is in place and recorded which will mitigate and identify risks		
2.2: Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	Environmental Audits are undertaken monthly and results are shared with Ward Managers and Matrons Green 'I am clean' stickers are used on shared equipment and is checked as part of the environmental audit process Example of cleaning sheet of shared equipment (hoist) that is used in Clwyd and Powys wards.		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in Assurance	RAG
5.1: Face masks are available for all patients and they are always advised to wear them	Ward stock of masks is monitored and refreshed regularly by dedicated PPE top up team. Stock levels are monitored daily and any shortages in supply are via a Daily Sitrep. The Sitrep is provided to the senior nursing and management team in the organisation to highlight any issues, regarding stock levels of PPE PPE usage and stock is recorded on NHS Foundry which facilitates the push of stock as required to those sites that are in need. All patients are advised to wear a face masks upon entering the building via the main entrance		
5.2: Monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	Posters are displayed in Green, amber and red pathways to irritate that staff and patients are to wear facemasks when moving around the ward. There is an SOP in place to guide staff in patients wearing face masks. Patient mask wearing compliance has been added to the COVID-19 checklists.		
5.3: There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control testing document	5-7 days swabbing audit demonstrates that we don't have full compliance in some areas (67.2% compliant) Day 13 swabbing guidance was implemented from 26/04/2021. Audit will be undertaken when data is available.		

6. Systems to ensure that all care workers (including contractors and responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	RAG
6.1: All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	PPE Champions have provided face to face training workshops on :- Hand hygiene PPE/FFP3 Fit Testing Donning/Doffing PPE Regular PPE audits are undertaken by the wards/depts. and spot checked by the IPC team. Audit results are available to each departmental manager on a monthly basis. PHE videos demonstrating donning and doffing on the intranet and COVID-19 portal IPCN provided training on isolation ward. All staff job descriptions include IPC responsibilities.		
6.2: Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	Adherence to PHE guidance is monitored regularly through the use of IPC team audit tools. Wards/departments carry out weekly audits and spot checks are undertaken by IPC Team. Feedback is given at the time. Audit results are reported each month on KPIs and sent to all ward managers/departments and analysis included in the quarter report. Feedback is also given at SNAHP meetings, IPC Committee and IPC Link meetings. Implementation of Perfect Ward in June will automatically create action plans.		
6.3: Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	Communications made advising staff not to car share. Lessons learned poster shared from other Trusts highlighting key learning points during the Covid-19 pandemic		

6.4: Clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Patients/visitors are greeted at the foyer by a volunteer are shown how to wear a mask correctly. Video made by IPC team for staff Poster for staff and patients are displayed throughout the hospital		

8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	RAG
8.1: That all emergency patients are tested for COVID-19 on admission	Audit to be undertaken to ensure compliance. All emergency admissions are treated on an Amber pathway. Patients are swabbed on admission, at 72 hours, day 7 and day 13.	Audit part completed Awaiting results of full audit to confirm compliance.	
8.2: That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	Patients are transferred into an isolation room within the ward if suspected of COVID-19. Red & Amber Pathway SOP now implemented.		
8.3: That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	All emergency admissions are treated on an Amber pathway. Patients are swabbed on admission, at 72 hours, day 7 and day 13. Audits are currently in progress to ensure compliance.	Audit part completed Awaiting results of full audit to confirm compliance.	
8.4: That sites with high nosocomial should consider testing COVID negative patients daily	Guided by microbiology lab if nosocomial rates were high Prevalence across Shropshire remains low		
8.5: That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge	IPC Governance Lead to perform an audit of testing patients 48 hours prior to discharge to a healthcare environment.	Audit in progress awaiting results to confirm compliance	

8.6: That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation	Patients complete 14 days isolation unless they are fit for discharge. Coronavirus Policy		
8.7: That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	Pre-op assessment process for patients on the green pathway. Audits required to ensure compliance. Audits in progress.	Audit in progress	

Key

	Complete
	On track
	Behind Plan
	Overdue
	Not started

IPC Board Assurance Framework - Action Plan

Action Number	Action	Name of Person Responsible	Progress (include dates)	Date Action Completed	Status
1.10	SK to remind all senior leadership colleagues to continue to check and challenge with compliance measures	Chief Nurse			On Track
5.2	Monitoring of compliance to patients wearing facemasks	Ward Managers/IPC Governance Lead	Compliance patients wearing facemasks has now been included into the COVID-19 checklist audits.		Completed
5.3	Full audit to be undertaken to establish compliance to swabbing requirements 72 hours, 5-7 day and 13th day	IPC Team/Ward Managers/Matrons/IPC Governance Lead	Audits in progress		On Track
8.1	Audit required to gain assurance that emergency patients are tested on admission	Surgical Site Surveillance Nurse	Audit is being undertaken as part of actions for 5.3		On Track
8.3	Audit required to gain assurance that emergency admissions are being tested on admission and tested on day 3 and again on day 5-7 post admission	Surgical Site Surveillance Nurse	Audit is being undertaken as part of actions for 5.3		On Track
8.5	Require audit of testing patients 48 hours prior to being discharged to care home	IPC Governance Lead	Audit is planned for completion by 30/5/21		On Track
8.7	Require audit of all elective patients are swabbed 3 days prior to admission and are asked to self-isolate from the day of their test until the day of their admission	IPC Governance Lead	Audit is being undertaken as part of actions for 5.3		On Track
Actions below are regarding the original BAF requirements					
1.3	Audit required to ensure swabs are completed 48hrs pre transfer and pre discharge and a 7 day screening audit required.	To be completed by Ward Managers, ACN / Matrons to arrange.	In progress, results to be shared at the next SNAPP 7 day screening audit completed	22.04.2021 03/03/2021	Completed Completed
1.4	IPC Audit Response and Escalation SOP required to action non-compliance or non-submission of audit data.	IPC Team	Action no longer required, as Perfect Ward to be implemented.	26.01.2021	Competed

1.5	Update Roles and Responsibilities of the IPC Link Nurse, to include expectations regarding COVD-19	IPC Team		31.01.2021	Completed
2.5	Toilets and bathrooms have their first clean using Tristel all public toilets have increased frequency of cleaning by a dedicated team 7 days a week.	Estates and Facilities	Trust has 7 day a week cleaning in place, supported by temporary contracts – 3 months; Results shared at IPC Committee Meeting	22.04.2021	Completed
5.7	Segregation of Reception areas in ward areas	Estates and Facilities	Complete	31.01.2021	Completed
6.8	To ensure all of the IPC team are on the distribution list for all IPC related incidents.	IPC Team / Governance	Complete	17.01.2021	Competed
8.2	Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	IPC Team	Information received and demonstrates compliance. Evidence added to the BAF.	31.01.2021	Completed
8.5	Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	IPC Team	Information received and demonstrates compliance. Evidence added to the BAF.	31.01.2021	Completed
10.4	New FFP3 fit testing is being carried out by an external company. This is due to stock of FFP3 due to expire in March 2021.	Health & Safety	In progress- continuing to do fit testing extended to June		On Track
10.8, 10.9, 10.10	SOP needs to be developed for staff who fail to be adequately fit tested and the options that are then available to the individual, through discussions with People Services and Occupational Health.	Health & Safety	Complete, SOP agreed at IPC Committee 26.01.21	31.01.2021	Completed

Appendix 1.

Updates to the Infection Prevention and Control Board Assurance Framework

1. Systems are in place to manage and monitor the prevention and control assessments and consider the susceptibility of service users and any risks posed by their environment and other service users:

   - There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative.

   - That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance

   - Monitoring of IPC practices, resources are in place to enable compliance with IPC practice
     - Staff adherence to hand hygiene?
     - Staff social distancing across the workplace
     - Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in clinical and non-clinical setting

   - Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting

   - Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace

   - Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.

   - There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace
   - That Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.
   - This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board
   - There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

   - Monitor adherence to environmental decontamination with actions in place to mitigate any identified risk
   - Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk

3. No changes

4. No changes

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

   - Face masks are available for all patients and they are always advised to wear them
   - Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)
   - There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document

6. Systems to ensure that all care workers (including contractors and responsibilities in the process of preventing and controlling infection

   - Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk
     - Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace
     - Clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas

7. No changes

8. Secure adequate access to laboratory support as appropriate

   - That all emergency patients are tested for COVID-19 on admission.
   - That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.
   - That those emergency admissions who test negative on admission are retested on day 3 of admission and again between 5-7 days post admission.
   - That sites with high nosocomial should consider testing COVID negative patients daily.
   - That those being discharged to a care home are being tested for COVID-19
   - 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge
   - That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.
   - That all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.

Chair's Assurance Report
People Committee: 6th May 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27th May 2021
Executive Sponsor:	Paul Kingston, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	People Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the People Committee on 6th May 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the People Committee. This Committee is responsible for seeking 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. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- There was good progress of actions from the previous meeting with all actions completed or updated
- The work plan was reviewed and agreed
- Good progress was reported on the corporate risk register
- To ensure the Trust is meeting it statutory and regulatory requirements in relation to workforce management
- To oversee the development and implementation of the People Plan and any related workforce plans
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'
- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising HR issues of significance

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 6th May 2021. The meeting was attended by the below Committee members;

Attendance:		
Attendance:		
Paul Kingston	Non-Executive Director (Chair)	PK
Harry Turner	Non-Executive Director	HT
Chris Beacock	Non-Executive Director	CB
Kerry Robinson	Director of Performance, Improvement and OD	KR
Sarah Sheppard	Chief of People	SS
Hilary Pepler	Board Advisor	HP
Sue Pryce	Head of People Services	SP
Alexander Yashchick	Consultant Anaesthetist	AY
Shelley Ramtuhul	Trust Secretary	SR
Jo Banks	Managing Director of MSK	JB
Alyson Jordan	Managing Director of SSU	AJ
Nia Jones	Managing Director of SpSU	NJ
Dawn Forrest	Managing Director of CSU	DF
Craig Macbeth	Chief Finance Officer	CM
Rob Freeman	Clinical Representation	RF
Mark Brandreth	Chief Executive Officer	MB
Stacey-Lea Keegan	Chief Nurse	SLK
David Low	Improvement and Organisational Development Manager	DL
Ruth Longfellow	Chief Medical Officer	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Performance and Assurance Workshop		
The issues of Performance and Assurance were debated at length by the committee with questions raised on the below: • Agreed outcome of the meeting • What a sustainable model will look like • What actions will be set to increase core clinical capacity • Workforce There was debate around these questions and what the key assurances for the committee are, suggesting there is a current gap in clarity of these assurances and the		

responsible owner of each element. The Non-Executive Directors also felt there was also a lack of alignment from the Board to each Unit to enable these gaps to be closed, which in turn would support assurances being progressed.		
2. Integrated Performance		
The key points were highlighted in red, and questioned how the committee wants to move forward on receiving assurances. Discussions took place over the owners of the areas and it was suggested that each lead presented their areas, to ensure responsibility is held within the correct areas. The sickness absence was presented noting there are no concerns, although there are hot spots and felt it would be useful for each Unit to complete a deep dive on hotspot areas, to ensure mitigations are being put in place. It was agreed that each Unit would present a report next month with support from the Unit Business Partners. The Committee discussed the Appraisals with data highlighting the low completion of these within certain Units. For assurance the committee requested deep dives into Unit Staff Appraisals from CSU/SSU/SpSU at next month' committee.	Y	
3. Nursing Workforce		
It was highlighted to the committee the Risk around international recruitment, due to the current pandemic, meaning there are currently 6 individuals who have been recruited from India who are currently unable to start due to the closure of the country. The Risk is being monitored closely, and added that there are 4 other individuals who have been recruited and due to commence at the Trust imminently. Further to the above Risk there is an Amber area for Health Care Support Workers, the committee were informed this is due to funding streams that the Trust were not successful for, hence the Amber rating, although the Trust will report on 0 vacancies for Health Care Support Workers as all vacancies have been filled. Areas of improvement included that are currently being concentrated on, being Marketing from a recruitment point of view along with retention. The main areas for retention to be reviewed are flexible working, retirement age and further training. The Marketing to recruitment needed refining, as the Trust is a Specialist Trust and this aspect needs to be highlighted, alongside the research undertaken by specialities to encourage staff to join the Trust.	Y	

3.4 Approvals

Approval Sought	Outcome
Integrated Performance Report – March	*Approved*
Nursing Workforce Update	*Approved*
Policy Work Plan	*Approved*
Terms of Reference	*Approved*

3.5 Risks to be Escalated

In the course of its business the Committee identified no risks to be escalated.

3.6 Conclusion

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

Chair's Assurance Report
Audit Committee: 10th May 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27th May 2021
Executive Sponsor:	David Gilburt, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	Audit Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Audit Committee Meeting held on 10th May 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the Audit Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It is responsible for seeking assurance regarding the Trust's internal and external audit programme, the local counter fraud service and compliance with the law and regulations governing the Trust's activities. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

Key points to highlight from the meeting

- The meeting was well attended
- There was good progress of actions from the previous meeting with all actions completed or updated
- The work plan was reviewed and agreed
- Good progress was reported on the corporate risk register which was reviewed in full
- Finance reports were submitted and approved with assurance by the committee

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Audit Committee which met on 10th May 2021. The meeting was quorate with three Non-Executive Directors present. A full list of the attendance is outlined below:

Attendance:		
Attendance:		
David Gilburt	Non-Executive Director (Chair)	DG
Paul Kingston	Non-Executive Director	PK
Harry Turner	Non-Executive Director	HT
Shelley Ramtuhul	Trust Secretary	SR
Diana Owen	Head of Financial Accounting	DO
James Shortall	Counter Fraud Specialist	JS
Gurpreet Dulay	Internal Audit Representative	GD
Yasmin Ahmed	Internal Audit Representative	YA
Mona He	Internal Audit Representative	MH
Mo Ramzan	External Audit Representative	MR
Simon Adams	Director of Digital	SA
Mark Salisbury	Operational Director of Finance	MS
Stacey Keegan	Chief Nurse	SLK
Apologies:		
Craig Macbeth	Chief of Finance and Planning	CM

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions which were due to be completed before the meeting were confirmed as accomplished.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Chair Report – Information Governance Meeting		
It was highlighted that the main element of the report being the training element which is being picked up by performance meetings to ensure further uptake on compliance of training which is currently at 88% with a goal of 95% across the Trust. A delay in Data quality audits was noted. It was noted to the committee and for the minutes regarding the volume of FOI/Subject Access Requests to the Trust, and wanted to thank the team for working through these, with only 1 breach in each area. The Trust noted the commendable work by the team.	Y	
2. Finance Governance Pack		
The committee were informed that £4.5m adjusted surplus has been covered by one part of NHSE funding from lack of	N	The committee requested the financial position is raised with the

income and funding for annual leave accrual of £1.4 m, noting that by removing these 2 transactions the Trust breaks even, which was the plan of the Trust for 2020/21. The Trust offered further context that the Trust' underlying financial position is not quite as healthy with a £1.8m deficit moving into 21/22, once funding is removed. It was confirmed that the covid funding would cease. The Committee discussed the sharing of the system deficit as 1 part of the £1.8m deficit is driven due to not being able to deliver on efficiencies during 2020/21. There is the intelligence fixed payment system which is a £2.6m reduction in income, giving the Trust an in year recurrent deficit in the region of £3.5 m.		Board as a Risk.
3. Register of Interests & Hospitality		
There was a noted drop in the last quarter since changing to rolling year rather than financial year reporting, with a current 70.7% compliance, compared to 83% compliance at last reporting in January. The non-compliance has been escalated to the Managing Directors of the Units and mitigations are in place	N	Drop in compliance to be raised with Board.
4. Board Assurance Framework		
Verbal update given and accepted.	Y	
5. Reference Costs Update		
The only voluntary tool included is the Costing Assessment tool which was not required last year due to Covid, although is now required. For reference in year 18/19 the Trust scored 92% with a position of 11th out of 120 Trusts that submitted, and the average peer percentage was 85% which is aimed to be improved on this year.	Y	
6. Counter Fraud Annual Plan		
Transitional year ahead, moving from NHS Counter Fraud Authority (NHSCFA) Standards for Providers, and moving forward with the Government Functional Standard for Counter Fraud. Set out in the plan is how the old standard fits in to the new, alongside with some additional elements.	Y	
7. LCFS Progress Reports		
No new allegations, aside from the NFI Leads, identified since the last report was submitted to the Audit committee.	Y	
8. Self Review Toolkit		
The toolkit was noted by the committee.	Y	
9. Review of Internal Audit Progress Report		
The following progress reports were noted: • Governance • DSP Toolkit • Research Governance • Plan • Draft Annual Opinion	Y	
10. Approval of Internal Audit Strategy and Plan		
Approved subject to confirmation of phasing the plan.	N	Further clarification regarding the phasing of plan to be confirmed

11. Research Audit Report		
Effectiveness and highlighted findings within the report; • Good practice – Clear Terms of Reference, and Chair Report taken to Q&S • Standard operating procedures in place on monitoring and auditing of sponsored and hosted studies: • Hosted studies – monitoring lies with the sponsor • Sponsored studies – monitoring lies with the Trust directly • Recent review by NIHR, BDO made sure not to duplicate any work completed by them • Sponsored Study – to be monitored by the Trust, with 2 Audits completed within 1 year and the study start date being 2013, therefore regular monitoring is required. • Hosted Study – Started in 2018 and not audited or monitored.		
12. Receipt of Annual Internal Audit Report and Associated Opinions		
Overall opinion offered is Moderate. Committee disappointed the report is still in draft and requested a final report is submitted before 10th June 2021.	Partial	The documents was presented in a draft format
13. External Audit Progress Report		
No significant issues needing to be raised and further reporting will be submitted at the next committee meeting.	Y	

3.4 Approvals

Approval Sought	Outcome
Review of Audit Committee Work Plan	*Approved*
Review of Audit Committee Terms of Reference	*Approved*
Policy Tracker	*Approved*

3.5 Risks to be Escalated

In the course of its business the Committee identified the following risks to be escalated:

- Financial Position of the Trust
- Audit Plan to be phased to ensure completion

3.6 Conclusion

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

Chairs Assurance Report
Finance Planning and Digital Committee 27th May 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27th May 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Digital	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Finance, Planning and Digital Committee was held on 25th May 2021. A verbal update will be provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance Planning and Digital 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.

2.2. Summary

Due to the timing of the committee it is not possible to provide a paper Chair's Report. The Non-Executive Director Chair of the committee will provide a verbal update.

2.3. Conclusion

The Board is asked to note the verbal report which will be provided during the meeting.

Finance, Planning and Digital Committee 25/05/2021

MEETING
25 May 2021 14:00

PUBLISHED
20 May 2021

Agenda

Location	*Date*	*Owner*	*Time*
	25/05/21		14:00

1. Introduction		14:00
1.1. Apologies	Rachel Hopwood	
1.2. Minutes from the previous meeting	Rachel Hopwood	
1.3. Action log/Matters arising	All	
1.4. Declaration of interests	All	
2. Performance		
2.1. Performance Overview Report	Kerry Robinson	14:10
2.2. IPR Annual Review (to follow)	Kerry Robinson	
2.3. Restoration & Financial Impact Committee Update (verbal)	David Gilburt	14:20
2.4. Finance Report	Mark Salisbury	14:25
3. Planning		
3.1. Efficiency Plan	Alison Reynolds	14:35
3.2. STW Stabilisation Plan H1	Craig Macbeth	14:45
4. Digital		
4.1. Chair Reports: EPR Programme Board	Simon Adams	14:50
4.2. Milestone Plan EPR	Simon Adams	14:55
4.3. Security Report	Simon Adams	15:00

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
	25/05/21		14:00

5. Committee Management

5.1. Chair Report from MSK Transformation Programme Board	Craig Macbeth	15:05
5.2. Chair Report from Trust Performance and Operational Improvement Board	Kerry Robinson	15:10
5.3. Chair Report from ICS Financial Sustainability committee	Craig Macbeth	15:15
5.4. Board Assurance Framework and Corporate Objectives	Shelley Ramtuhul	15:20

6. Governance

6.1. Review of the Work Plan	Shelley Ramtuhul	15:30
6.2. Attendance Matrix	Shelley Ramtuhul	15:35
7. Top Risks	Shelley Ramtuhul	15:40
8. Any Other Business	All	15:45

9. Next meeting: Tuesday 22nd June 2021

IPR Setting: - 2021/22

0. Reference Information

Author:	Stephanie Wilson, Performance Insight & Improvement Manager	Paper date:	27/05/2021
Executive Sponsor:	Kerry Robinson, Director of Performance, Improvement and OD	Paper Category:	Performance & Improvement
Paper Reviewed by:		Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	

1. Purpose of Paper

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

As agreed through the Trust Performance Management Framework an annual review will be undertaken on the Trust's performance measures reported within Integrated Performance Reports (IPRs).

The Board is asked to review and note the recommendations for suggested changes to the Trust IPRs.

2. Executive Summary

2.1. Context

The purpose of this paper is to ensure an annual review of the IPR is undertaken as set out in the Trust's Performance Framework. The paper recommends updates to existing measures as well as recommending new metrics that are aligned with internal, local and national priorities.

As the NHS focuses on restoration and recovery of services impacted by COVID-19 it is to be expected that further guidance will be released. Therefore further reviews and amendments will be required to the IPR in year in recognition of the changing landscape we are now in.

The paper will summarise the suggested amendments, recommended new service measures and potential future additions in development or to be confirmed.

2.2. Summary

The paper will summarise the review of the Trust IPRs and categorise the recommendations in to the following:

- Target changes, amendments and updated trajectories
- New Service Measures
- Additions in development / to be confirmed

The paper will also propose additional in-year reviews required for our Trust IPRs during 2021/22. This is in recognition that the NHS planning and local and national expectations has changed significantly since COVID-19 and continues to do so. Planning this year has also been split in to 2 periods:

- H1 (April 2021 to September 2021)
- H2 (October 2021 to March 2022)

IPR Setting: - 2021/22

3. The Main Report

3.1. Background

In line with the Trust Performance Management Framework the Trust will annually enter a 'Planning phase'. This is where objectives and performance measures are annually agreed via the Board and its committees. Following review these measures can be refreshed.

This paper is to highlight some key changes to performance measures to note for the financial year 2021/22 that will require review and agreement of the new metrics proposed. In recognition of the recent events of COVID-19 NHS E/I planning and expectations has also seen significant changes with further guidance expected. Further evolvement of IPRs is therefore expected this year in ensuring the Trust aligns with new guidance released.

Furthermore, the usual annual cycle of planning is being split this year in to two halves:

- H1: - covering April 2021 to September 2021
- H2: - covering October 2021 to March 2022

H1 plans are currently at a draft stage and H2 guidance is yet to be released. The current known NHS E/I submission dates for our 2021/22 plans are as follows:

- 6th May – first draft System narrative 2021/22 and Operational Plan submitted to NHSE
- 3rd June – final System narrative 2021/22 and Operational Plan submitted to NHSE
- TBC – H2 planning and expectations

The proposals within this paper will align to draft H1 plans and expectations. Further reviews and amendments will be required as H1 plans are finalised and H2 guidance is released. Target suggestions currently align to the 25th March 2021 release of the NHS E/I 2021/22 priorities and operational planning guidance. Further recommendations are made that align to local and national programmes of work. This is in recognition that our hospital is also at the forefront of other transformational programmes that are in progress within our health system. This includes but is not limited to collaborative work with the Getting It Right First Time (GIRFT) within our local health system as an example.

The objectives for this review is to ensure that key information is available that enables the Board and other key personnel to understand, monitor and assess the Trust's quality and performance against current requirements and expectations.

This paper therefore sets out the following:

- Target changes, amendments and updated trajectories
- New service measures
- Additions in development / to be confirmed

3.2. Target changes, amendments and updated trajectories

The trajectories and targets were originally based on the third phase of the NHS response to COVID-19 and implementation. Trajectories and plans will move from 'phase 3' to 'H1' and align to H1 NHS E/I planning submissions as well as reflect impacts seen following the latest wave.

Targets are equally to be updated to recognise expectations for the NHS as set out in the national 2021/22 priorities and operational planning guidance.

- Plans and trajectories will be updated and referred to as 'H1 plans' during April to September.

The baseline and targets for activity achievement remains a value based on all elective activity delivered in 2019/20.

- This baseline will be adjusted and align with NHS E/I adjustments for COVID19 impacts, working days etc.
- The expectations for elective activity against this baseline for April 2021 is to be set at 70%, rising by 5 percentage points in subsequent months to 85% from July. This is as referenced in the 2021/22 priorities and operational planning guidance.

IPR Setting: - 2021/22

Outpatient currencies have also seen recent changes in the latest planning guidance. Historically within the Trust there has been a focus on monitoring our consultant-led attendances. H1 plans have seen this evolve to include consultant and non-consultant led attendances.

- Outpatient monitoring for 2021/22 from April 2021 will be inclusive of consultant and non-consultant led activity to align with NHS E/I monitoring and H1 plans.

Within the 2021/22 priorities and operational planning guidance there is no specific targets against 2019/20 baselines mentioned for diagnostics. However it does reference that *"Recovery of the highest possible diagnostic activity volumes will be particularly critical to support elective recovery*".

- Diagnostic targets against 2019/20 for H1 will be set at the maximum achievement expected within H1 plans. This ensures that activity levels are on track to deliver these expected levels. These are:
    - MRI 92%
    - Ultrasound 95%
    - CT 100%

The Trust has also seen a significant impact to its overdue follow-up backlog and 52 weeks as a result of COVID-19. The overdue follow-up backlog was considered an internal assurance metric for 2021/22 and will continue to be so.

- Overdue follow-up backlog targets will be reviewed in recognition this has been significantly impacted during COVID-19. Trajectories will also be updated and align with improvement plans to address this.
- 52 weeks trajectories will be updated to reflect impacts from the latest wave and align to H1 submitted plans.

3.3. New Service Measures

This section aims to highlight new KPIs to be added/referenced from month 1 of our 2021/22 IPRs and the committees these will present to. These are an accumulation of metrics derived from the following:

- GIRFT: - Midlands Elective Delivery Programme (MEDP)
- National Operational Planning Guidance 2021/22
- Mutual Aid: - Activity delivered at RJAH to support wider NHS
- National Waiting Lists and Clinical Prioritisation

New data included within IPRs will be underpinned by a robust rolling data quality programme which is overseen by the Audit Committee.

<u>GIRFT: - Midlands Elective Delivery Programme (MEDP)</u>

The Shropshire, Telford and Wrekin (STW) health system is working in collaboration with the Getting It Right First Time (GIRFT) team. The system is focusing on three specialties; ENT, ophthalmology and orthopaedics. The focus is to drive equity of access & excellent clinical outcomes for the population through standardisation of pathways and adoption of best practice. As a system one of the recommendations we have agreed to prioritise is primary hip length of stay:

- To examine in-hospital pathways for primary hip replacement, including anaesthesia, to demonstrate improvement in length of stay.

It is recommended that this measure is monitored through the Restart, Recovery and Renewal sub-committee. It is also recommended this is monitored through Quality and Safety committee due to the clinical transformation of pathways expected.

The performance measure (top decile/national standard) as referenced in GIRFT best practice guidance is an achievement of <=3.00 days.

The recommended new measure is as follows:

Measure	Committee	Responsible Unit	Type	Target
Inpatients: - Primary hip LOS	Restart, Recovery and Renewal sub-committee & Q&S	MSK	Operational	3.00 days

IPR Setting: - 2021/22

National Operational Planning Guidance 2021/22

This section aims to highlight the specific outpatient transformation programmes as referenced in national planning guidance and being submitted as part of the Trust's H1 plans.

The national planning guidance aims to take *"..all possible steps to avoid outpatient attendances of low clinical value and redeploying that capacity where it is needed, alongside increased mobilisation of Advice & Guidance and Patient Initiated Follow Up services".* The national guidance also states *"Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation".*

The following 3 additional outpatient measures are therefore recommended within the Trusts IPRs as follows:

- It is recommended that these measures are monitored through the Restart, Recovery and Renewal sub-committee.
- It is also recommended that the Virtual Attendances % is monitored through the Financial, Planning & Digital committee as it is understood this will be an Elective Recovery Fund (ERF) 'gateway criteria' to be met.

Measure	Committee	Exec Lead /Responsible Unit	Type	Target
Outpatients: - Virtual Attendances %	Restart, Recovery and Renewal sub-committee & FPD	CSU	Assurance	25%
Outpatients: - Advice and Guidance	Restart, Recovery and Renewal sub-committee	CSU	Assurance	As per Trust H1 planning submission
Outpatients: - PIFU	Restart, Recovery and Renewal sub-committee	CSU	Assurance	As per Trust H1 planning submission

Mutual Aid: - Activity delivered at RJAH to support wider NHS

The NHS has seen many changes during 2019/20. In supporting our population and in ensuring our patients have equitable access to services within the STW system this has also meant commencement of mutual aid arrangements to support this. RJAH is currently supporting our neighbouring provider in delivering orthopaedic surgery. This contribution should be recognised within IPRs as well as monitored due to the potential of wider mutual aid being required within the NHS. The recommended KPI is therefore as follows:

Measure	Committee	Exec Lead /Responsible Unit	Type	Target
Mutual Aid: - Elective	Restart, Recovery and Renewal sub-committee	MSK	Operational	N/A

National Waiting Lists and Clinical Prioritisation

The Trust has also seen clinical prioritisation be introduced during 2019/20 and assurance that our patients are being dated and treated aligned to national clinical prioritisation guidance should continue.

Nationally waiting list reporting is evolving to collect both RTT and non-RTT pathways. This is in recognition that both RTT and non-RTT pathways have been impacted during covid-19. It is therefore recommended that transparency of these waiting lists within our committees should continue.

Furthermore the NHS is now reporting vast amount of >52 week patients. NHS E/I is reporting these as a % of the providers overall open pathways and it is recommended the Trust should also do the same.

The recommended new KPI metrics for 2021/22, of which some are a continuation of new metrics introduced during 2020/21 is therefore as follows:

IPR Setting: - 2021/22

Measure	Committee	Exec Lead /Responsible Unit	Type	Target
Non-RTT Backlogs	Restart, Recovery and Renewal sub-committee	CSU, Specialist and MSK	Operational	N/A
Surgical Waiting Lists by Priority	Restart, Recovery and Renewal sub-committee	Specialist and MSK	Operational	N/A
>52 weeks as % of open pathways	Restart, Recovery and Renewal sub-committee	Specialist	Operational	N/A

3.4. Additions in development / to be confirmed

This section aims to recognise internal, local and national programmes of work that may require IPR changes within the year as these are further evolved. These are for example but not limited to:

- National: - Elective Recovery Fund (ERF) 'gateway criteria'
- Internal and National Expectations: - Workforce
- National: - Final H1 plans and H2 plans
- STW System: - 6 Big Ticket items
- National: - Reducing variation in access and outcomes
- Internal and National Expectations: - Long Waiters
- Upcoming NHS E/I directives and new submissions

National: - Elective Recovery Fund (ERF) 'gateway criteria'

The national operational planning guidance sets out additional funding the Government has made available to support further recovery to systems that achieve activity levels above set thresholds. Acute providers' access to the ERF will be subject to meeting 'gateway criteria' including addressing health inequalities, transformation of outpatient services, implementing systemled elective working, tackling the longest waits and supporting staff. Whereas the funding is understood to be dependent on the system (all providers) collectively meeting this criteria we also need to monitor our individual performance as a Trust. It is understood 'virtual attendances' will be one measure as part of transformation outpatient services for example and this has been included within the report as a recommended 'new measure'.

Addressing health inequalities is another example of areas to be addressed as part of the 'gateway criteria'. This will have continued focus during 2021/22. Although no changes have been recommended to date within Trust IPRs the Trust continues to review health needs by deprivation and ethnicity. As a Trust we will aim to ensure we are delivering inclusive services with IPRs devised where further focus is required.

In total the ERF comprises 5 components as follows:

1. Clinical Validation, Waiting List and Long Waits	Plans should ensure ongoing clinical validation and shared decision making between patients and clinicians as well as maintain a continuous focus on waiting list data quality.
2. Addressing Health Inequalities	Plans should take due regard of the need to reduce pre-pandemic and pandemic related health inequalities using related waiting list data that is embedded within system performance frameworks to measure access, outcome and experience for BAME populations (and those in the bottom 20% of IMD scores).
3. Transforming Outpatients	Plans should demonstrate rapid progress on Patient-Initiated Follow-up (PIFU), uptake of Advice and Guidance or similar models; telephone or video consultations should be maintained for necessary outpatient attendances.
4. System-led Recovery	Plans should ensure that Patient Tracking List (PTL) management is undertaken at a system level and that all capacity (including IS) is being used to the benefit of the whole-system population.
5. People Recovery	Plans should demonstrate how the health and wellbeing of staff will be monitored using an appropriate set of measures and that the rate of service restoration takes account of the need for people to recover from their individual experiences and consider the wider workforce capacity availability.

IPR Setting: - 2021/22

Reviews of the ERF gateway criteria and metrics are underway. As the ERF gateway criteria is further understood further amendments to IPRs may be required specifically to support where further focus is required. The recommendation is therefore:

- To review IPR measures and align to ERF gateway criteria where appropriate in year.

Internal and National Expectations: - Workforce

The Trust has a recruitment plan underway for 2021/22. This recruitment plan is a key enabler in supporting the Trust to achieve the activity levels required for restoration and recovery.

- A group of KPIs is to be devised and aligned to IPRs where appropriate to provide assurance of the delivery of the Trust's recruitment plan.
    - This is inclusive of but not limited to reporting of the Trust's core available consultant clinical capacity.

The National Operational Planning Guidance 2021/22 also references the following for staffing expectations: - *"Providers are asked to show how they intend to meet the highest level of attainment as set out by our 'meaningful use standards' for e-job planning and e-rostering".* A further recommendation is therefore as follows:

- E-job planning and e-rostering available metrics and attainment will be reviewed. Where further assurance is required these will be flagged through Unit reviews.

National: - Final H1 plans and H2 plans

H1 plans were submitted as draft on the 6th May 2021. Further changes may be required. The proposed approach for IPRs this year is:

- 2021/22 IPRs will initially be based and reflect draft H1 plans.
- IPRs to be updated to reflect final H1 plans after submission on the 3rd June.
- IPR metrics, targets and trajectories to be further reviewed following release of H2 guidance.

STW System: - 6 Big Ticket items

The Shropshire, Telford and Wrekin health system has set out '6 big ticket items'. The aim of the new approach is to develop a system plan that enables us to work towards delivering common goals to achieve shared priorities. Although organisations will still have a requirement to have their own plans these will be much more aligned than in previous years. STW faces significant challenges in the coming year in relation to quality improvements, finance, workforce and restoration from Covid19 and we need to develop our plans in this context. The 6 big ticket items have been identified as follows:

- MSK transformation
- Hospital Transformation Programme – step on from future fit
- Alternatives to Hospital Admission
- Outpatients transformation
- Integrated Procurement/Joint Commissioning
- Creating a Sustainable workforce

It is recommended:

- The Trust as part of its work within the system flags and identifies specific metrics that will require further focus/assurance within the Trust.

National: - Reducing variation in access and outcomes

The system is already working in collaboration with the GIRFT as part of MEDP. Whereas the system has already identified primary hip LOS as one performance measure to be improved and monitored there are also other areas to be explored.

The national operational planning guidance sets out the following*: "To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and thereby improve*

performance in three specialties: cardiac, musculoskeletal (MSK) and eye care with support via the National Pathway Improvement Programme. The aim should be to achieve what was top quartile performance against benchmarks on those pathways, and we will ask the National Pathway Improvement Programme in conjunction with GIRFT to support the development of and accredit plans as part of the national elective recovery programme."

The Trust should identify and collectively agree further focus areas. This will include goals to ensure we are an orthopaedic provider that is as a minimum within the top quartile. The recommendation is as follows:

- To review alongside the Chief Medical Officer further GIRFT areas for focus by Units / committees as appropriate.

Internal and National Long Waiters:

The National Operational Planning Guidance asks Trusts that they focus on tackling and addressing the longest waits. It is understood that tackling long waits will also be part of the ERF 'gateway criteria'. This is under review within the Trust and the system. Any recommendations to address the longest waits should be reflected in updated assurance KPIs within IPRs e.g. >104+ weeks.

- Following Trust reviews and decisions long wait KPIs should be created and included within IPRs for assurance.

Upcoming NHS E/I directives and new submissions

It goes without saying that the NHS is facing significant challenges in its continued response, recovery and restoration from covid-19. New NHS E/I mandated returns, guidance and priorities are regularly being released. In reviewing and responding to new guidance the Trust will continue to ensure its appropriateness of its IPR targets and measures. The final recommendation is therefore as follows:

- The Trust will continue to review new NHS E/I released guidance and align with IPRs where appropriate.

3.5. Summary and Recommendations

The Trust has moved out of phase 3 plans, has seen further covid waves and is in the process of submitting H1 plans (April 2021 to September 2021).

- IPRs, targets, currencies and trajectories will be updated to reflect H1 plans.
- Targets will be updated to reflect expectations as released in the national 2021/22 priorities and operational planning guidance.

Trajectories will be further amended in recognition of the impact from covid-19 for the following metrics:

- Overdue follow-up backlog
- 52 weeks trajectories

New metrics have been recommended to align with local and national programmes of work and expectations. New data included within IPRs will be underpinned by a robust rolling data quality programme which is overseen by the Audit Committee. The new metrics and their recommended committees are:

Measure	Committee	Exec Lead /Responsible Unit	Type	Target
Inpatients: - Primary hip LOS	Restart, Recovery and Renewal sub-committee	MSK	Operational	3.00 days
Outpatients: - Virtual Attendances %	Restart, Recovery and Renewal sub-committee	CSU	Assurance	25%
Outpatients: - Advice and Guidance	Restart, Recovery and Renewal sub-committee	CSU	Assurance	As per Trust H1 planning submission

IPR Setting: - 2021/22

Outpatients: - PIFU	Restart, Recovery and Renewal sub-committee	CSU	Assurance	As per Trust H1 planning submission
Mutual Aid: - Elective	Restart, Recovery and Renewal sub-committee	MSK	Operational	N/A
Non-RTT Backlogs	Restart, Recovery and Renewal sub-committee	CSU, Specialist and MSK	Operational	N/A
Surgical Waiting Lists by Priority	Restart, Recovery and Renewal sub-committee	Specialist and MSK	Operational	N/A
>52 weeks as % of open pathways	Restart, Recovery and Renewal sub-committee	Specialist	Operational	N/A

To recommend that although the Performance framework recommends an annual review of measures that for 2021/22 a further review should be undertaken to align to H2 plans. Further amendments will also be required to reflect final submissions of H1 plans and to align with in-year STW and national expectations.

Areas for further review and reporting within IPRs where deemed appropriate are but not limited to:

- National: - Elective Recovery Fund (ERF) 'gateway criteria'
- Internal and National Expectations: - Workforce
- National: - Final H1 plans and H2 plans
- STW System: - 6 Big Ticket items
- National: - Reducing variation in access and outcomes
- Internal and National Expectations: - Long Waiters

The committee is asked to note and agree the recommendations for amendments and additions to the Integrated Performance Reports for 2021/22.

The changes, recommendations and additional review(s) in year of the IPR for 2021/22 is aligned to the NHS challenges, uncertainties of further COVID impacts and levels of transformation required to support recovery and restoration of our services. Measures will therefore evolve during 2021/22 to support further focus where required.

Month 1 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	27/05/2021
Executive Sponsor:	Kerry Robinson	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

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

The committee is asked to note the overall performance as presented in the month 1 (April) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

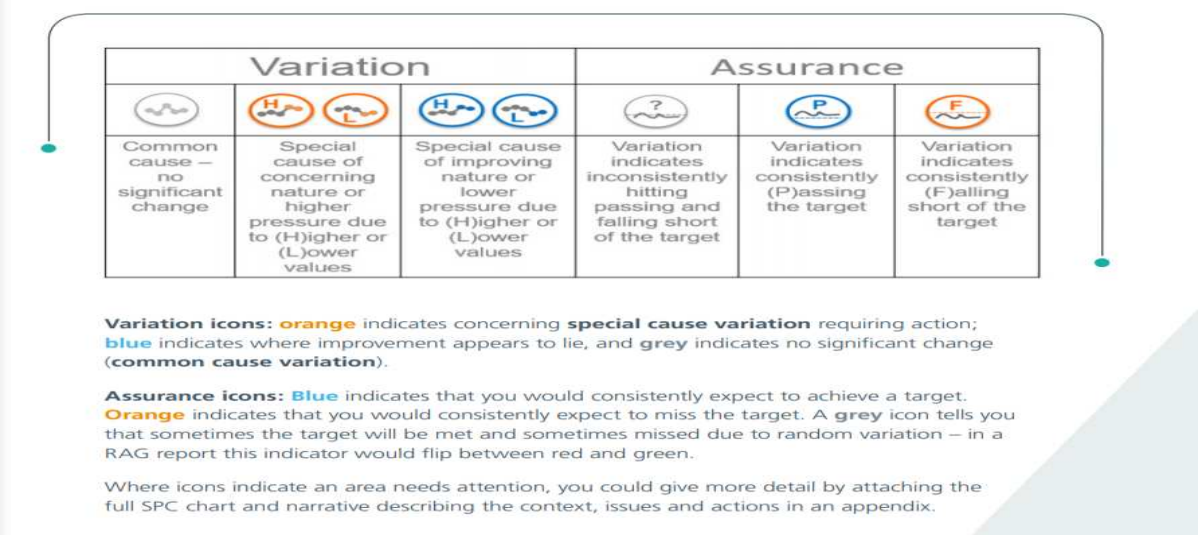
The paper incorporates the monthly integrated performance report with associated narrative and descriptions of key actions.

This month sees the introduction of a new format to the IPR. Although the IPR did already utilise Statistical Process Control (SPC) graphs, the Trust have never fully moved away from utilising RAG heat maps. The new format now relies on the use of SPC and associated variation and assurance icons, as recommended by NHSEI. The development of this new format has utilised NHSEI guidance and training, as well as researching those Trust IPRs they rate as exemplary for reference.

The scheduled Board Strategy meeting in June will include a presentation from the NHSEI 'Making Data Count' team to provide further training and oversight on this approach to presenting and utilising data.

The reading guide within the IPR gives a full explanation on the interpretation of SPC graphs and the icons but for quick reference this explains the use of the icons:

Month 1 Integrated Performance Report



Some KPIs are not appropriate to display as an SPC graph. This could be because the data points are usually zero or a small number or perhaps the metric does not have enough data points yet. It is recommended that 15+ data points are required for robust analysis. The IPR will display the variation icon as 'N/A to SPC' for these KPIs and will rate assurance based on performance against the target over the last three months.

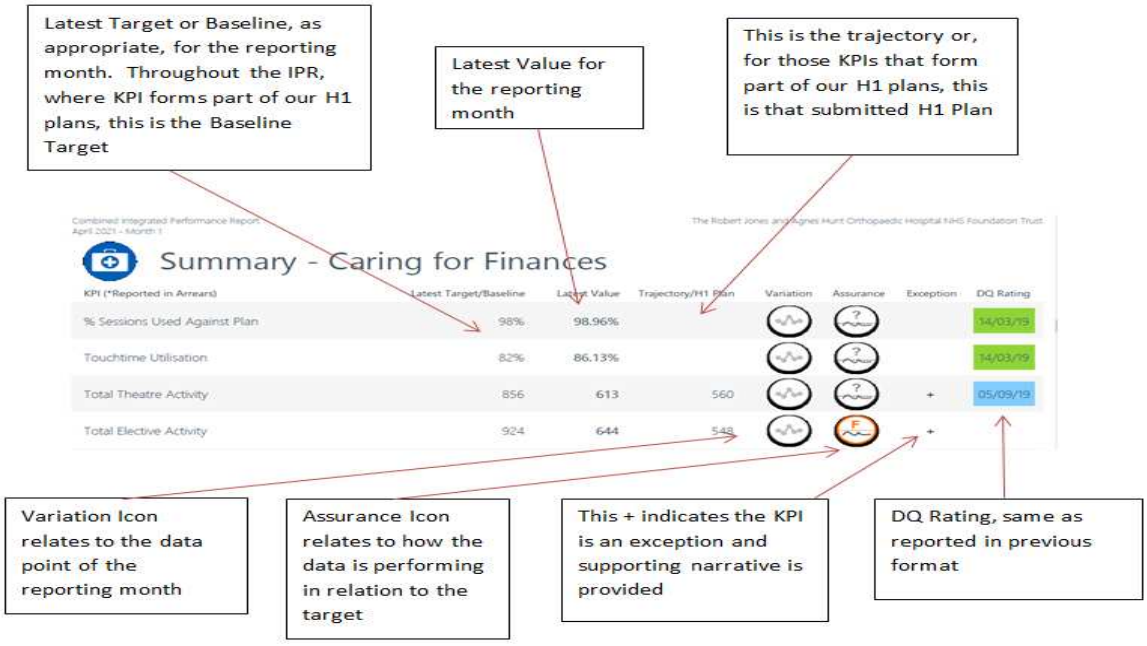
The assurance target relates to the target/baseline rather than the trajectory/H1 plan.

The sections of the IPR now read as follows:

- Summary;

The summary pages remain with KPIs reported in the usual domains of Caring for Staff, Caring for Patients and Caring for Finances.

The summary page is laid out as follows:



When reading the data displayed, using Total Theatre Activity as an example from the picture above, it can be read as:

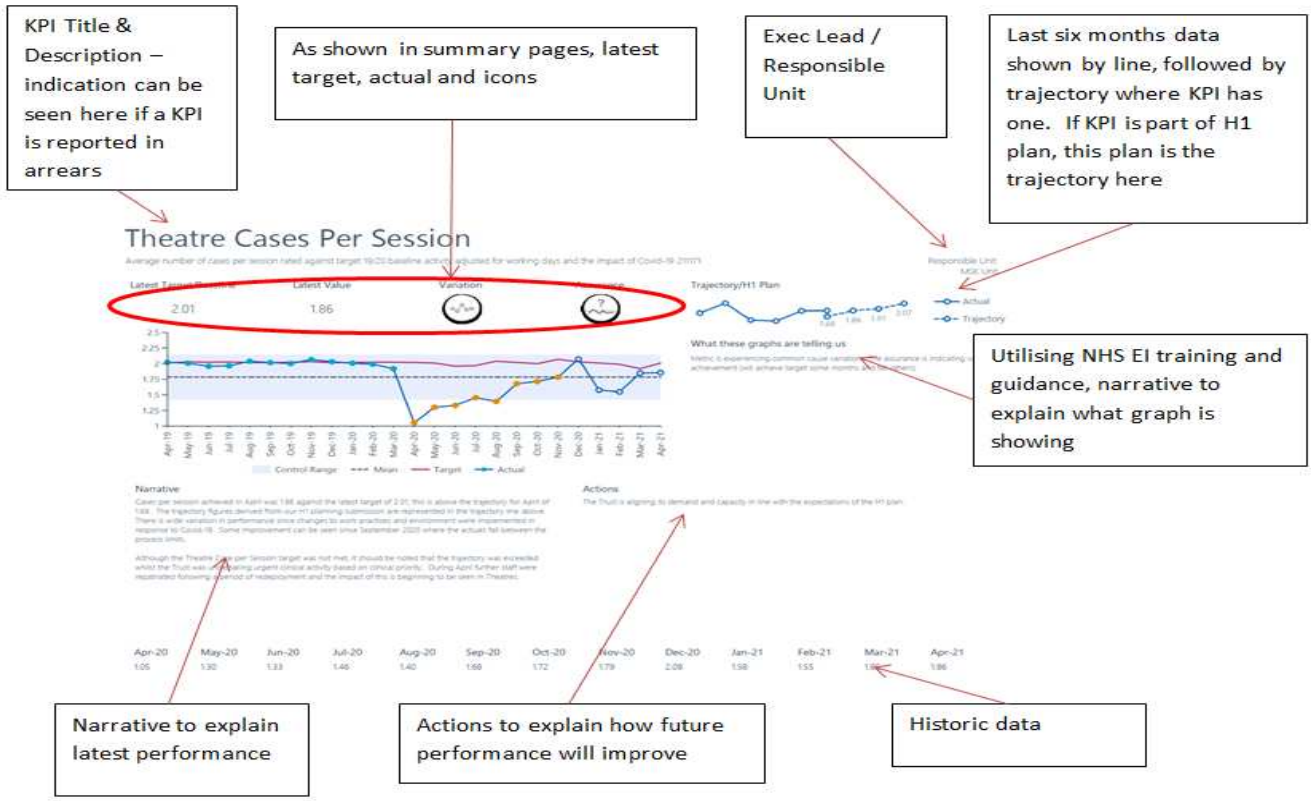
"Total Theatre Activity baseline figure was 856 (19/20 activity with adjustment for working days and covid), the performance was 613, the H1 plan was to achieve 560 (theatres proportion of the elective plan)".

Narrative/Exception Pages;

The narrative/exception pages are included in the following circumstances:

- The icons indicate a measure should be an exception
- A metric is within common cause variation but has missed the target for three months
- A metric for low number incidents, e.g. Serious Incident or Never Event

The narrative/exception page is laid out as follows:



2.2. Overview

The Board through this IPR should note the following;

Caring for Staff;

- Sickness absence;
  - Improving position.
  - Inconsistently meeting target.

Caring for Patients;

- Never events; low number of incidents have taken place.
- Cancer 62 days standard; falling short of target
- 18 Weeks RTT Open Pathways (exception report included);
  - Metric is consistently failing target as expected from covid impact
  - Is showing a concerning nature which aligns to Trust response for mutual aid and restart of elective
  - All above results in a failure of assurance.

    - Actions in place monitored through Restart, Recovery & Renewal sub-committee
- Patients Waiting Over 52 Weeks (Combined) (exception report included);
    - Metric is experiencing special cause variation of a concerning nature as expected given covid
    - Actions in place monitored through Restart, Recovery & Renewal sub-committee
- 6 and 8 Week Wait for Diagnostics (exception report included);
    - Metric indicates common cause variation with variable achievement
    - Actions in place monitored through Restart, Recovery & Renewal sub-committee

Caring for Finances;

- Total Elective Activity; metric consistently failing target, although must be acknowledged that trajectory/H1 plan was met in April
- Bed Occupancy – All Wards – 2pm; metric is consistently failing target
- Cash Balance; metric indicates failing assurance due to latest target above control range

2.3. Conclusion

The Board is asked to ***note*** the report and where insufficient assurance is received seek additional assurance.

Integrated Performance Report
April 2021 – Month 1

The Robert Jones and Agnes Hun
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NHS Foundation Trust





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SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

Different colours have been used to separate these trends of special cause variation; • **blue points** have been used to show **areas of improvement** and • **orange points** for **areas of concern.** It should be noted that SPC charts do not compare performance against targets; that is the purpose of the red and green heatmap indicators.

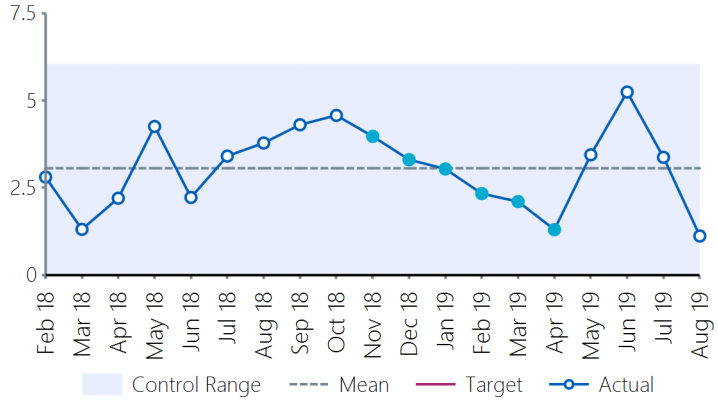
Some examples of these are shown in the images to the right:

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

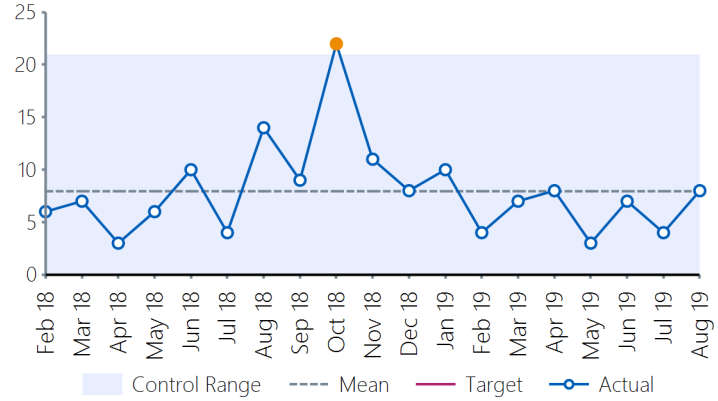
b) shows a point of concern sitting above the control range.

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

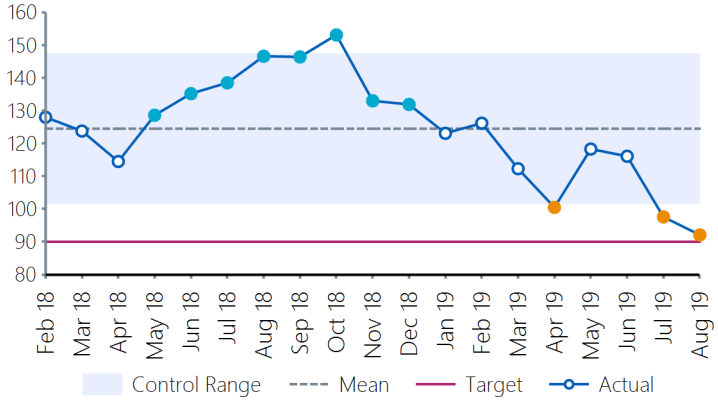
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

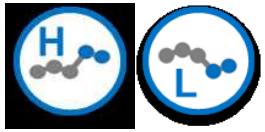
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually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

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

Variation Icons

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

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



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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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.

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.6%	2.77%					27/02/20
Voluntary Staff Turnover - Headcount	8%	7.24%					05/09/19

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	?		16/04/18
Never Events	0	2		N/A to SPC	?	+	16/04/18
Number of Complaints	8	10			?		11/05/18
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		16/04/18
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		06/06/19
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		16/04/18
Unexpected Deaths	0	0		N/A to SPC	?		16/04/18
31 Days First Treatment (Tumour)*	96%	100%			?		28/11/19
Cancer Plan 62 Days Standard (Tumour)*	85%	0%	100%		?	+	
18 Weeks RTT Open Pathways	92%	56.68%		L	F	+	
Patients Waiting Over 52 Weeks – English	0	1509	1498	H	F	+	28/11/19

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Patients Waiting Over 52 Weeks – Welsh	0	816		H	F	+	28/11/19
6 Week Wait for Diagnostics - English Patients	99%	86.99%			?	+	
8 Week Wait for Diagnostics - Welsh Patients	100%	85.86%			?	+	

Summary - Caring for Finances

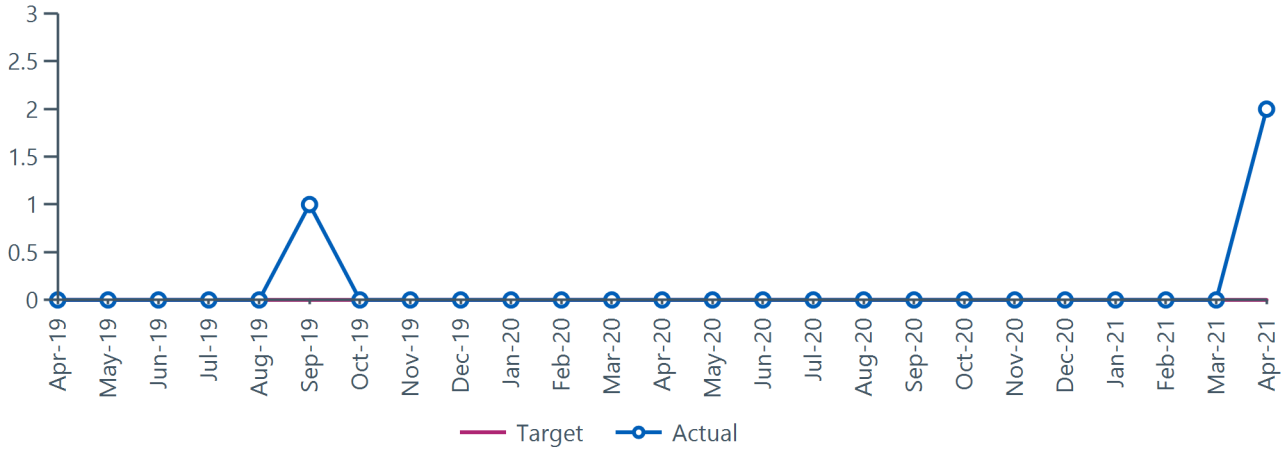
KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	924	644	548		F	+	
Bed Occupancy – All Wards – 2pm	87%	75.81%			F	+	05/09/19
Total Outpatient Activity	16727	12863	11232	N/A to SPC	?		
H1 Plan Performance	629.37	757.35	467		?		
Income	9747.6	10021.9	9759		?		
Expenditure	9162.99	9311.37	9336		?		
Efficiency Delivered	94.33	158	94.33		?		
Cash Balance	16000	15928	14858	H	F	+	
Capital Expenditure	116	126	491		?		

Never Events

Number of Never Events Reported in Month

Exec Lead:
Chief Nurse and Patient Safety Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
0	2	N/A to SPC	?



Trajectory/H1 Plan

What these graphs are telling us

This measure is not appropriate to display as SPC. Based on the performance in the last three months, the assurance icon indicates variable achievement (will achieve target some months and fail others).

Narrative

There were two never events reported in April. One related to a patient given an injection in the wrong hand and the second a wrong sided anaesthetic block was given.

Actions

These incidents are still under review as per governance procedures.

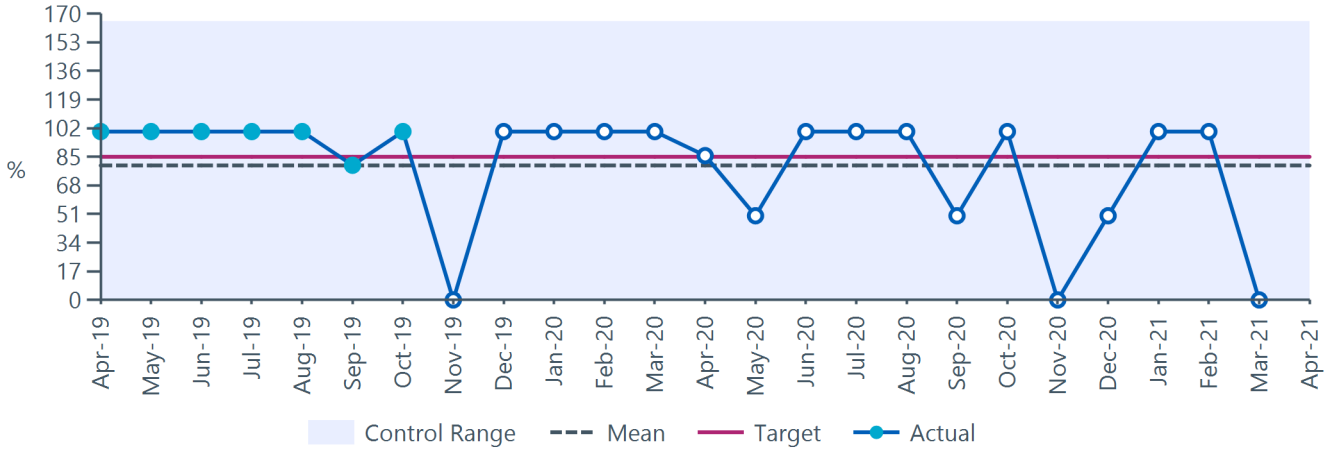
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00

Cancer Plan 62 Days Standard (Tumour)*

% of cancer patients treated within 62 days of referral (*Reported one month in arrears)

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
85%	0%		



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

The Cancer 62 day standard was not met in March. There was one patient pathway reportable against this standard in March where RJAH was responsible for the whole pathway. The patient required a custom made implant that led to the increased waiting time.

Actions

As this was a unique case where the bespoke implant was required, there are no appropriate actions.

Due to reduced capacity in this area, the Trust is reviewing performance over the coming months. Our trajectory reflects those patients being treated during this reduced capacity phase. We are working with a partner organisation to ensure the timely care of patients.

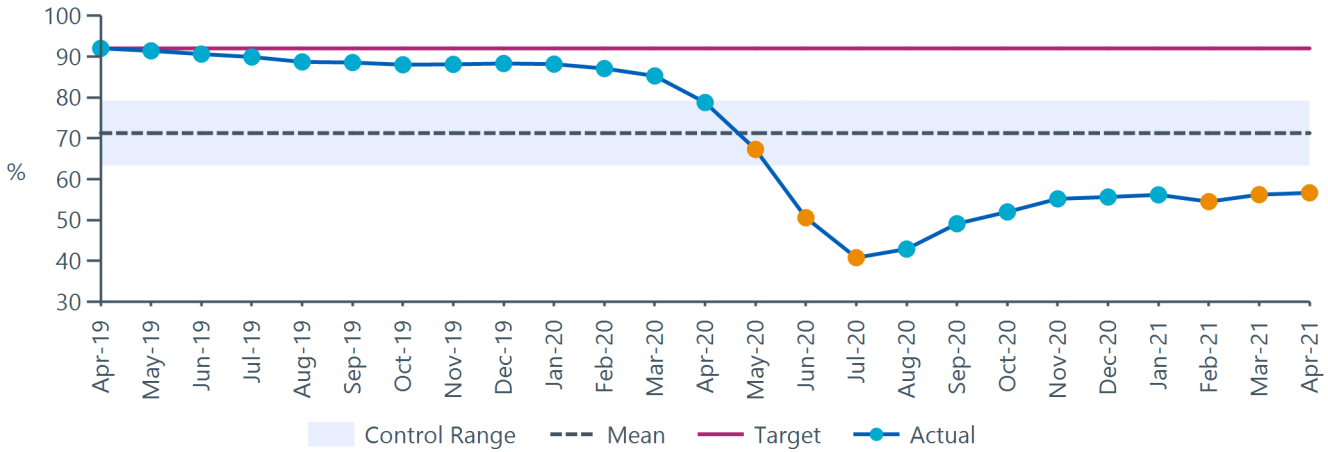
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
85.71	50.00	100.00	100.00	100.00	50.00	100.00	0.00	50.00	100.00	100.00	0.00	

18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92%	56.68%	L	F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

Our April performance was 56.68% 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 - 6935 patients waiting of which 1716 are breaches, MS2 - 1135 patients waiting of which 683 are breaches, MS3 - 4195 patients waiting of which 2914 are breaches.

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

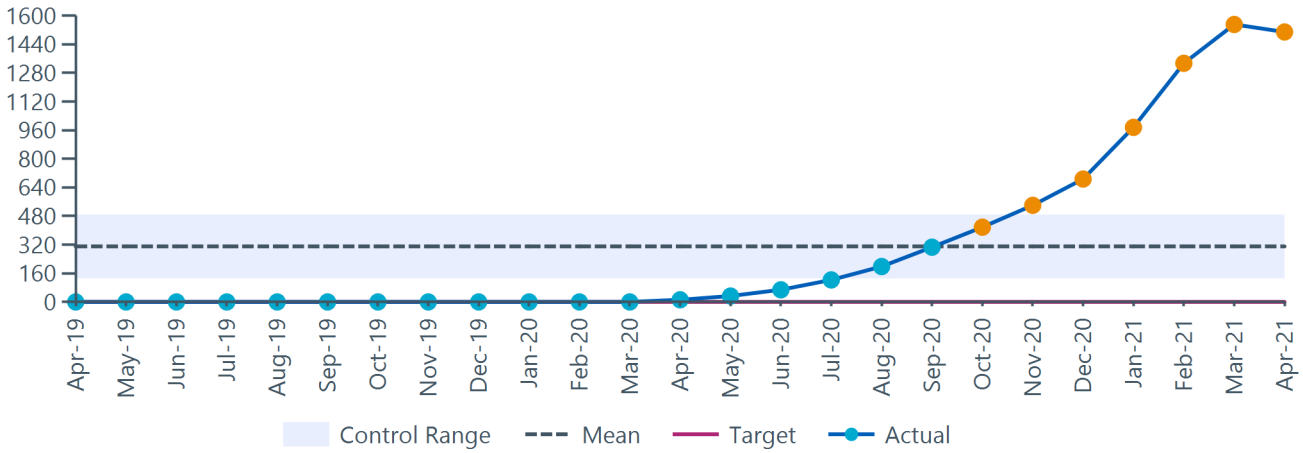
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
78.77	67.30	50.60	40.82	42.93	49.13	52.01	55.21	55.66	56.19	54.53	56.23	56.68

Patients Waiting Over 52 Weeks – English

Number of English RTT patients currently waiting 52 weeks or more

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1509	H	F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

At the end of April there were 1509 English patients waiting over 52 weeks, just above our trajectory of 1498.

The patients are under the care of the following sub-specialities; Arthroplasty (466), Spinal Disorders (390), Knee & Sports Injuries (298), Upper Limb (188), Foot & Ankle (88), Spinal Injuries (32), Paediatric Orthopaedics (20), Tumour (13), Metabolic Medicine (9), Neurology (2), SOOS GPSI (1), Physiotherapy (1) and Rheumatology (1).

The number of patients waiting, by weeks brackets is:
- >=52 to <60 weeks - 366 patients
- >=60 to <70 weeks - 694 patients
- >=70 weeks to <80 weeks - 297 patients
- >=80 weeks to <104 weeks - 150 patients
- >=104 weeks - 2 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

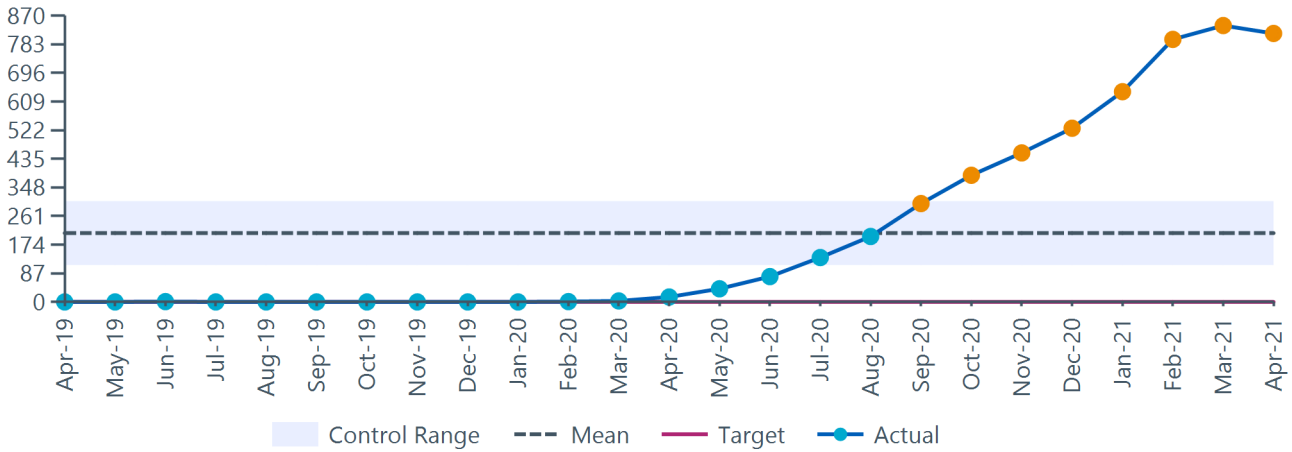
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
12.00	33.00	68.00	123.00	198.00	306.00	418.00	540.00	687.00	976.00	1334.00	1551.00	1509.00

Patients Waiting Over 52 Weeks – Welsh

Number of RJAH Welsh RTT patients currently waiting 52 weeks or more

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	816	H	F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

At the end of March there were 816 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (354), Arthroplasty (197), Knee & Sports Injuries (105), Upper Limb (64), Foot & Ankle (60), Paediatric Orthopaedics (15), Spinal Injuries (10), Tumour (6), Neurology (4) and Physiotherapy (1) . The patients are under the care of the following commissioners; BCU (452), Powys (349), Hywel Dda (12) and Aneurin Bevan (3).

The number of patients waiting, by weeks brackets is:
- >=52 to <60 weeks - 183 patients
- >=60 to <70 weeks - 290 patients
- >=70 weeks to <80 weeks - 181 patients
- >=80 weeks to <104 weeks - 157 patients
- >=104 weeks - 5 patient

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

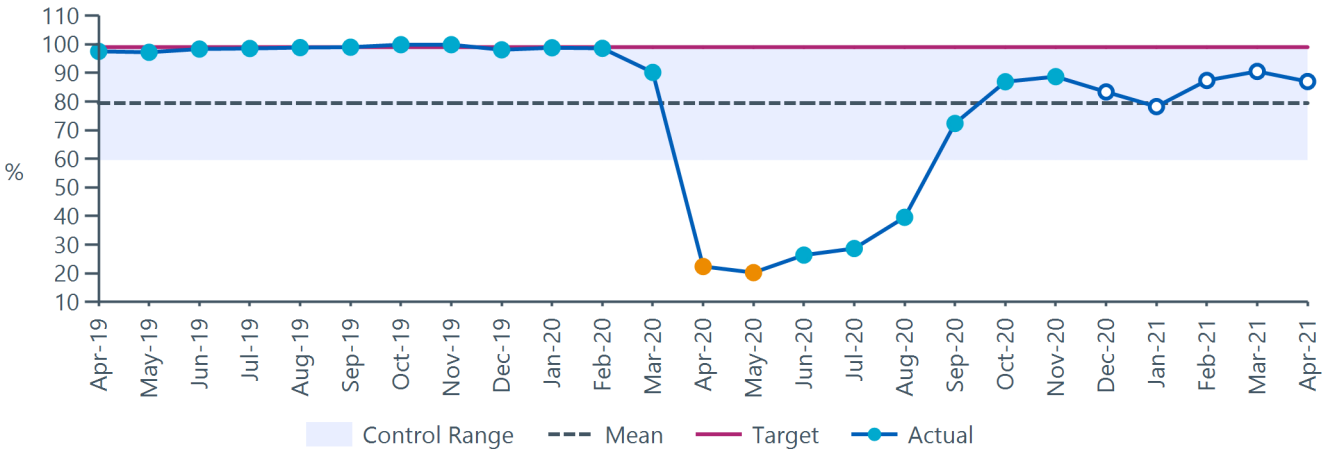
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
15.00	40.00	77.00	135.00	199.00	299.00	385.00	453.00	528.00	639.00	798.00	840.00	816.00

6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99%	86.99%		



Trajectory/H1 Plan

Actual
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 6 week standard for diagnostics was not achieved this month and is reported at 86.99%. This equates to 122 patients who waited beyond 6 weeks.
The breaches occurred in the following modalities:
- MRI (113 - with 109 dated)
- Ultrasound (1 dated)
- CT (8 - with 6 dated)

The majority of breaches relate to the MRI modality. However, performance for the H1 Plan Total MRI against baseline - English Only was reported at 98% in April.

Actions

Review current processes to understand current diagnostic waiting lists and how waiting list is managed.
Review number of referrals the department is receiving.
Analyse Total MRI against baseline - both English and Welsh patients and ascertain why we are achieving restoration for MRI but failing both 6 and 8 week wait for diagnostics.

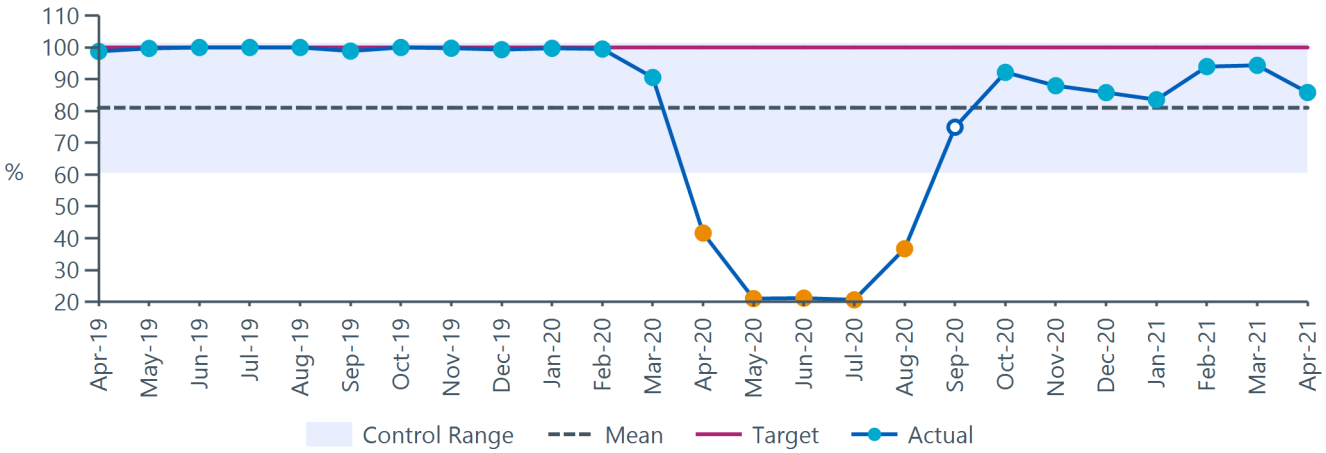
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
22.38	20.24	26.36	28.66	39.56	72.35	86.92	88.70	83.37	78.24	87.38	90.53	86.99

8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100%	85.86%		



Trajectory/H1 Plan

What these graphs are telling us

Following a period of concern in Q1 of last year, the metric is showing seven months of improvement. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 85.86%. This equates to 70 patients who waited beyond 8 weeks.
The breaches occurred in the following modalities:
- MRI (64 - with 62 dated)
- CT (6 dated)

Actions

Review current processes to understand current diagnostic waiting lists and how waiting list is managed.
Review number of referrals the department is receiving.
Analyse Total MRI against baseline - both English and Welsh patients and ascertain why we are achieving restoration for MRI but failing both 6 and 8 week wait for diagnostics.

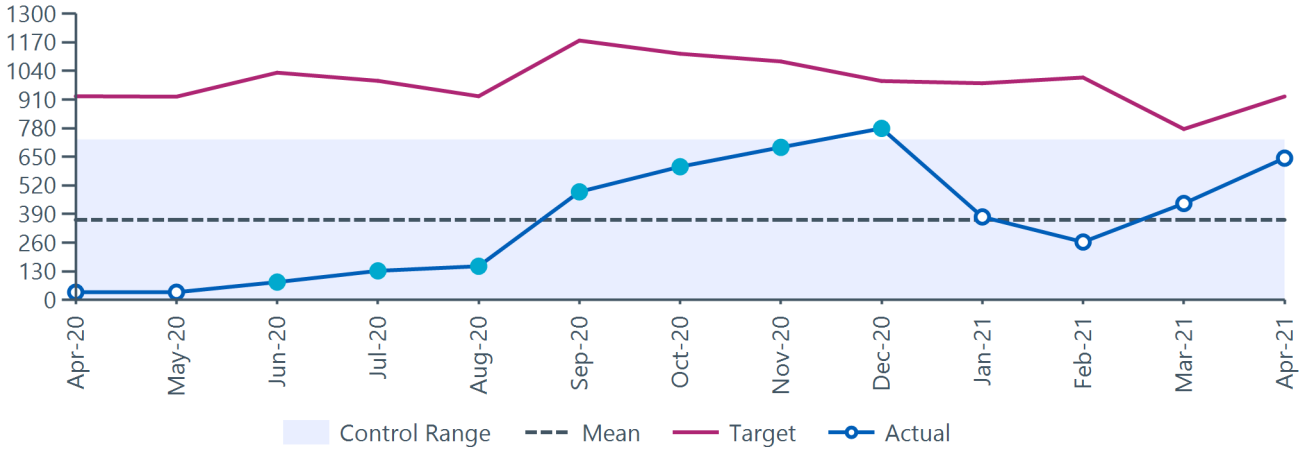
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
41.65	21.04	21.20	20.66	36.73	74.93	92.18	87.99	85.82	83.58	94.00	94.40	85.86

Total Elective Activity

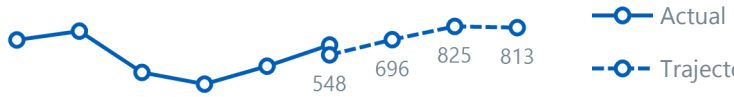
All elective activity in month rated against 19/20 baseline activity adjusted for working days and the impact of Covid-19

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
924	644		F



Trajectory/H1 Plan



What these graphs are telling us

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

Narrative

Total elective activity undertaken in April was 644 against the latest target of 924; this is above the trajectory for April of 548. The trajectory figures are from our H1 planning submission and are represented in the trajectory line above. The actual achieved against the target 19/20 baseline figure is 69.7%.

This measure has not hit the monthly target since changes to work practises and environment were implemented in response to Covid-19. There has been considerable monthly variation since April 2020 causing the process limits to widen.

Although the Total Elective Activity plan was not met, it should be noted that the trajectory was exceeded whilst the Trust was undertaking urgent clinical activity based on clinical priority. During April further staff were repatriated following a period of redeployment and the impact of this is beginning to be seen.

Actions

The April target, as set by NHS EI, was to meet 70% of baseline 19/20 activity. Please refer to 'H1 Plan - Total Elective against Baseline' for further detail.

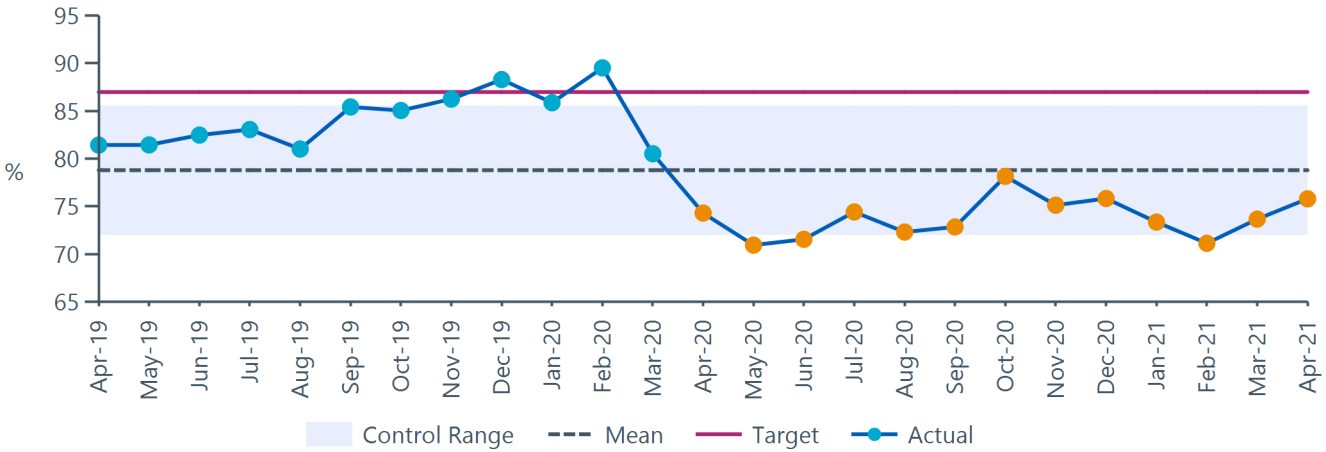
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
35.00	35.00	81.00	132.00	153.00	491.00	605.00	693.00	779.00	377.00	263.00	438.00	644.00

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87%	75.81%		F



Trajectory/H1 Plan

What these graphs are telling us

Thirteen months of concerning performance. Metric is consistently failing the target.

Narrative

The occupancy rate for all wards is reported at 75.81% for April. The breakdown below gives the April occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:
MSK Unit:
- Clwyd - 74.96% - compliment of 22 beds; open to 18-20 beds throughout month
- Powys - 70.39% - compliment of 22 beds; open to 18-20 beds throughout month
- Kenyon - Ward closed throughout month
- Ludlow - 47.70% - compliment of 14 beds open throughout month

Specialist Unit:
- Alice - 52.49% - compliment of 16 beds; open to 4-12 beds throughout month
- Oswald - 77.21% - compliment of 10 beds open throughout month
- Gladstone - 93.29% - compliment of 29 beds open throughout month
- Wrekin - 94.84% - compliment of 15 beds open throughout month
- Sheldon - 72.57% - compliment of 20/24 beds open throughout month

Actions

The Trust has a plan in place and a business case is in progress to implement enhanced recovery.

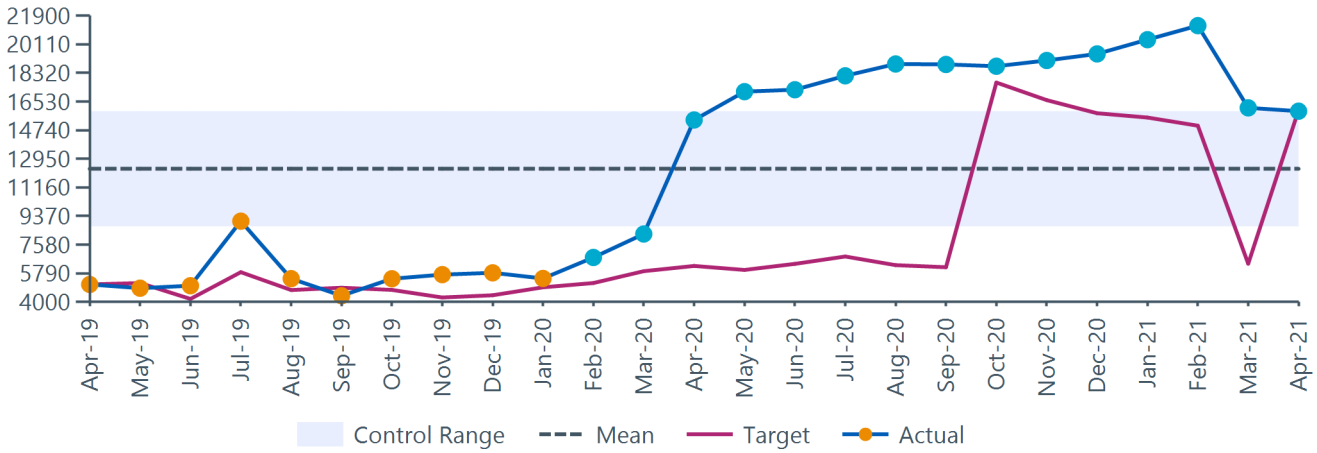
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
74.31	70.96	71.57	74.43	72.33	72.86	78.17	75.14	75.84	73.37	71.15	73.68	75.81

Cash Balance

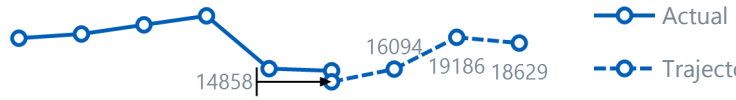
Cash in bank

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
16000	15928	H	F



Trajectory/H1 Plan



What these graphs are telling us

Metric is experiencing special cause variation; trend is showing a positive performance above the mean. Based on the latest target outside the control limits, the assurance indicates the metric is failing the target.

Narrative

Cash balances of £15.9m.
Movement of £0.2m due to repayment of system support monies offset by HEE funding.

Actions

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
15380.00	17150.00	17270.00	18140.00	18880.00	18850.00	18740.00	19100.00	19510.00	20402.00	21278.00	16137.00	15928.00

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th April 2021

Performance Against H1 Plan £'000s

Category	H1 Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	48,450	8,072	8,397	325	8,072	8,397	325
System Discretionary	2,560	427	427	0	427	427	0
System Top Up Funding	1,194	199	199	0	199	199	0
Covid-19 Funding	1,452	242	242	0	242	242	0
Private Patient income	1,877	329	318	(12)	329	318	(12)
Other income	2,973	479	440	(39)	479	440	(39)
Pay	(33,936)	(5,638)	(5,586)	52	(5,638)	(5,586)	52
Non-pay	(19,342)	(2,964)	(3,166)	(202)	(2,964)	(3,166)	(202)
EBITDA	5,228	1,146	1,271	125	1,146	1,271	125
Finance Costs	(3,369)	(562)	(560)	1	(562)	(560)	1
Capital Donations	1,900	317	111	(206)	317	111	(206)
Operational Surplus	3,759	901	821	(80)	901	821	(80)
Remove Capital Donations	(1,900)	(317)	(111)	206	(317)	(111)	206
Add Back Donated Dep'n	269	45	47	2	45	47	2
Control Total	2,127	629	757	128	629	757	128
EBITDA margin	9.4%	12.3%	13.3%	0.9%	12.3%	13.3%	0.9%

Capital service	1	I&E Margin	1
Liquidity (days)	1	Variance in I&E Margin	1
Agency	1		

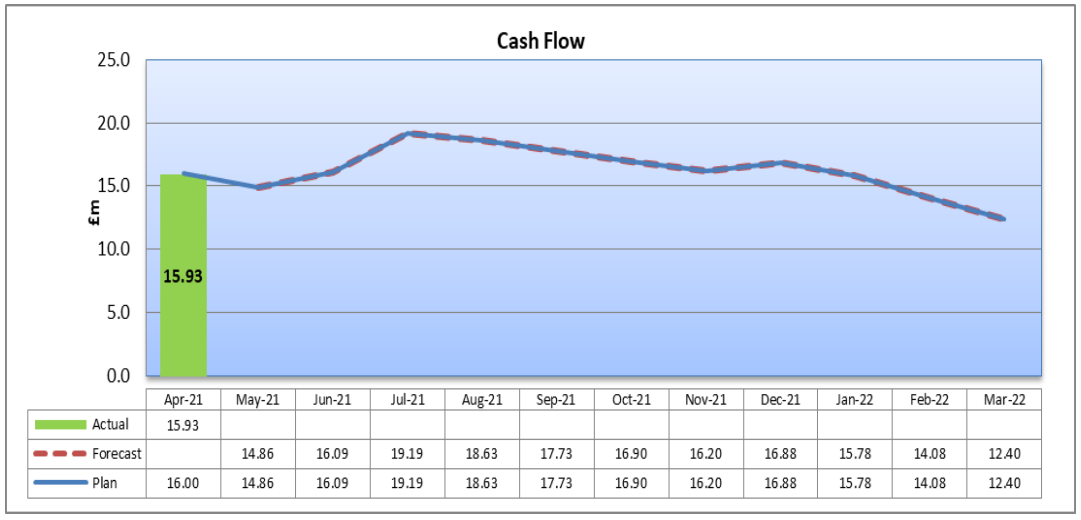
	YTD
Debtor Days	31
Creditor Days	47

Statement of Financial Position £'000s

Category	Mar-21	Apr-21	Movement	Drivers
Fixed Assets	79,946	79,677	(269)	Additions less depreciation
Non current receivables	1,194	1,250	56	
Total Non Current Assets	81,140	80,927	(213)	
Inventories (Stocks)	1,389	1,338	(51)	
Receivables (Debtors)	7,525	9,963	2,438	Increase in accrued income and prepayments.
Cash at Bank and in hand	16,137	15,928	(209)	
Total Current Assets	25,051	27,229	2,178	
Payables (Creditors)	(15,258)	(16,415)	(1,157)	Increase in deferred income - Commissioner and Health Education income
Borrowings	(1,307)	(1,315)	(8)	
Current Provisions	(711)	(707)	4	
Total Current Liabilities (< 1 year)	(17,276)	(18,437)	(1,161)	
Total Assets less Current Liabilities	88,915	89,719	804	
Non Current Borrowings	(4,470)	(4,470)	0	
Non Current Provisions	(1,002)	(985)	17	
Non Current Liabilities (> 1 year)	(5,472)	(5,455)	17	
Total Assets Employed	83,443	84,264	821	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,397)	(22,397)	0	
Revenue Position	0	(821)	(821)	Current period surplus
Revaluation Reserve	(24,938)	(24,938)	0	
Total Taxpayers Equity	(83,443)	(84,264)	(821)	

Sustainability (Recurrent) Plan 2021/22

Category	Annual Position (£'000)			In Month Position (£'000)		
	Opening Control Total Plan	In Year Adjustments	Revised Control Total Plan	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	102,561	(60)	102,501	8,542	8,525	(17)
Private Patient income	5,229		5,229	495	496	1
Other income	6,636	(330)	6,306	526	519	(6)
Pay	(70,986)	200	(70,786)	(5,892)	(5,918)	(26)
Non-pay	(40,868)	190	(40,678)	(3,317)	(3,399)	(82)
EBITDA	2,572	0	2,572	353	223	(130)
Finance Costs	(6,738)		(6,738)	(562)	(560)	1
Capital Donations	3,800		3,800	317	111	(206)
Operational Surplus	(366)	0	(366)	108	(227)	(334)
Remove Capital Donations	(3,800)		(3,800)	(317)	(111)	206
Add Back Donated Dep'n	537		537	45	47	2
Control Total	(3,629)	0	(3,629)	(164)	(291)	(126)

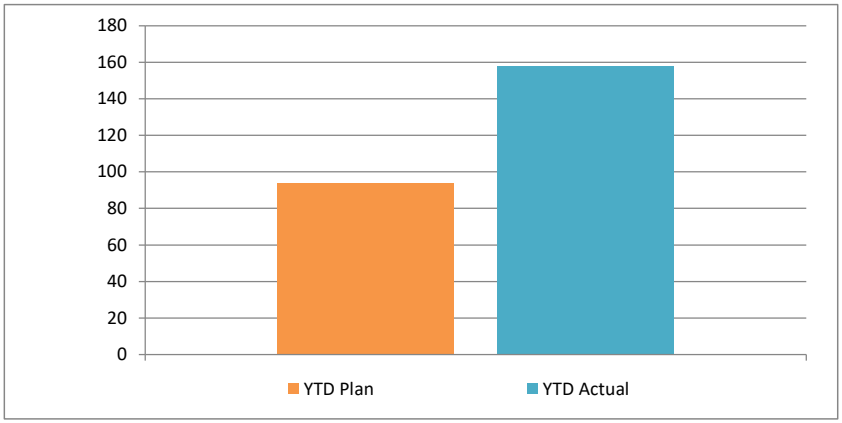


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	15.93											
Forecast		14.86	16.09	19.19	18.63	17.73	16.90	16.20	16.88	15.78	14.08	12.40
Plan	16.00	14.86	16.09	19.19	18.63	17.73	16.90	16.20	16.88	15.78	14.08	12.40

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 30th April 2021

Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's

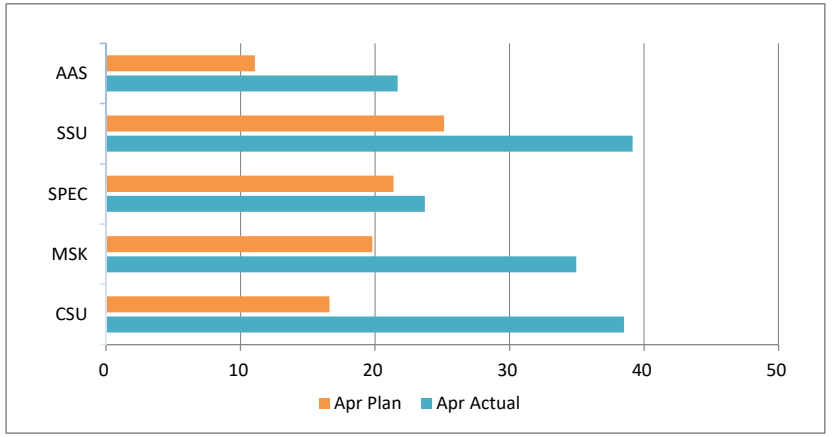


Capital

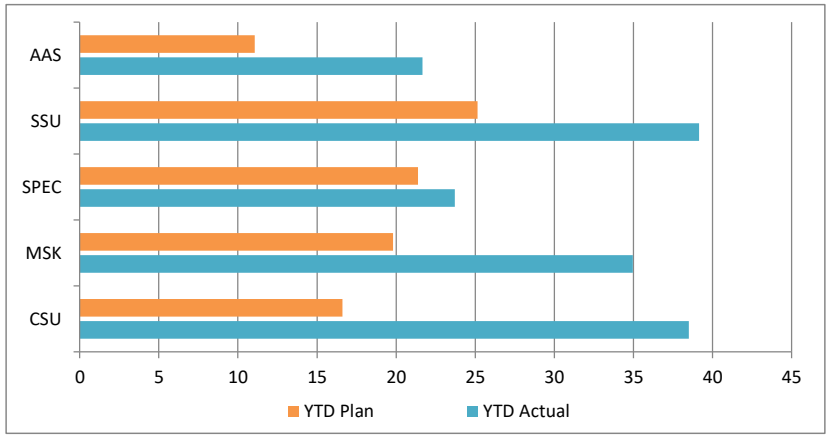
Position as at	2122-01	Capital Programme 2021-22						
Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn
Backlog maintenance	600	8	1	7	8	1	7	600
I/T investment & replacement	300	0	0	0	0	0	0	300
Capital project management	100	8	10	-2	8	10	-2	100
Equipment replacement	500	0	-0	0	0	-0	0	500
Diagnostic equipment replacement	1,800	0	5	-5	0	5	-5	1,800
Contingency	500	0	0	0	0	0	0	500
EPR planning & implementation	2,000	0	0	0	0	0	0	2,000
Invest to save	200	0	0	0	0	0	0	200
Capital Funding (NHS)	6,000	16	15	1	16	15	1	6,000
Donated medical equipment	200	100	111	-11	100	111	-11	200
Veterans' centre	4,500	0	0	0	0	0	0	4,500
Total Capital Funding (NHS & Donated)	10,700	116	126	-10	116	126	-10	10,700

Efficiencies by Theme

In Month Efficiencies Achievement £000's



Year To Date Efficiencies Achievement £000's



Provider Licence Declarations

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27 May 2021
Executive Sponsor:	Mark Brandreth, Chief Executive	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board is asked to **consider** the proposed declarations and **approve** the same

2. Executive Summary

2.1. Context

Under the NHS Provider Licence, Risk Assessment Framework and Health and Social Care Act 2012, the Trust is required to self-certify whether or not they have complied with the requirements and have the required resources available if providing commissioner requested services. Further it must confirm whether or not it has complied with governance requirements.

2.2. Summary

In accordance with the above outlined requirements, this paper presents the proposed self-assessment declarations for the Board to consider and approve

The Board is required to make the following declarations:

a. That it has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) **Deadline 31 May**
b. That if providing commissioner requested services, it has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) **Deadline 31 May**
c. That it complies with the required governance arrangements (Condition FT4(8)) **Deadline 30 June**

2.3. Conclusion

Following review of the licence and governance requirements and the assurances in place regarding compliance, it is recommended that the Board confirm self-certification against the requirements of General Conditions G6, CoS7 and FT4(8)

3. Main Report

3.1. Background

Condition G6 requires NHS Foundation Trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

In addition, Trusts must annually review whether these processes and systems are effective and publish their G6 self-certification within one month following the deadline for sign-off (31 May)

CoS7 applies to NHS foundation trusts designated as providing commissioner requested services (CRS). This places a requirement for Trusts to confirm whether or not the required resources will be available over the next financial year.

This requirement is only applicable to NHS Foundation Trusts for 12 months from the date of authorisation in which case it applies to all services. Alternatively, after 12 months, Trusts may receive a specific designation from the Commissioner.

Condition FT4 (8) is split in to two parts:

a) NHS Foundation Trusts are required to in place processes and systems that achieve the objectives set out in the licence conditions. Whilst there is no set approach to these standards and objectives, it is expected that Trusts will have in place demonstrably effective board and committee structures, reporting lines and performance and risk management systems.
b) NHS Foundation Trusts must reflect on whether their governors have received enough training and guidance to carry out their roles.

3.2 The Trust's Position

Condition G6
When considering the requirements of Condition G6, the following evidence is brought to the attention of the Board:

- The Trust has in place an approved Risk Management Strategy and approach to identifying, managing and escalating risk. This has been subject to internal audit which found '*The Trust has in place an effective risk management system and a hierarchy of reporting arrangements to ensure the Board is provided with evidence based assurance of the adequacy of the Trust's processes for the management of risks so that its objectives can be achieved*. There were some key recommendations made regarding the link between the risk registers and the Board Assurance Framework, clarity around roles and responsibilities, risk management training and the recording of key dates in the lifecycle of a risk and these have been taken forward.

- The Audit Committee monitors effective internal controls across the organisation
- The Risk Management Committee oversees the delivery of the Trust's Risk Management Strategy and provides regular assurance to the Board.
- The Trust has in place a Board Assurance Framework which is reviewed on a monthly basis by the Executive Team and quarterly by the Risk Management Committee. Audit Committee and the Board of Directors.
- Internal and External Audit reports on regulatory compliance are undertaken throughout the year.

CoS7
The Trust does not provide commissioner requested services and as such is not required to make any declarations against this requirement.

Condition FT4 (8)
The Trust is able to demonstrate compliance with the requirements of FT4(8) should therefore self-certify that it is compliant. The full statements and evidence to support are outlined in the attachments.

The proposed statements have been circulated to the Council of Governors for their views and they are supportive of the statements being made

4. Conclusion

Following review of the licence requirements and the assurance in place regarding compliance, it is recommended that the Board confirm self-certification against the requirements of General Conditions G6, CoS7 and Condition FT4 (8).

Appendix 1: Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	N/A	Please Respond

OR

Provider Licence Declarations

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

N/A

Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

N/A

Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

- The Trust has in place an approved Risk Management Strategy and approach to identifying, managing and escalating risk. This has been subject to internal audit which found '*The Trust has in place an effective risk management system and a hierarchy of reporting arrangements to ensure the Board is provided with evidence based assurance of the adequacy of the Trust's processes for the management of risks so that its objectives can be achieved*. There were some key recommendations made regarding the link between the risk registers and the Board Assurance Framework, clarity around roles and responsibilities, risk management training and the recording of key dates in the lifecycle of a risk and these have been taken forward.
- The Audit Committee monitors effective internal controls across the organisation
- The Risk Management Committee oversees the delivery of the Trust's Risk Management Strategy and provides regular assurance to the Board.
- The Trust has in place a Board Assurance Framework which is reviewed on a monthly basis by the Executive Team and quarterly by the Risk Management Committee. Audit Committee and the Board of Directors.
- Internal and External Audit reports on regulatory compliance are undertaken throughout the year.

Provider Licence Declarations

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Worksheet "Corporate Governance Statement"

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has in place robust systems and processes of governance and assurance regarding their application is obtained via the Audit Committee and through comprehensive programme of audit
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust has in place a Board Governance Pack which outlines its governance arrangements. This is reviewed by the Board on a regular basis.
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board's committee structure and responsibilities are outlined in the Board Governance Pack. The Audit Committee has oversight of the effectiveness and completeness of those committees meeting their terms of reference.
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	a) External audit provide a Value for Money Opinion b)The Board receives and reviews the balanced scorecard and performance reports on a monthly basis c) The terms of reference and workplans for the Board and Board Committees ensure adequate oversight of compliance with all regulatory requirements with audit opinions obtained as required throughout the year d) The Board has in place a regular programme of audit which includes scrutiny of its financial management. The Board considers its going concern status on an annual basis e)All assurance committees have in place a clear remit and workplan and will utilise the following to inform business decisions; KPI's in balanced scorecard reviewed and agreed annually, programme of data quality, programme of audits overseen by the Audit Committee, Board Assurance Framework, Operational plan, Corporate Objectives (and the delivery of) f)The Trust meets monthly with NHS Improvement with regard to quality, finance and operational performance, these meetings allow for early identification of any licence issues g) As set out above (f) h) The above outlined enables the Trust to comply with all applicable legal requirements and in the event of any uncertainty independent legal advice is available
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	a) The Board is made up of suitable skill and expertise to provide leadership on all of its business, including quality of care b) The Board receives quality information through the performance report and various detailed reports from management. The Trust has in a place a Quality and Safety Committee and the Board receives a Chair's Report which higlights the topics discussed and any assurance gained. c) Quality of care data is captured as early as possible. The Trust's data quality processes are overseen by the Audit Committee. d) As outlined above (b) e) The Trust has in place several mechanisms for engaging with staff, patient and external stake holders. E.g For Patients - Patient Collaborative, Patient Panel, Inpatient Survey, for Staff - staff survey, pulse checks, big conversations, staff forums and a dedicated barometer group attended by staff across the organisation, External - quality meetings with its commissioners and regulators. f) The Trust's Chief Nurse is the lead for Quality of Care with support from the Chief Medical Officer. There is a Quality and Safety Committee which is responsible for oversight of quality issues and escalating as required to the Board.
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board reviews its requirements and continues to develop plans for succession to Board and senior positions across the organisation.

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature **Signature**

Name Frank Collins **Name** Mark Brandreth

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

Worksheet "Other declarations"

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5	**Certification on AHSCs and governance**	**Response**
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC.	
	The Board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; • have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • maintain the register of interests and no residual material conflicts identified; and • engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	**N/A**
6	**Training of Governors**	
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		**Signature**	
Name	Frank Collins	**Name**	Mark Brandreth
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Veterans Briefing – May 2021

Local Contractor

PAVEAWAYS BuildingContractors

Local Contractor who has a long history with the Trust, having completed the Main Entrance and the Hydrotherapy Pool

The Veterans Building

The Veterans Building Outside and In






Ground Floor

Key:

Café & Veterans Hub Purple

Clinic Rooms Green;

Enhanced Treatment Room Blue;

Minor Procedures Room Yellow;

Recovery Room Orange.

Quiet Rooms Pink

First Floor

Key:

Welfare Room Purple

Training Rooms Green;

MDT Blue;

Medical Photography Yellow;

Simulation Room Orange.

Research Room Pink

Timeline

What	When
Site Set up & Enabling Works	26/04/21 to 10/05/21
Enabling Works	10/05/21 to 17/09/21
Veteran's Centre Construction	05/07/21 to 08/02/22
External works	09/02/22 to 25/04/22
Completion Works	16/05/22 to 17/06/22
Handover	17/06/22

Chair's Assurance Report
Quality & Safety Committee 15th April 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27th May 2021
Executive Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Performance/Governance
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Quality and Safety Committee held on 15th April 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the Quality and Safety Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It is responsible for seeking assurance regarding the Trust's internal and external audit programme, the local counter fraud service and compliance with the law and regulations governing the Trust's activities. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- There was good progress of actions from the previous meeting with all actions completed or updated.
- The Committee approved the Harms Policy pending a few minor amendments.
- A new agenda item 'Health Inequalities' was well received by the Committee.

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from Quality and Safety Committee which met on 15th April 2021. A full list of the attendance is outlined below:

Attendance:	
Attendance:	
Chris Beacock	Non-Executive Director (Chair)
Paul Kingston	Non-Executive Director
Stacey Keegan	Chief Nurse
Ruth Longfellow	Chief Medical Office
Shelley Ramtuhul	Trust Secretary
Hilary Pepler	Trust Board Advisor
Mark Brandreth (part)	Chief Executive
Nicki Bellinger	Assistant Chief Nurse for Specialist Service
Sara Ellis	Assistant Chief of Professions
Mark Salisbury	Operational Director of Finance
Apologies:	
Apologies were received from David Gilburt, Jo Banks and Ian Maclennan.	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions were marked as complete pending one outstanding action which will be completed by the Trust Secretary prior to the next meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Serious Incidents, Never Events & Learning from Incidents		
The paper was well received by the committee and it was confirmed that they are happy with the format of the paper. The actions stated within the report were reviewed by the committee and it was discussed whether there is another route for actions to be marked as complete, as opposed to waiting for MDCAM which only runs every six months. The alternative is for outstanding actions and learning to be taken to the Rolling Half Days which will be looked at going forwards.	Y	
2. Harms Reviews		
Harms Reviews Data and Governance: This paper provided an overview of the current process in	Partial	Partial – The committee received partial assurance on these

place prior to the new changes within the Harms Policy which was also on the agenda at the committee for approval. The committee were pleased that the actions included within the paper provided them with assurance on what is being done to strengthen and improve the monitoring and reporting process of harms reviews. Harms Policy: Changes have been made to the harms policy; 52 week waiting patients would get prospective harms reviews and the Clinician would create judgement on whether an Outpatient would require a harms review. This has been amended as it was reported by the Clinicians that the original process was not feasible to do. Clarity was also explained to the committee on how GP's would be sited on the new policy and it was confirmed that the intent is that if the GP contacts the Trust with a concern about a patient, then this would prompt a harms review The committee approved the harms policy. Harms Review Audit: Within the paper provided there were three questions that require to be answered in order to provide full assurance. The audit will enable answers to these questions. The plan is that for those patients identified as having waited over 52 weeks to each have an audit carried out to ensure a harms review has already been completed. If the harms reviews haven't been carried out, then they will be issued to be completed.		agenda items as work is still ongoing around the harms reviews and patients waiting. The committee were however pleased that progress is being made.
3. Legal Claims Update – Q4		
A few of the key legal claim updates were presented to the committee from the paper. Updates will be continued to be brought to the committee.	Y	
4. Health Inequalities		
This agenda item was a new agenda item brought to the committee. The committee were pleased with the work already started on health inequalities. Recommendations and next steps were shared with the committee. The committee agreed that this agenda item will be brought back on a quarterly basis for further updates on the work.	Y	
5. Learning from Deaths Report – Q4		
The report was well received by the committee. It was discussed whether a little extra detail could be included going forwards with regards to the management of relatives following an expected death.	Partial	Partial
6. Specialist Unit Quality Report		
The committee were pleased with the positive report from the Specialist Services Unit. Key points were shared and it was discussed how clinical engagement can be increased	Y	

in order to share learning and feedback. Suggestions were made around looking into other centres for support and to provide comparative data around assisted falls on MCSI to see if anything could be improved in this Trust. Feedback was well received and the committee felt assured on the report.		
7. Board Assurance Framework & Corporate Objectives		
The BAF has now been aligned to the new objectives. The closing report will be brought to the committee next month to see how the Trust has done against the objectives for 2021.	Y	
8. Integrated Performance Report - Verbal		
A verbal update was brought to the committee this month due to the timings of the papers. Key highlights were shared and we well received by the committee.	Y	
9. CIP Quality Impact Assessment Update – Q4		
The committee were made aware that all units QIA's have been signed off and the Trust have already commenced efficiency meetings with all of the units. The aim is to ensure all of the schemes are signed off by May 2021, which will come through Quality and Safety at a later date.	Y	
10. Chair Reports		
Research Committee – The committee noted this chair report. *Patient Safety Committee* – The committee noted this chair report. *Trust Performance & Operational Improvement Board* – The committee noted this chair report.	Y	
11. Review of the Work plan – 21/22		
The committee reviewed the work plan for 2021/22, wishing to ensure that Health Inequalities is added as a standing agenda item going forwards on a quarterly basis.	Y	

3.4 Approvals

Approval Sought	Outcome
Harms Policy	Approved

3.5 Risks to be Escalated

No new risks were required to be escalated following the committee meeting.

3.6 Conclusion

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

Chair Assurance Report
Finance, Planning and Digital Committee
27th April 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	27th May 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Finance, Planning and Digital Committee meeting held on 27th April 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance Planning and Digital 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.

2.2 Summary

- The meeting was quorate
- The Committee discussed the EPR Outline Business Case

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Finance, Planning and Digital Committee which met on 27th April 2021. The meeting was quorate with one Non-Executive Director and three senior leaders in attendance. A full list of the attendance is outlined below:

Attendance:	
Members:	
Rachel Hopwood	Non-Executive Director (Chair)
Craig Macbeth	Chief Finance Officer
Kerry Robinson	Chief Performance, Improvement and OD Officer
Mark Brandreth	Chief Executive
In attendance:	
Shelley Ramtuhul	Trust Secretary
Simon Adams	Director of Digital
Mark Salisbury	Operational Director of Finance
Apologies:	
David Gilburt	Non-Executive Director

3.2 Actions from the Previous Meeting

The Committee received the action log which showed there were no outstanding actions.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1 EPR Outline Business Case		
The Committee received a presentation highlighting key points of the EPR Outline Business Case. The business case is due to be signed off from NHS Digital and NHS X as well as the System and potentially other organisations. The Trust is awaiting the completion of the tender process. The Committee were assured that a full open tender process was the best option as at present there is no preferred supplier and therefore an open tender exercise is necessary. The tender is being completed	Y	

through a framework of pre-selected criteria so the window for bids has been narrowed down significantly. The Committee confirmed that as the procurement process progresses, there needs to be governance considerations. The Trust thanked the finance team for their hard work. It was noted there had been discussions amongst the Board regarding the benefits of an EPR and the importance of not being overly optimistic and feeling the need to overstate the financial benefits due to the benefits to patients that the EPR will bring.		
2 Performance Overview Report		
The Trust confirmed this month is the last month the IPR would be RAG rated; in future there will be more focus on variation and assurance which will be more valuable in the current context. The KPI figures were outlined as detailed in the pack, the overall feeling being one of continued improvement. The Committee noted the good trajectory within diagnostics. The Trust explained the target still may not be hit for April due to the ongoing issues regarding MRI which are mitigated.	Y	
3 Restoration and Financial Impact Committee Update		
The headline of the update was that there is positive progress and the trajectory is on the up. The FPD Committee extended its thanks to the Restoration and Financial Impact Committee for the hard work involved in this.	Y	
4 Finance Report		
It was highlighted that the £4.5 million surplus position has been possible due to two significant sums of funding that had been received very late in the year for the Trust's annual leave position and monies lost from non NHS income.. As a consequence of the extra funding, the System support has been repaid. The recurrent financial position is a £1.8 million deficit due to missed efficiencies as a result of the pandemic. Cash balance has ended at £16.1 million which has enabled some investments in the capital plan. The Committee suggested one way to interpret the messaging issues within the System is that surplus has been achieved but it is at the cost of our patients as it has only been achieved by being unable to carry out the work needed for our patients.	Y	
5 Financial Plan		
The Trust explained the plan for the first six months of	Y	

21/22 is named H1. The targets are taken from the figures from the Trust's Q3 performance last year and doubled. The Trust had a surplus in Q3 so the target for H1 is £2.1 million. A plan needs to be submitted in line with this expectation; it is believed the Trust is able to manage the risk contained within this. The System is still in a deficit position. The System are required to submit a break even plan as an aggregate of organisations. The latest figures show that the System is around £6 million away from a break even position. If the £6m can't be bridged through specific mitigations within organisations, there might be some form of apportionment or risk share that is required. It was noted that the recurrent underlying position is actually likely to be of more significance than the H1 plan. The Committee noted there are clear parts of the System plan that are beneficial, in terms of the Trust being able to contribute without jeopardising patient care. The Committee noted in the recurrent underlying position, the Trust is being told there needs to a minimum of 3% efficiency delivered, yet the national target through H1 is 0.28% delivery. Therefore the 3% figure needs to be the real focus, rather than the 0.28% despite, the 0.28% being the official target for next few months according to the H1 plan. As such, there is much focus on efficiency planning at the moment. At present, the Trust isn't quite reaching the 3% figure but it's getting closer as time goes on. It was agreed by all that this practice needs to be extended across the rest of the System.		
6 Capital Programme 21/22		
The Trust noted that whilst The Trust could still re-invest its cash balances to fund the programme the overall value needed to be contained within a system capped spending limit. The programme is based on further delivery of our 5 year plan. It has been agreed internally and confirmed as affordable within the system allocation but will need £3.24m of cash balances to finance. The programme also includes £6m £4.6m of charitable investments which are outside of the system limit. The programme excludes externally funded schemes such as EPR funding which will be added once confirmed. A new MRI is included in the plan and there is a possibility of further diagnostic equipment through national initiatives but this hasn't been clarified as yet. The bulk of the Veterans build will come under 21/22 plan.	Y	

The Committee agreed for the Quality and Safety Committee to have sight of the Capital Programme next year to ensure clinical input. The Trust confirmed there were some items in the backlog maintenance programme, but confirmed a theatre refurbishment was not in the broader estates strategy this year. The Trust noted there are staffing issues preventing theatre 12 currently being utilised, once the staffing issues are worked through it should be able to be brought back online. The Committee requested some further confirmation on what spend would be needed to get this theatre up and running.		
7 Chair Reports		
Chair Report: MSK Transformation Programme It was noted it had been decided that the MSK Alliance has been superseded by the ICS and the new intelligent fixed payment system. As such, a collaboration agreement is being worked on currently, rather than the Alliance mechanism that was in place before. *Chair Report: Trust Performance and Operational Improvement Board* The part to highlight for FPD committee is the delays of transfer of care. A piece of improvement work has been commissioned to be completed with the units involved in delays of transfer of care.	Y	
8 Board Assurance Framework		
The Trust confirmed the risks relevant to FPD committee haven't changed as the objectives remain the same. The Trust confirmed only items that link in with the Trust's objectives are on the BAF. The Committee suggested there could be an argument for cyber security to be on the BAF, as, depending on the severity of an attack, it could impact on the Trust's ability to meet its objectives.	Y	
8 Review of the work plan		
The following was noted: • ensure any relevant System items are included in the work plan. • the ICS Financial Sustainability Committee chairs report should report to this committee. • The full efficiency plan should be available for	Y	

next month.		
9 Attendance Matrix		
The Committee *noted* the Attendance Matrix.	Y	
13. Top Risks		
The top risks the committee identified included: • EPR and the interaction with the System versus our own internal governance. • Risk linked with the finance of the system. • wait times, as the Trust is currently at 104 weeks. The Committee noted we may be at risk of being an outlier due to the long waiters the Trust accepted from Betsi Cadwaladr University Health Board.	Y	

3.4 Approvals

No approvals were sought.

3.6 Risks to be Escalated

In the course of its business, there were no risks identified that required to be escalated to the Board of Directors.

3.5 Conclusion

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