The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 07.09.2022

MEETING
7 September 2022 09:30

PUBLISHED
7 September 2022

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	7/09/22		09:30
1. Welcome			09:30
1.1. Apologies		All	
1.2. Declarations of Interest		All	
1.3. Minutes from the previous meeting July 2022		Chairman	
1.4. Matter Arising		All	
2. Presentations			
2.1. Patient Story - Ms Helene Faure		Chief Nurse and Patient Safety Officer	09:40
2.2. Research Presentation - Mr Andrew Roberts		Chief Medical Officer	09:55
3. Chairman / CEO Update		Chief Executive Officer	10:10
4. Integrated Performance Report		Chief Operating Officer	
5. Board Assurance Framework		Trust Secretary/Director of Governance	

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	7/09/22		09:30
6. Quality and Safety			10:20
6.1. IPR Exception Report (page 45 - 50)		Chief Nurse and Chief Medical Officer	
6.2. Chair Report from Quality and Safety Committee		Non Executive Director	
6.2.1. Learning from Deaths Q1 Report		Chief Medical Officer	
6.3. Chair Report from IPC Quality Assurance Committee		Non Executive Director	
6.3.1. IPC Improvement Plan		Chief Nurse and Patient Safety Officer	10:55
6.3.2. IPC Annual Report		Chief Nurse and Patient Safety Officer	
6.3.3. IPC Q1 Report		Chief Nurse and Patient Safety Officer	
BREAK			11:05

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Board Room, Conference Suite at RJAH	7/09/22		09:30
7. People and Workforce			11:20
7.1. IPR Exception Report (page 42 - 44)		Chief People Officer	
7.2. Chair Report from People Committee		Non Executive Director	
7.2.1. Freedom to Speak Up Update (verbal)		Trust Secretary/Director of Governance	
7.2.2. Guardian of Safe Working Hours Q1 Report		Chief Medical Officer	
8. Performance and Governance			11:40
8.1. IPR Exception Report (page 51 - 64)		Chief Operating Officer	
8.1.1. Long Waiters (Presentation)		Chief Operating Officer	
8.2. Finance Performance Report (page 65 - 68)		Chief Finance and Planning Officer	
8.3. Chair Report from Finance, Planning and Digital Committee		Non Executive Director	
8.4. Chair Report from Audit and Risk Committee		Non Executive Director	
9. Questions from the Governors and Public		Chairman	12:10
10. Risk Review		All	12:15
11. Overall Board Reflection and Comments		All	12:20
12. Any Other Business		All	12:25
12.1. Next Meeting: 2 November 2022 (Public)			

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Harry Turner ☎ 01691 404358
Chairman

BOARD OF DIRECTOR – PUBLIC MEETING
6 JULY AT 9.30AM, BOARD ROOM AT RJAH
MINUTES OF MEETING

Present:

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

In Attendance:

David Gilburt	Associate Non-Executive Director	DG
John Pepper	Associate Non-Executive Director	JP
Sarah Sheppard	Chief People Officer	SS
Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
Jacqueline Barnes	Improvement Director from NHSE/I	JB
Mary Bardsley	Assistant Trust Secretary - Minute Secretary	MB
Colin Chapman	Governor	CC
Victoria Sugden	Governor	VS
Colette Gribble	Governor	CG

MINUTE NO	TITLE
06/07.01	**APOLOGIES** There were no formal apologies to note.
06/07.02	**MINUTES OF THE PREVIOUS MEETINGS** 04 May 2022 - the minutes were agreed as an accurate reflection of the meeting and therefore approved by the Board of Directors.
06/07.03	**MATTERS ARISING** There were no further items to be tabled for discussion.
06/07.04	**DECLARATION OF INTERESTS** There were no declaration of interests shared.
06/07.05	**PATIENT STORY** SEA introduced Mr John Rigby who agreed to share his story. John is a patient to Mr Balain due to severe spinal issues. The following key points were noted: ▪ undergone several x-rays and outpatient appointments within RJAH which have all been positive experiences ▪ John expressed that he felt listened to at each appointment with Mr Balain ▪ It was recognised that staff go the extra mile and are always friendly and helpful ▪ John complimented every member of staff who he has communicated with by email or over the phone – they were all friendly, professional, helpful, and considerate ▪ Improvements could be made with the location of the physiotherapy department as it is a long walk from the main entrance HT thanked John for his time and sharing his experiences with the Board. SEA highlighted John's suggestion for improvement and explained that the Estates Strategy is actively reviewed with the priority of delivering outpatient services at the West end of the site, nearest to the main entrance and car park. To mitigate the issue in the meantime, the Trust are opening other entrances nearer points of care to support.

	HT thanked John for his time and sharing his experiences with the Board and agreed to share his comments with staff.
06/07.06	**GREEN PLAN 2021/2024** CM welcomed Simon Everett, Estates Manager and Sustainability Lead to the meeting to present the Green Plan. Simon highlighted the following: ▪ Completed our £1.2m energy saving scheme, aiming to remove carbon by 809 CO2 tonnes each year ▪ The plan sets ambitious targets requiring all NHS organisations to become Net zero by 2040 ▪ It is a 3year strategy to support the Trust in achieving the agreed targets The Board commended the well written and clear strategy and commented on the following: ▪ Suggested milestones are added to the action plan. The Trust confirmed the Sustainability working group have oversight of the action plan which reports to the Finance, Planning and Digital Committee ▪ Suggested improving cycling facilities for staff. Simon explained that the League of Friends are currently supporting the review ▪ The Board queried if there were grant supports available. It was noted that the government have released a £1b funding pot through Celex. The next phrase of funding will be available from September. ▪ Queried the Veterans build and if the building is above regulations. Simon confirmed that the building is of BREEAM standards but will not require an assessment. The Trust has noted the possibility of adding solar panels to the building ▪ Queried the Trusts consideration to food wastage. Simon explained that there are rules and restrictions, but the Trust is currently investigating a digital system to record meals which would reduce waste. ▪ Waste from the recent refurbishments have been managed by contractors, the Trust insist on the contractors recycling where possible as part of their contract. The Board thanked Simon for this time and congratulated the Trust on a clear Strategy.
CHAIR AND CHIEF EXECUTIVE OFFICER UPDATE	
06/07.07	**CHAIR AND CHIEF EXECUTIVE UPDATE** Welcome - HT welcomed Penny Venables, Non-Executive Director and Mike Carr, Chief Operating Officer who have both joined the Trust since the last Public Board meeting. Covid19 - SK acknowledged the 40% increase of positive covid cases within the past week. The Trust re-introduced face masks along the corridor and within the main entrance and restaurant (along with clinical areas). ICB – SK informed the Board the ICB is now established, and the Trust will continue to support the system with collaborative working. Frank Collins, OBE – On behalf of the Board, SK congratulated former Chair, Frank Collins who has recently been named an OBE in the latest Honours list unveiled to mark the Queen's 70th Jubilee for his services to the NHS. The Trust also congratulated Trevor McMillan, Non-Executive Director, STW ICS who was awarded an OBE for services to Higher Education. Pride – The Trust celebrated pride month with a t-shirt competition for children and unveiling of our new Pride Progress flag outside our hospital, the progress flag recognises the diversity within LGBTQ+ communities. Health Hero (June) - Mike Nowell, who works as part of the Digital Services Department had been recognised for going above and beyond to support the Pharmacy Team who recently upgraded their computer systems. Health Hero (May) – Louise Jones, Operating Department Practitioner who has been recognised for her commitment to the environment and for setting a shining example for infection prevention and control (IPC) standards across the Trust.
PERFORMANCE REPORT	
06/07.08	**PERFORMANCE REPORT** CM explained that each exception report be presented throughout the meeting before highlighting the overall flash report: ▪ The Trust welcomed back from staff who were supporting mutual aid in May

	▪ 104 week waiters remain a key focus ▪ Performance has been measured against the original plan and resubmission – more information to follow throughout the meeting ▪ A forecast for June is presenting 12 patients ahead of trajectory ▪ Noted improvements within private practice activity from July onwards
EXCEPTIONAL ITEMS	
06/07.09	**IPC IMPROVEMENT PLAN** There are currently 32 actions completed within the improvement plan and some actions have moved from red to amber noting the increased engagement and improvements embedded. HT highlighted the letter received from NHS England and congratulated the Trust on the improvements which have been noted. The Trust highlighted the following areas of concerns to the Board via the Chairs assurance report from the IPC Quality Assurance Committee: ▪ the case of need housekeeper role - it was noted that gaining funding for the roles has been challenging and an escalation letter has been sent to the system ▪ training compliance – a re-occurring theme of training being reported as red ▪ SSI – a deep dive into SSI for all specialities has been requested by the Quality and Safety Committee CM added the Trust have a further escalation meeting with the investment panel to discuss the triple lock process. The Board suggested seeking support from counterparts within the system along with an sharing an update at the Quality system meeting to ensure oversight of the risks. JB commended the significant progress which is to be embedded and sustained. There has been a noted increase in ownership and engagement across the organisation. PK added the People Committee has asked for a full analysis of the training compliance and asked for consideration to embed a grace period for new modules in order for staff to be given the time to complete before being reported as red. The training records which have previously been filed on the wards have been incorporated into ESR. A compliance report is shared with Senior Leaders every 2 weeks and is presented to the IPC Quality Assurance Committee. MN commended the Trust on the improvements and queried whether visitors increase the risk to the organisation. SEA explained that a booking system is in place for visitor and staff are encouraged to educate visitors. SEA confirmed lateral flow tests and faces masks continued to be encouraged. CB suggested the Trust scan visitors for a high temperature upon arrival at the main entrance. SEA confirmed that the questions are asked before they visit the Trust. Following DG comment, SEA confirmed that the recommendations outlined in the letter will be added to the IPC improvement plan. The Trust will continue to align evidence to the plan. SN asked for further assurance on the actions noted as completed. SEA explained that each actions has an evidence file saved which is approved by either the Chief Nurse or Head of Governance.
QUALITY AND SAFETY	
06/07.10	**IPR EXCEPTION REPORT – CARING FOR PATIENTS** The following exceptions were highlighted: ▪ Number of Complaints - off target for four consecutive months ▪ Unexpected deaths - one death reported which was noted as sudden but not unexpected ▪ WHO Documentation Audit - % Compliance - five months off target. The Trust have introduced training following a never event and enhance the process to ensure step 4 is completed. CB commented on the acquired MRSA and queried whether the information can be recorded within the performance report to which the Trust agreed.

	The Board discussed the incomplete documents recorded for the WHO documentation. DG suggested the process is incorporated into the new EPR system as a way of ensuring each section is complete to which the Board agreed with. SK commented that the reported was discussed at the theatre working group meeting where feedback and learning has been shared. HT reminded the Trust that the WHO compliance has previously been highlighted within the Trusts CQC inspections. RL has asked for support from partner organisations and agreed with DG comment regarding a digital solution.
06/07.11	**CHAIR REPORT FROM QUALITY AND SAFETY COMMITTEE** CB presented the chairs' assurance report, highlighting the following: ▪ Commissioned a deep dive into complaints ▪ Concerns raised over recruitment which is being oversee by the People Committee ▪ There are several overdue audit and action logs being presented, the Committee have increased the reporting to gain further assurance ▪ The Committee discussed the harms review and whether patients' mental health has been considered as part of the review The Board noted the Chairs' assurance report.
06/07.12	**SAFEGUARDING ANNUAL REPORT** SEA presented the annual report for the Board noting it has been considered by the Quality and Safety Committee. The following key points were highlighted: ▪ A noted an increase in domestic abuse cases ▪ Increase in DoLs referrals following increased education ▪ Summary of training with level 3 safeguarding in children and adults remaining an area of focus ▪ Summary of objectives that have been fully and partially achieved for 21/23 ▪ Outlines key priorities for 22/23 JP queried the Trust trigger for safeguarding referrals. SEA explained this would be following a did not attend at an appointment and confirmed the policy states this would be 2 DNA. DG suggested consideration is to be given to the report before publishing in the public domain to ensure patients are non-identifiable. The Board approved the annual report.
06/07.13	**PATIENT EXPERIENCE ANNUAL REPORT** SEA presented the annual report for the Board noting it has been considered by the Patient Experience Committee before the Quality and Safety Committee. HT commented the importance of the themes noted within the report which highlights areas of focus ahead. PV suggested that a deep dive is to be completed into values and behaviours relating to the code of conduct training as volunteers can be placed in a difficult situation where there is potential conflict and challenge. JP suggested if the Trust can investigate the value of a GP letter being written to expedite patients' surgery before noting that Consultant have a comprehensive oversight of the patients requirements due to the specialist needs. Suggesting that advice is to be shared with patients that if their condition changes they are to gain support from their GP. RL thanked JP for his comments and explained the Trust are looking into waiting lists on prioritisations based on metrics. The Board thanked the Trust for the update.
06/07.14	**CHAIR REPORT FROM IPC QUALITY ASSURANCE COMMITTEE** The report was presented along side the IPC Improvement Plan for greater oversight.
PEOPLE AND WORKFORCE	
06/07.15	**IPR EXCEPTION REPORT – CARING FOR STAFF** PK highlighted the following concerns to the Board: ▪ STW People Plan - concerns raised with ownership of risks and understanding the baseline metrics of the people plan. The Board requested further information on the metrics and where the Trust are against the plans.

	▪ Consultant Recruitment Plan – concerns raised relating to targets not being met and the unknown impact on delivery of the operational and financial plan. ▪ DBS Checks – a briefing paper to be presented following a review of other organisations. Concerns raised regarding the timeframes of DBS being undertaken. The Committee noted the Chairs assurance report.
06/07.16	**CHAIR REPORT FROM PEOPLE COMMITTEE** The following was exceptions were highlighted: ▪ Sickness Absence - metric showing special cause variation of a concerning nature but back within control range. Both long term and short-term sickness remain as special cause variation of concern. SS reminded the Trust that as of 1 September staff will only receive sick pay for covid if they are entitled to it. ▪ Voluntary Staff Turnover – an exception at Trust level and specific Staff Groups are consistently off target. There has been a noted increase across the NHS relating to retirement and life choice. • Vacancy Rate - overall showing special cause variation of an improving nature
06/07.17	**FREEDOM TO SPEAK UP UPDATE** The national survey 2021/22 was shared with the Board for information. SR highlighted the following to the Board: ▪ The Trust continue to roll out training to the Board ▪ Champions recruitment has been launched – a training programme has been scheduled ▪ The launch of the champions has been scheduled for August HT encouraged the Trust to engage with staff and PV reflected on the importance of the champion role before encouraging the Trust to continue to ensure those individuals have ongoing training and support. The Board thanked SR for the update.
PERFORMANCE AND GOVERNANCE	
06/07.18	**IPR EXCEPTION REPORT** The following key points were highlighted: • 18 Weeks RTT Open Pathways - metric continues to fail the 92% target. As expected from covid impact, this will continue for a considerable time. The Board asked for further benchmarking information to gain an understanding of how the Trust are comparing to other organisations. • Patients Waiting Over 52 Weeks - both English and Welsh showing special cause variation with increases reported this month. For month 2 our English patients waiting over 52 weeks is 80 patients above our planned trajectory. At the end of June, the Trust reported 12 patients ahead of trajectory. A key challenge is the workforce. • Patients Waiting Over 78 Weeks - both English and Welsh showing special cause variation with increases reported this month. For month 2 our English patients waiting over 78 weeks is 33 patients above our planned trajectory. There is an agreed target of 0 by the end of March. • Patients Waiting Over 104 Week - English and Welsh individually showing special cause variation of concern. For month 2 our English patients waiting over 104 weeks is 14 patients above our planned trajectory • 6 and 8 Week Wait for Diagnostics - both English and Welsh standards showing as special cause variation and both consistently off target DG suggested that the Trust report spinal and non-spinal patients separately going forward to support with the monitoring of individuals.
06/07.19	**104 WEEKS PRESENTATION** The Board welcomed Dawn Forrest to the meeting who joined to present the update on the 104-week waiters. Dawn shared information on the national priorities, the trust trajectory, trip in management, key actions which are to be incorporated and Welsh guidelines. Following a in depth discussion, the Board asked for support from the Finance, Planning and Digital Committee to gain further assurance via a deep dive into the following: ▪ Risk on reaching the activity targets, the trajectory is to be extended until December 2022 ▪ Patient validation ▪ Recruitment plans and in impact on activity if the Trust is unable to recruit ▪ The regulations for both English and Welsh patients and impact on activity

	The Trust thanked Dawn for the update and reiterated that the patients are scheduled following the prioritisation guidance and clinical need.
06/07.20	**FINANCE EXCEPTION REPORT** CM highlighted the following relating the Trust finances: ▪ Overall £663k deficit in month, £161k adverse to plan ▪ Year to date deficit of £1,797k, £156k adverse to plan ▪ Income recorded at £225k adverse to month with the main driver being a shortfall in private patient activity. There is an expected recovery forecasted for July. ▪ Cash levels were £0.5m lower than plan mainly due to inflationary uplifts not yet incorporated into clinical income contracts The Board noted the risk on not achieving the performance activity and therefore the Trust will continue to monitor and update the Board as required.
06/07.21	**CHAIR REPORT FROM FINANCE, PLANNING AND DIGITAL COMMITTEE** SN presented the chair report, highlighting the following the Board: ▪ 104 Weeks – further consideration is required at the Finance, Planning and Digital following the discussion held within today's meetings ▪ EPR contract has been signed ▪ Concerns have been raised regarding recovery reporting CB suggested that the Trust consider withdrawing from mutual aid support if Covid increases within the winter months. The Trust confirmed a deep dive into consultant recruitment is to be completed within Covid expectation considered. The Board discussed the impact of the plan for 2021/22 which does not include the impact of covid following a clear direction although it was noted that the units efficiencies are delivered more than expected. The Board noted the Chair's assurance report.
06/07.22	**OPERATIONAL AND FINANCIAL PLAN (PRESENTATION)** CM presented the slides to the Board highlighting the following: ▪ Resubmitted plans required to achieve activity at 104% of 19/20 baseline value at system level ▪ Inpatients – restorations of 102% (no change) ○ Stretch from 102%-104% require further 229 spells for RJAH (added by ICS as additional independent sector activity stretch wot clear narrative o risk as part of submission) It was noted that this isn't recognised in the internal plan and look to achieve to support the shortfall. ▪ Outpatient – restoration of 96% (previous submission was 91%) ▪ Diagnostics activity - no change following IPC review ▪ The regulator has requested a further update to financial plans ▪ RJAH deficit of£1.6m has improved to £0.8m ▪ ICS deficit of £38.1m improved to £19m deficit against a breakeven requirement The Board thanked CM and the team for the efforts.
ITEMS FOR APPROVAL	
06/07.23	**RESEARCH STRATEGY** The Research Strategy was shared with the Board for consideration and approval. The Strategy has been formulated to support the Trusts research as an important core clinical activity to support the world-class patient care. The Trusts objectives include: ▪ Developing our workforce ▪ Building on our world class infrastructure and facilities ▪ Strengthen our existing and develop new partnership ▪ Developing our systems HT highlighted the importance of incorporating research discussion into routine board matter and asked from support from the Trust to give an oversight on what is needed/required to achieve world class care. The Board approved the Strategy and invited the Research Department to present to the Board in September
06/07.24	**BOARD GOVERNANCE PACK** The Board considered the Governance Pack which has previously been circulated for comments. SR confirmed that each document within the pack has been approved at the

	relevant committees. HT encouraged comments from the Chairs of each assurance Committee before the Board approved the pack.
REFLECTIONS/ANY OTHER BUSINESS	
06/07.25	**QUESTIONS FROM THE GOVERNORS** The Governors thanked the Board and the Trust and no questions were asked.
06/07.26	**QUESTIONS FROM THE PUBLIC** There were no questions shared at the meeting.
06/07.27	**OVERALL BOARD REFLECTION AND COMMENTS** The Board agreed to complete the discussion in the private meeting to allow for a reflection of the whole day.
FOR INFORMATION ONLY	
06/07.28	**STW GREEN PLAN** The STW Green Plan was shared with the Board for information only.
06/07.29	**CLOSING REMARKS:** HT thanked everyone for attending the meeting and for their contribution in the discussions.
NEXT PRIVATE MEETING: 7 SEPTEMBER 2022	

BOARD OF DIRECTOR – PRIVATE MEETING
06 JULY 2022
SUMMARY OF ACTIONS

REFERENCE/TITLE	LEAD	STATUS
Actions from the Previous Meeting – May 2022		
None outstanding.		
Actions from the Meeting – July 2022		
None to note.		

WORLD-CLASS RESEARCH

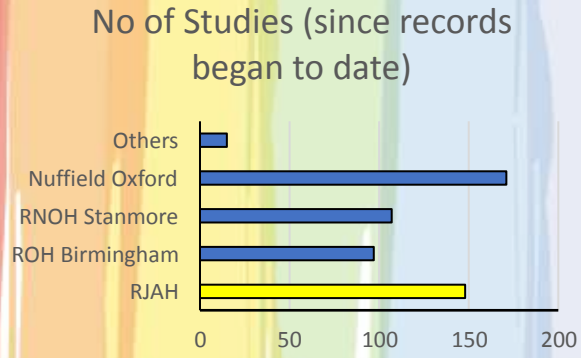
Research Director: Andrew Roberts
Research Manager: Teresa Jones

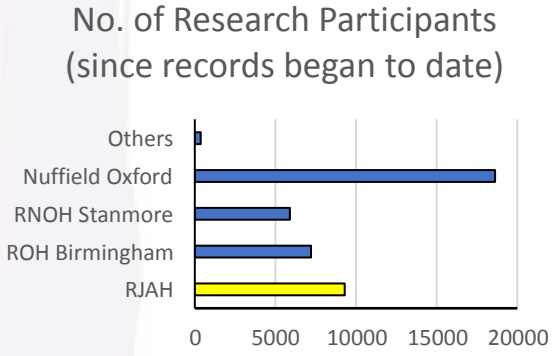
NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

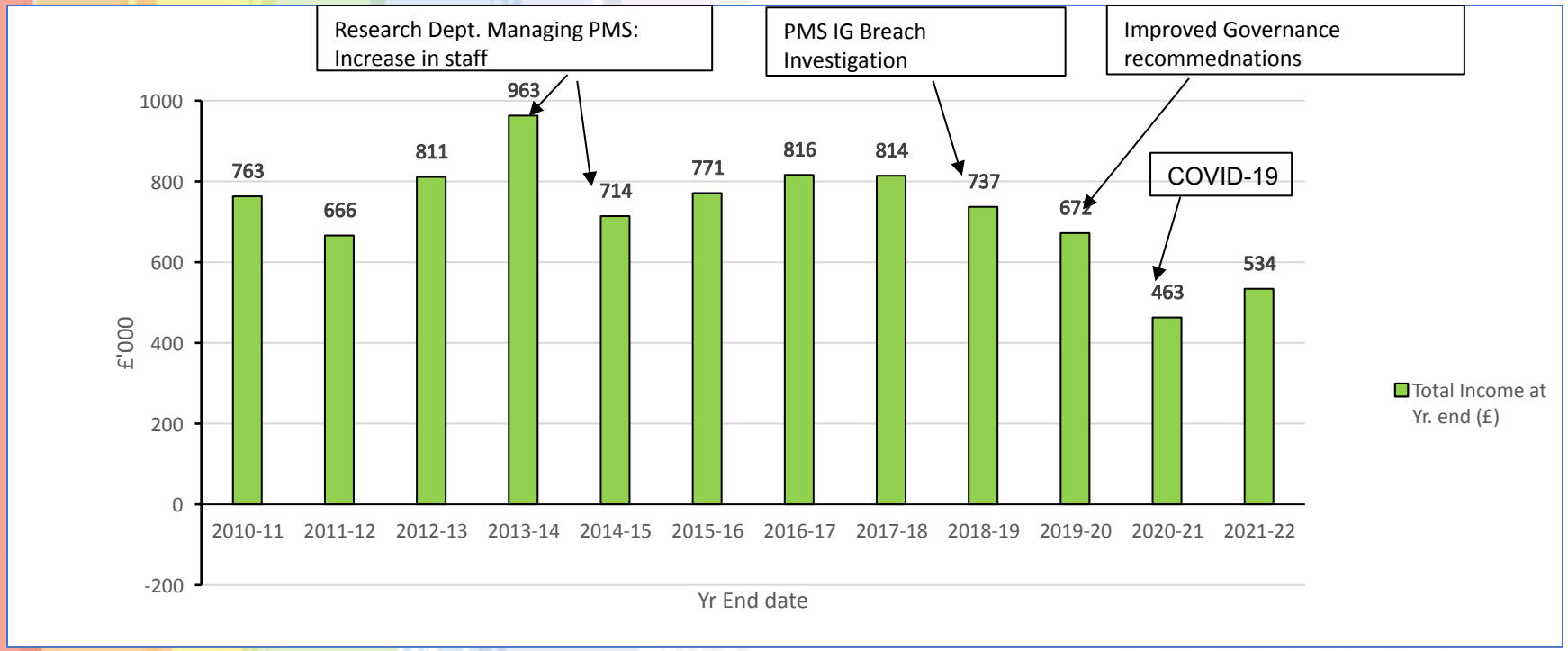
Baseline

- Staff research capability unknown
- Research Evaluation Framework
- Comparison with other centres





Finances


Research Dept. Managing PMS: Increase in staff
PMS IG Breach Investigation
Improved Governance recommednations
COVID-19
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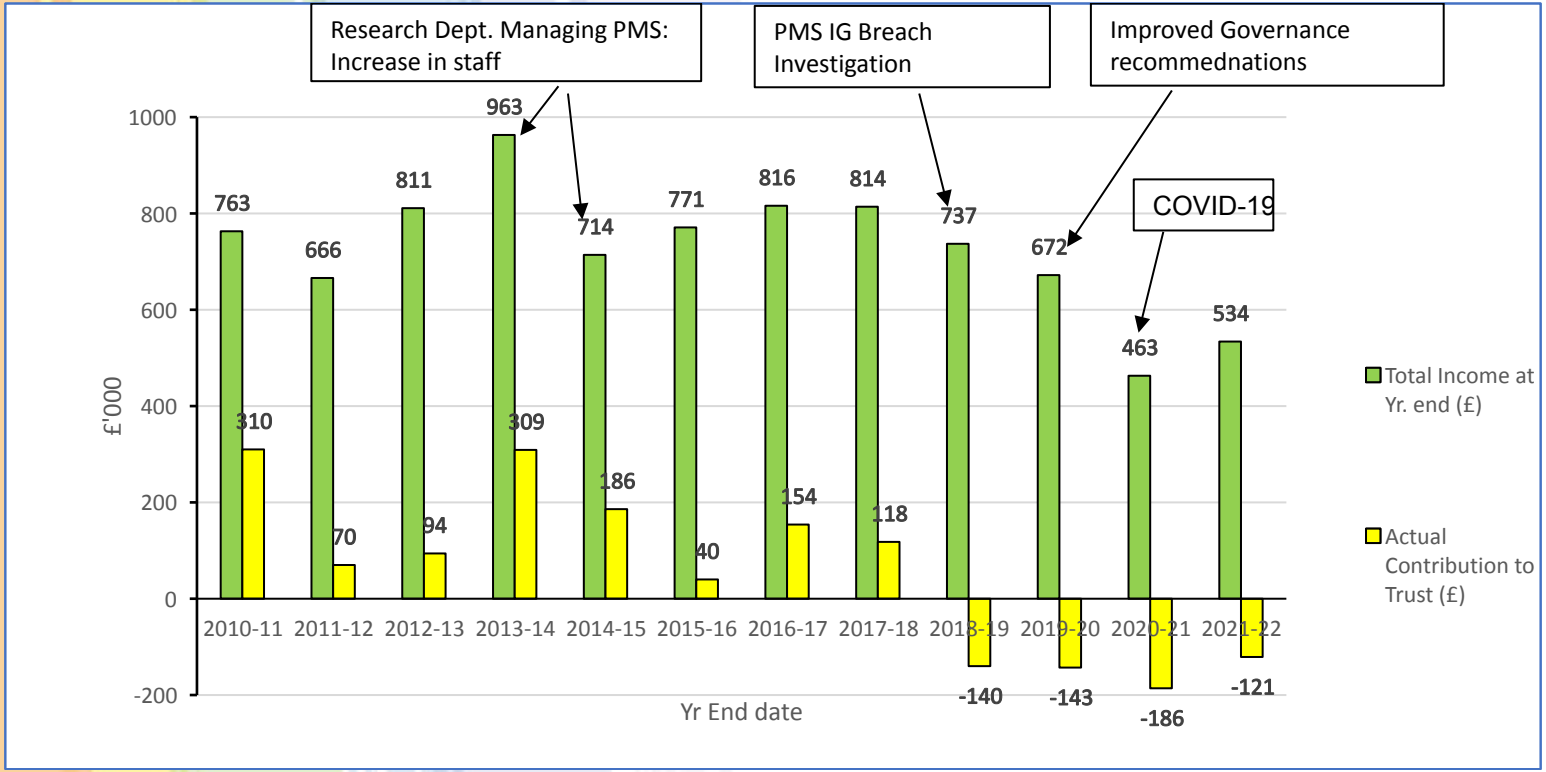
Yr End date
Total Income at Yr. end (£)

Finances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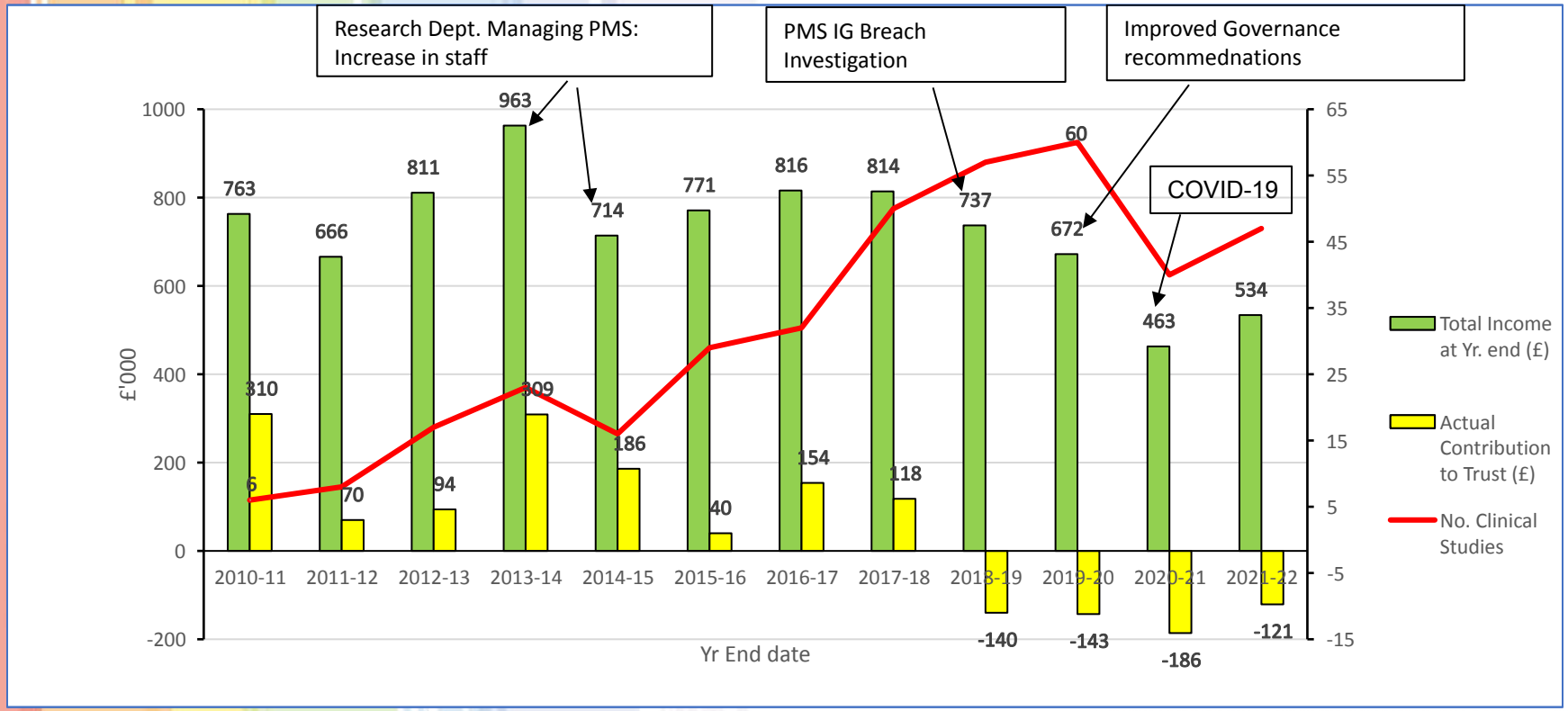
2021-22
Yr End date
Total Income at Yr. end (£)
Actual Contribution to Trust (£)

Finances



Aspiring to deliver world-class patient care

Gap Analysis

- Deficient expectations of our new staff
- No declaration of intent
- The excluded tribes
  - Nurses
  - Therapists
  - Pharmacists
  - Radiographers

Benefits

- Caring for patients
  - Quality outcomes; reduced mortality and complications
- Caring for Staff
  - Upskilling staff to undertake research
  - Attracting and retaining high quality staff
  - Creating world-class culture
- Caring for Finances
  - Commercial research
  - Reduced complications and costs

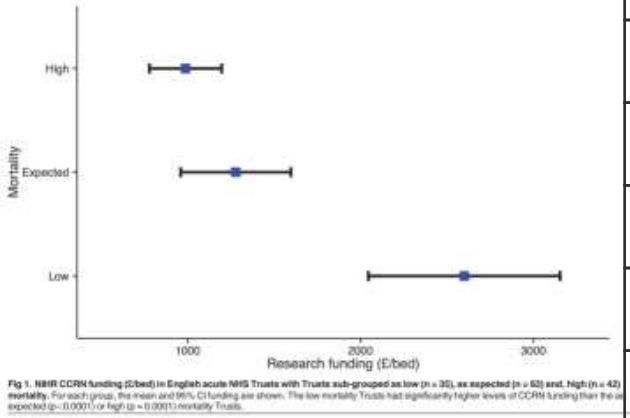


Fig 1. NIHR CCRN funding (£/bed) in English acute NHS Trusts with Trusts sub-grouped as low (n = 35), as expected (n = 62) and, high (n = 42) mortality. For each group, the mean and 95% CI funding are shown. The low mortality Trusts had significantly higher levels of CCRN funding than the as expected (p< 0.0001) or high (p = 0.0001) mortality Trusts.

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Research Impact

- FAST – confirmed no benefit gained from provision of orthotic shoes compared with shop purchased shoes.
- ACI – NICE guidelines.
- Pico – reduced risk of infections
- GTPS – non-invasive low cost intervention
- Enhanced Recovery – enables total hip pts. to go home day after surgery.
- STAR Care Pathway – NOA Excellence in Orthopaedics Awards short list. Clinically and cost effective low cost intervention for people with chronic knee pain following knee replacement at 3 months.

World-Class Knowledge

Aspiring to deliver world-class patient care

Innovation Team

- Research – *management of ignorance*
- Outcomes – *measurement of effectiveness*
- Clinical Audit – *measurement of process*
- Library Services – *curation of evidence*

Innovation need

- Management of Spinal Injury Pressure Sores
  - Research – *identification and participation in studies*
  - Outcomes – *effectiveness of current care*
  - Clinical Audit – *identifying compliance with gold-standard care*
  - Library Services – *evidence of best practice*

The Future

- Veterans – social and psychological care too
- MSK Alliance – evidence based
- Biomarkers – right pathway
- System working – spreading our impact
- RJAH@

0. Reference Information

Author:	Stacey Keegan, Chief Executive Officer	Paper date:	7 September 2022
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	2 September 2022
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2. Conclusion

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

3. The Main Report

1. Saying 'Thank you' to all our people

We're busy celebrating Togetherness Week over the course of this week (5th-9th September). This is something we are doing this year instead of our traditional awards, as a way of recognising all our people for their hard work over the last couple of years. We've got plenty going on, so hopefully there is something for everyone! We want people to have fun, but there is a serious message too – that we see what you have done and we are so very grateful. RJAH has always been a special place to work with a huge bond between its staff. That has been tested throughout the pandemic, but this week is about recapturing that spirit.

2. Recognition in the NOA Awards

I'm delighted to report that RJAH has three finalists in the inaugural National Orthopaedic Alliance Awards.

- Our work on the Path of Positivity is up for the Staff Wellbeing initiative;
- The RJAH Green Plan is one of three finalists for the Working Towards Net Zero Award; and
- Our My recovery project has made the last three for the Patient Engagement Award, which is all about supporting patients through their treatment journey with the use of digital.

Congratulations to all three finalists, and I hope we end up with at least one winner from the actual awards, which take place in October.

3. RJAH named as Quality Data Provider by NJR

RJAH has been named a Quality Data Provider by the National Joint Registry (NJR), for the fourth year running, after completing a national programme of local data audits.

The NJR collects high-quality orthopaedic data, and the Quality Data Provider certificate scheme celebrates those hospitals that have met targets set by the NJR.

4. ORLAU Award

Engineers in ORLAU, in partnership with Ricoh 3D, won the Healthcare Application Award at the TCT Awards.

The team won the award for their work to update an old-fashioned knee alignment device which had become expensive to source, repair and replace. The device is used in the Gait Lab in ORLAU where the walking gait of patients is analysed.

The new device was designed through 3D printing and has new and improved features to support performance for clinicians and patients.

5. EPR Contract signed with System C

We signed the contract with System C, after a competitive procurement process, to provide a new Electronic Patient Record (EPR).

The new EPR will support staff to deliver care to patients by providing the right information at the right time to deliver the best possible care. The solution will bring electronic notes to wards, provide electronic prescribing and allow patients to modify their own appointments. The formal project will commence this month.

6. Wedding Bells for Phil and Shirley

Cancer patient Phil Bryers and partner Shirley Astbury decided to make the most of every minute together and get married at RJAH, after Phil was placed on a palliative care pathway.

The couple had already postponed their wedding, which was meant to take place at their church in Newtown, due to Phil being admitted into hospital.

The couple were married by Rev Canon Nia Morris, with support from Hospital Chaplain Rev Simon Airey, in a ceremony that took place in the Multifaith Chapel at RJAH. Macmillan Specialist Nurse Pip Page-Davies was involved in organising the ceremony and reception for the couple

7. Alice Ward benefit from gaming carts

Patients on Alice Ward at RJAH now have access to two state-of-the-art gaming carts with some of the latest Xbox computer games, thanks to a donation from TheRockinR Gaming Charity.

The gaming carts resemble portable gaming systems on wheels and will be used as coping tools for children undergoing treatment and to promote social interaction. They have been funded by the League of Friends, RJAH Charity and the Starlight Children's Foundation.

8. 202 (Midlands) Field Hospital

I was privileged to welcome Regimental Sergeant Major John Priestly to RJAH last month to discuss the care and services we provide here, including the plans for the Headley Court Veterans Orthopaedic Centre

9. Theatres

A big thank you to Mr Robin Banerjee and the theatre team who welcomed me into theatres to work with them and observe first-hand the fantastic care and treatment that we provide for our patients.

10. Face to Face Integrated Care Board

On the 27th of July, the Integrated Care System (ICS) held its first face to face Integrated Care Board (ICB) as opposed to virtual and Board Development session; an important coming together of system leaders to focus on the priorities of the ICS, ways of working and to continue relationship building.

11. Hospital Transformation Programme (HTP)

The Department of Health and Social Care and NHS England's Joint Investment Committee has formally approved the Strategic Outline Case (SOC) submitted by Shropshire Telford & Wrekin Integrated Care System (ICS) for the reconfiguration of acute hospital services at Shrewsbury and Telford hospitals. , The SOC has been approved subject to a number of conditions that will be addressed as the Outline Business Case is developed, during the next stage of the Hospitals Transformation Programme (HTP). This moves the ICS another step closer to delivering better health outcomes and a vastly improved experience of care for our communities whilst, at the same time, addressing many of the long-term sustainability challenges.

12. Health Hero Award

Two teams have won our Health Hero Award since our last public Board meeting:

- July's winners of the Health Hero Award were the Covid-19 Testing Team, who are responsible for ensuring patients are tested for covid-19 prior to surgery. They were nominated by Jo-Anne Bidmead, Pre-Op Assessment Unit Manager.

  She said: "They have worked tirelessly over the past 12 months or so to ensure patients have their pre-admission covid-19 test, while accommodating the ever-changing infection prevention and control guidance."

  Well done to the team!

- Our August winners were Ben Parrish, Steve Bishton and Louise Evans, who won the award for stepping up to fill an unexpected period of leave from their manager.

  They were nominated by Jane Dewsbury, Orthotics Services Manager, who said: "Ben, Steve and Louise have all worked extremely hard in the absence of their unit manager, taking on additional tasks to ensure the Orthotics Manufacturing Department continues to deliver everything it needs to - both to Clinical Orthotics and also to their external customers."

  Well done, all!

4.0. Conclusion

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

Month 4 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	07 September 2022
Executive Sponsor:	Mike Carr	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 provides information summarising the key performance indicators, highlighting areas of high or low performance for operational and financial metrics.

The committee is asked to note the assurance provided on overall performance as presented in the month 4 (July) Integrated Performance Report, against all areas, and actions being taken to meet targets where missed, providing assurance on the process to meet the target.

2. Executive Summary

2.1. Context

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

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

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

2.2. Reporting Changes This Month

Following a review of the IPR the following changes have been made to this committee version this month:

- New KPI – 'Outbreaks'
  - All confirmed outbreaks reported in month will be included in this metric

2.3. Overview

The Board through this IPR should note the following;

The legacy of covid continues to impact delivery of our statutory targets and waiting times. A final plan has now been submitted in line with national guidance. Measures throughout this IPR are monitored against that plan.

Patients continue to be booked in line with guidance regarding clinical priority as a primary rather than date order, with an additional focus on eliminating our longest waiting patients.

There is an IPR review planned with all authors in early September to ensure best practice and a consistent approach to completing the narrative and actions section, it is anticipated this will result in more significant changes ahead of the August IPR.

Caring for Staff;

- Sickness Absence
  - Metric showing special cause variation of a concerning nature but does remain within control range
  - Long term sickness remains as special cause variation of concern and short term sickness now reports common cause variation
- Voluntary Staff Turnover – an exception at Trust level and specific Staff Groups are consistently off target
  - Additional Clinical
  - Administrative and Clerical
  - Add Prof Scientific and Technic
  - Allied Health Professionals
  - Estates and Ancillary
  - Nursing and Midwifery
- Vacancy Rate
  - Metric showing special cause variation of concern as reported above control range

Caring for Patients;

- RJAH Acquired C. Difficile
  - One infection reported in July, a relapse of the same patient reported in June
- RJAH Acquired E. Coli Bacteraemia
  - One case of E. Coli Bacteraemia reported in July
- RJAH Acquired MSSA Bacteraemia
  - One case of MSSA Bacteraemia reported in July
- Surgical Site Infections
  - Two infections confirmed in July relating to surgery in June
- Outbreaks
  - Six outbreaks confirmed in July
- Total Deaths
  - One expected death reported in July
- Cancer Plan 62 Days Standard (Tumour)
  - One shared pathway did not meet the standard in June (reported one month in arrears); performance reported at 50%
- 18 Weeks RTT Open Pathways
  - Metric continues to fail the 92% target. As expected from covid impact, this will continue for a considerable time
- Patients Waiting Over 52 Weeks
  - Both English and Welsh showing special cause variation of concern
  - For month 4 our English patients waiting over 52 weeks is 33 patients below our planned trajectory

- Patients Waiting Over 78 Weeks
  - Both English and Welsh showing special cause variation of concern
  - For month 4 our reported positions in relation to trajectory were:
    - English – 41 patients above trajectory of 534
    - Welsh – 10 patients below trajectory of 329
- Patients Waiting Over 104 Weeks
  - English and Welsh individually showing special cause variation of concern
  - For month 4 our reported positions in relation to trajectory were:
    - English – 1 patient below trajectory
    - Welsh – 12 patients below trajectory
- Overdue follow up backlog
  - Special cause variation of an improving nature but consistently failing the target
  - Ongoing validation to continue
- 6 and 8 Week Wait for Diagnostics
  - Both English and Welsh standards showing as special cause variation and both consistently off target

Caring for Finances;

- Elective Activity Against Plan (volumes)
  - Elective activity reported 91.72%; 87 behind plan
- Bed Occupancy – All Wards – 2pm
  - Metric shown as special cause variation of an improving nature, although consistently failing target
- Total Outpatient Activity against Plan
  - 1930 below plan - 86.07%
- Income
  - Adverse in month
- Agency Core
  - Above cap

2.4. Conclusion

The Board is asked to **note** the assurances provided on overall performance as presented in the month 4 (July) Integrated Performance Report, against all areas and actions being taken to meet targets providing assurance on process to meet the target and where insufficient assurance is received seek additional assurance.

	IPR Position	August 2022 Unvalidated Position		
Metric	**Jul-22**	**Snapshot Date**	**Snapshot Position**	**Supporting commentary**
Sickness Absence	5.97%	23/08/2022	4.42%	Sickness Absence % within Trust on snapshot date.
Vacancy Rate	7.69%	23/08/2022	8.62%	Unvalidated. Inclusive of August's payroll transactions. Subject to change.
Never Events	0	23/08/2022	1	The Trust has reported a never event in August which is related to retainment of foreign object.
Serious Incidents	0	23/08/2022	0	
Surgical Site Infections	0	23/08/2022	0 (2 July)	2 SSIs confirmed in August that relate to procedures in July
Patients Waiting Over 104 Weeks - English	60	23/08/2022	71	As per latest weekly submission made to NHS EI on snapshot date.
Private Patient Activity	134% (67 against a plan of 50)	23/08/2022	152.38% (64 against a plan of 42)	Snapshots include upcoming booked activity. Subject to change.
Total Elective Activity against Plan	91.72% (964 against a plan of 1051)	23/08/2022	88.40% (953 against a plan of 1078)	
Total Theatre Activity against Plan	80.31% (783 against a plan of 975)	23/08/2022	80.55% (816 against a plan of 1013)	
Total Outpatient Activity against Plan	86.07% (11,924 against a plan of 13,854)	23/08/2022	88.03% (12,366 against a plan of 14,047)	

Integrated Performance Report
July 2022 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

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

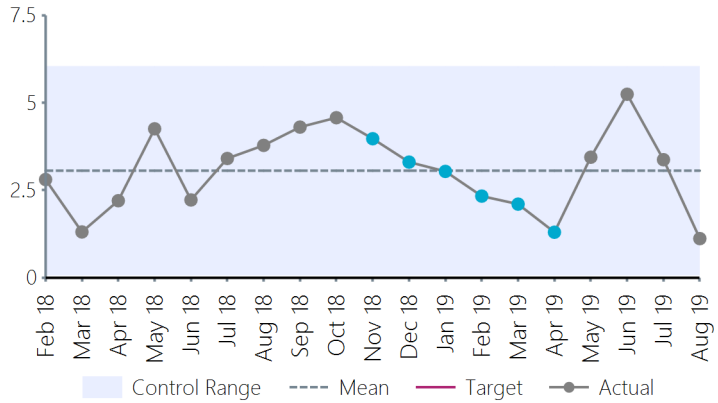
Some examples of these are shown in the images to the right:

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

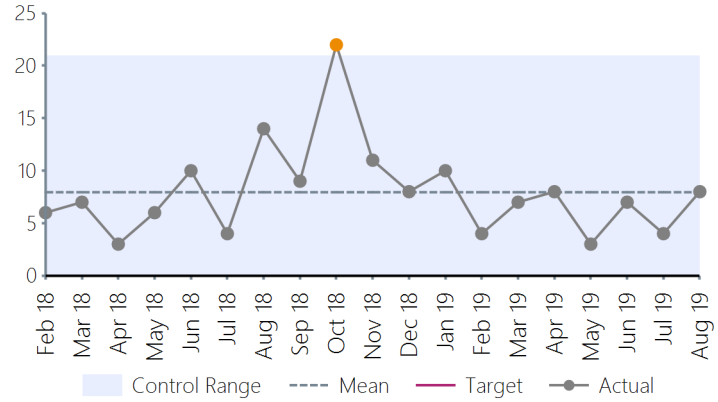
b) shows a point of concern sitting above the control range.

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

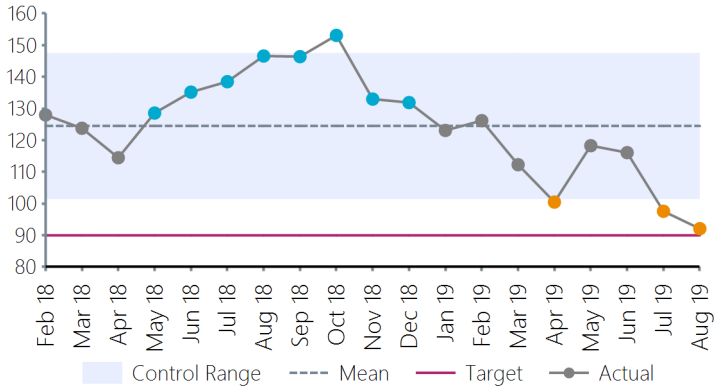
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	5.97%		H	?	+	27/02/20
Staff Turnover - Headcount	8.00%	11.68%		H	?	+	24/06/21
Vacancy Rate	8.00%	7.69%		H	P	+	14/03/19

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	P		
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	14			?		
RJAH Acquired C.Difficile	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired E. Coli Bacteraemia	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	1		N/A to SPC	?	+	
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Outbreaks	0	6		N/A to SPC	?	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Surgical Site Infections	0	0			?	+	
Total Deaths	0	1		N/A to SPC	F	+	16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P		
31 Days First Treatment (Tumour)*	96%	100%		H	?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85%	50%			?	+	
18 Weeks RTT Open Pathways	92.00%	52.07%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,932	1,965	H	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		1,071		H	No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	575	534	H	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		319	329	H	No Target	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patients Waiting Over 104 Weeks - English	0	60	61	H	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		74	86	H	No Target	+	
6 Week Wait for Diagnostics - English Patients	99.00%	53.30%		L	F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	56.03%		L	F	+	
Overdue Follow Up Backlog	5,000	13,710		L	F	+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	1,051	964		H	Moving Target	+	
Bed Occupancy – All Wards – 2pm	87.00%	88.07%		H	F	+	09/03/22
Total Outpatient Activity against Plan (volumes)	13,854	11,924			Moving Target	+	
Total Outpatient Activity - % Moved to PIFU Pathway	3.00%	3.35%		N/A to SPC	Moving Target		
Total Diagnostics Activity against Plan - Catchment Based	2,165	2,374			Moving Target		
Financial Control Total	-91	-84		N/A to SPC	Moving Target		
Income	10,542	10,918		N/A to SPC	Moving Target	+	
Expenditure	10,685	10,728		N/A to SPC	Moving Target		
Efficiency Delivered	145	257		N/A to SPC	Moving Target		
Big Ticket Item (BTI) Efficiency Delivered	0	0		N/A to SPC	P		

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Cash Balance	23,462	25,081					
Capital Expenditure	1,655	443					
Agency Core	132	200				+	

Sickness Absence

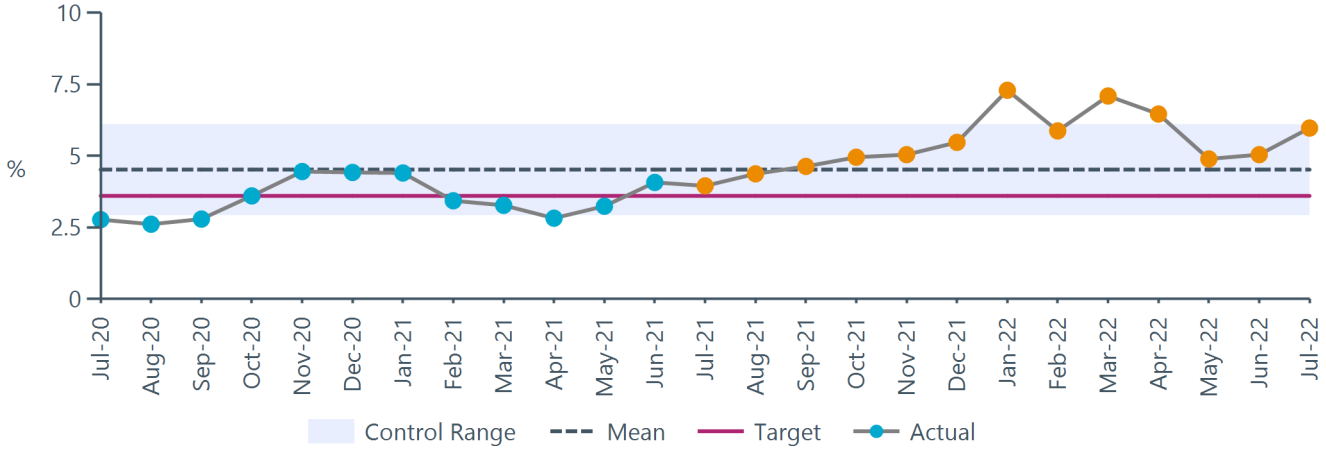
FTE days lost as a percentage of FTE days available in month 211161

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
3.60%	5.97%	H	?

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The sickness absence reported for July is 5.97% where 'infectious diseases' accounted for 1.91%, leaving remaining sickness at 4.06%. The rate is shown as special cause variation of concern but remains within our control range. Unit level detail below for those areas that are above target:
* MSK Unit - 7.08% (4.49% excluding 'infectious diseases')
* Assurance & Standards Team - 4.34% (2.91% excluding 'infectious diseases')
* Specialist Unit - 5.84% (4.28% excluding 'infectious diseases')
* CSU - 7.52% (5.74% excluding 'infectious diseases')

'Infectious Diseases' was the highest reason for absence in all areas

Staff groups with the highest levels of sickness absence were:
* Radiographers - 12.06%
* Healthcare Assistants - 10.25%
* Registered Nursing Staff - 6.57%

Actions

Actions in relation to sickness include:
* Data Quality improvements where 'other known reasons' is recorded as absence reason; Workforce Information Team cross-checking against doctors' notes to update where possible
* People Services Business Partners continue to provide regular engagement and coaching to managers whilst targeting areas with highest levels of absence
* People Services Business Partners to explore what training opportunities are available to managers to equip them in supporting staff; particularly those staff absent due to anxiety/stress/depression
* Emphasis on preventative actions to support staff to be in the workplace; this could include redeployment or agreement of flexible working
* Wellbeing interventions remain in place for staff with multiple sources of support available and accessible via intranet, which has been reviewed with a further action to now raise awareness
* Wellbeing System guide disseminated to managers. Business Partners to explore options available through the system and ensure managers are aware
* Some analysis (limited as the results are not at dept. level) of staff survey results has been undertaken with some correlation seen between engagement and sickness levels

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
3.95%	4.37%	4.63%	4.95%	5.04%	5.47%	7.29%	5.87%	7.09%	6.46%	4.89%	5.04%	5.97%

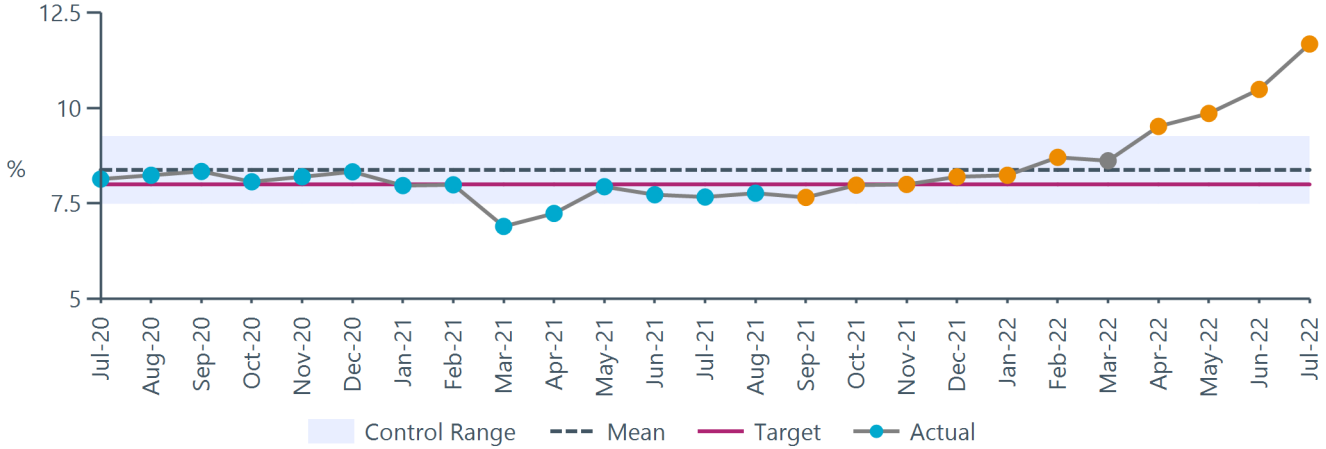
Staff Turnover - Headcount

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

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	11.68%	H	?

Trajectory



What these graphs are telling us

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

Narrative

Voluntary Staff Turnover, at Trust level, has now been reported above the 8% target since November-21. The July rate of 11.68% is now the fourth point above the control range. Six out of eight staff groups are reported above 8% as follows:
- Estates and Ancillary - 14.19%
- Allied Health Professionals - 13.68%
- Nursing and Midwifery - 13.54%
- Additional Clinic - 12.79%
- Add Prof Scientific and Technic - 10.26%
- Administrative and Clinical - 10.02%

In the latest twelve month period, August-21 to July-22, there have been 190 leavers throughout the Trust. This is in relation to a headcount in post of 1627, as at 31st July 2022. The top three reasons for leaving that accounts for 112 leavers/59% at Trust level were:
* Retirement age - 42 / 22.11%
* Voluntary Resignation - Other/Not Known - 39 / 20.53%
* Voluntary Resignation - Work Life Balance - 31 / 16.32%

Actions

Actions in relation to voluntary staff turnover include:
* In line with the 'Looking after our people' section in the Single Oversight Framework and NHS People Plan, need to consider the flexible working patterns being offered and taken up by staff; requirement to review the process to ensure there is accurate means of capturing this data for monitoring purposes. This can then be reviewed alongside turnover and retention data.
* Flexible working options now part of natural conversations held by managers with staff. People Services Business partners explored CIPD research on flexible working with findings taken to Unit Board meetings.
* Review the flexible working options the Trust has in place and utilise this when recruiting, for example; shift patterns in clinical areas, working from home
* Turnover in Therapies remains a 'hot spot' area; a review has been undertaken with a set of actions underway being supported with external expertise. A timeline being developed to closely monitor vacancies and recruitment in this area. This is being led by the Assistant Chief Nurse for this Unit.
* Further 'hot spot' area on one ward; review has been undertaken with independent report recently received by Unit MD. Initial actions include streamlining agency sign-off process and reinstated enhanced bank across all wards .

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
7%	7%	7%	7%	8%	8%	8%	8%	8%	9%	9%	10%	11%

Vacancy Rate

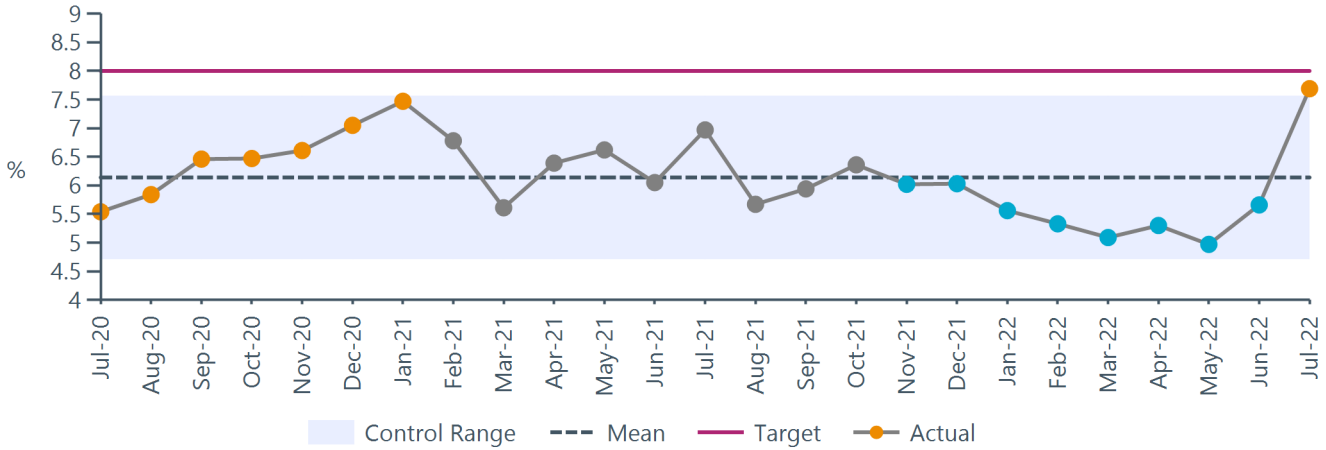
% of Posts Vacant at Month End 211183

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
8.00%	7.69%	H	P

Trajectory

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature. Metric is consistently meeting the target as the control range sits below the target line.

Narrative

Although the vacancy rate is reported below the 8% target it is included as an exception this month due to the 7.69% being reported above our usual control range and so displayed as special cause variation. The Units above the 8% target are:
- Specialist Unit - 12.58%
- Assurance & Standards - 9.51%
- MSK Unit - 8.32%

Further details on the staff groups is provided against other KPIs.

Actions

Actions in this area include:
* People Business Partners to ensure recruitment aligned with submitted planning assumptions
* Oversight of vacancies now in place with regular updates from the Information Workforce team that then allows pro-active recruitment with People Business Partners supporting managers. Reporting breaks down stages of recruitment
* People Business Partners working with managers in areas where there have been difficulties recruiting; reviewing labour market as vacancies arise, assessing skill mix and utilising training posts where appropriate
* Analysis of the data provided by Information Workforce team summarising data on reasons for leaving and length of service to identify if any themes
* Improve on data recorded for leavers where the reason is stated as 'Other/Not Known'
* Establish if any themes from staff survey results can be correlated with vacancy rates
* Long term action to improve the Exit process and capturing of data; consideration to preventative actions at suitable time in the process
* Continue to explore use of international recruitment but recognising it does bring with it some challenges

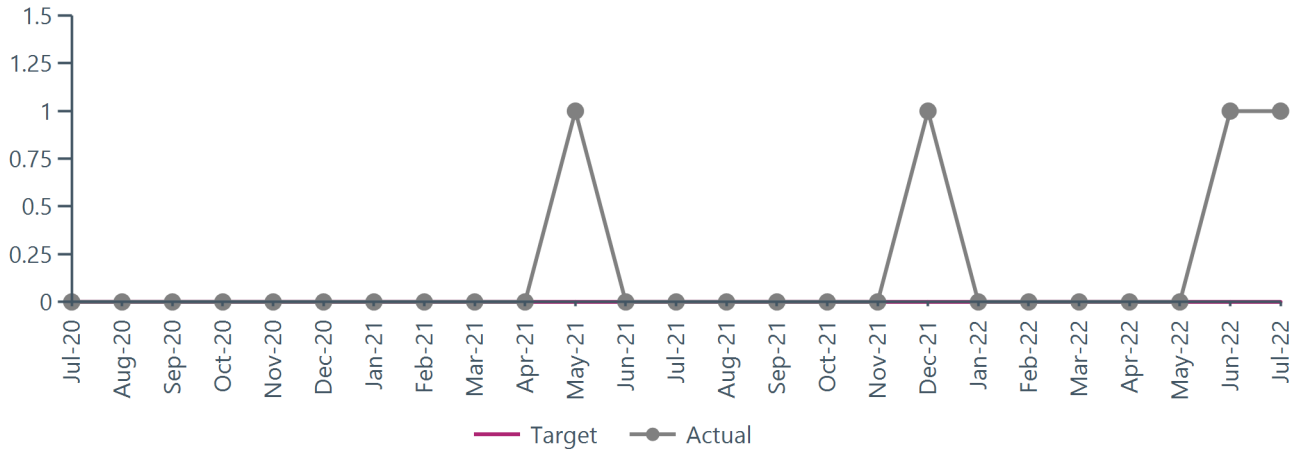
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
6.97%	5.67%	5.94%	6.36%	6.02%	6.03%	5.56%	5.33%	5.09%	5.30%	4.97%	5.66%	7.69%

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month 211149

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory

What these graphs are telling us

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

Narrative

There was one case of C.Difficile reported in July. This was a relapse of the same patient reported in June.

Actions

The post infection review has taken place where it was deemed the source of infection was likely to be the result of antibiotic usage. All antibiotics had been prescribed appropriately with microbiology input. An after action review poster has been completed and circulated to all staff for shared learning.

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

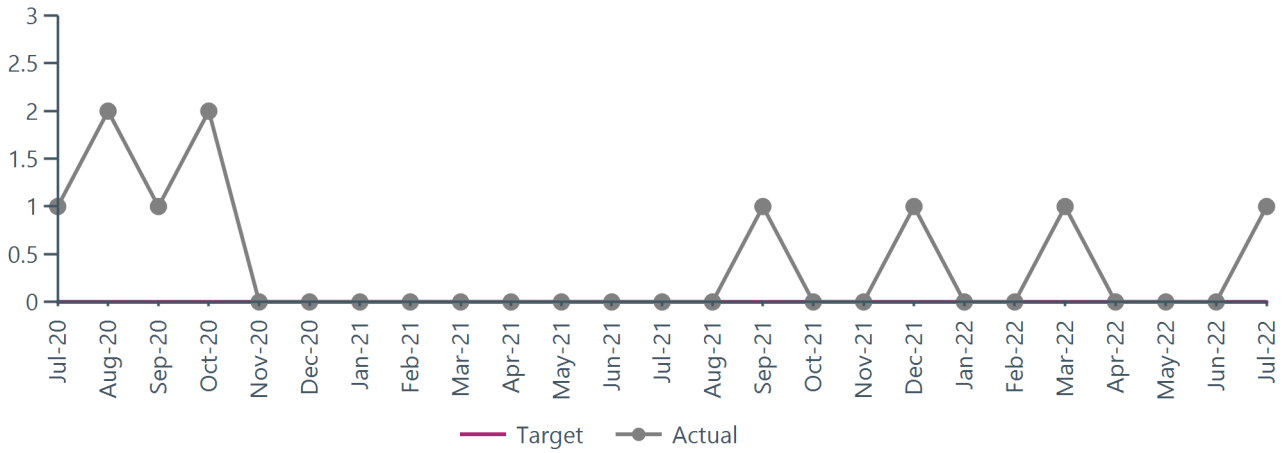
- Staff - Patients - Finances -

RJAH Acquired E. Coli Bacteraemia

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

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory

What these graphs are telling us

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

Narrative

There was one case of E.coli Bacteraemia reported in July.

Actions

The post infection review has taken place that confirmed the infection was managed in line with protocols and there was no lapse in care. The source of infection was not identified. An after action review poster has been completed and circulated to all staff for shared learning.

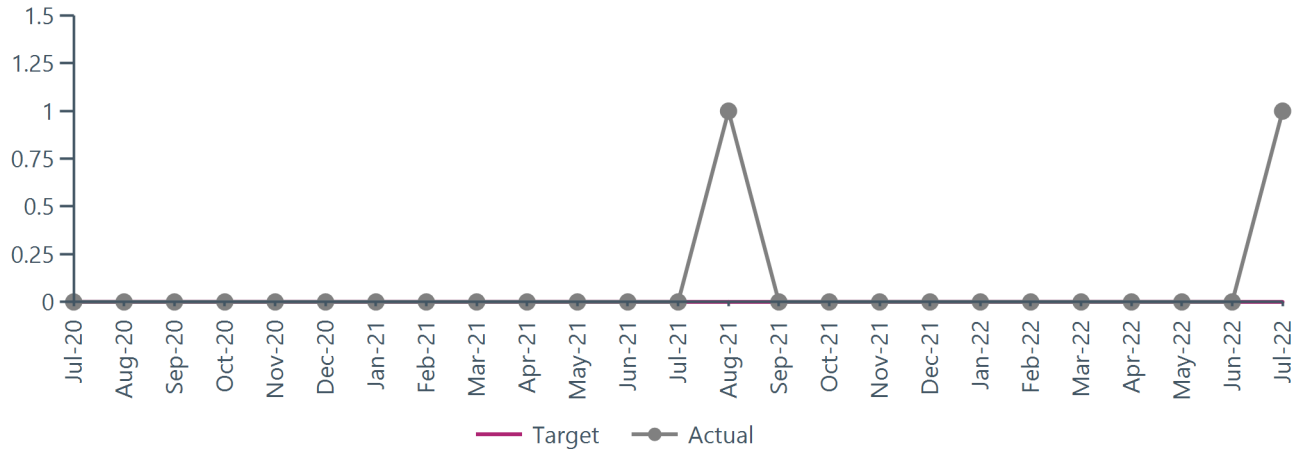
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
0	0	1	0	0	1	0	0	1	0	0	0	1

RJAH Acquired MSSA Bacteraemia

Number of cases of MSSA bacteraemia in month 211152

Exec Lead:
Chief Finance and Planning Officer

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



Trajectory

What these graphs are telling us

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

Narrative

There was one case of MSSA Bacteraemia reported in July.

Actions

This infection was identified on 31st July. At time of IPR production, post infection review was scheduled to take place on 18th August.

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

- Staff - Patients - Finances -

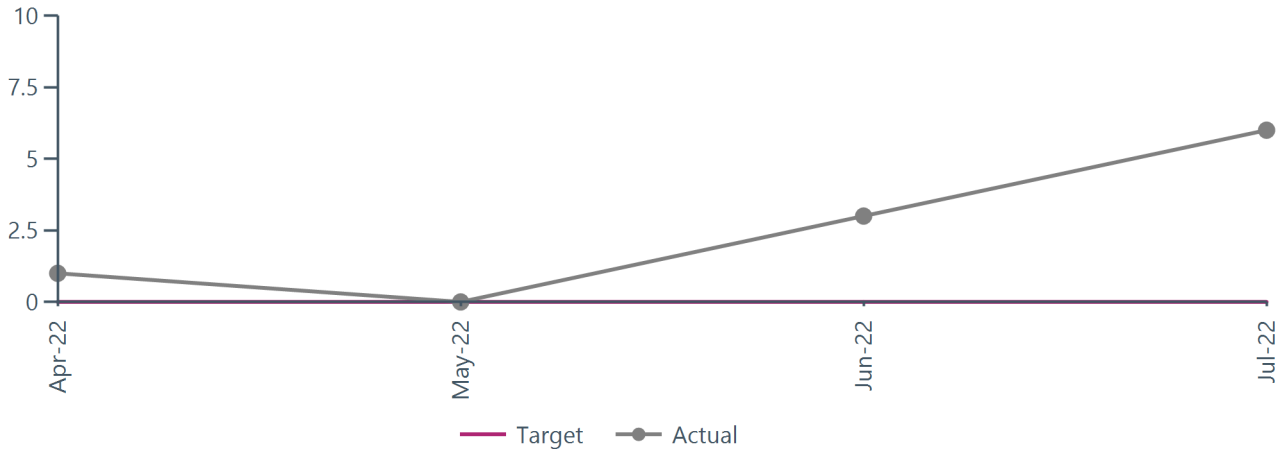
Outbreaks

Number of declared outbreaks in month 217806

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	6	N/A to SPC	?

Trajectory



What these graphs are telling us

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

Narrative

This is a new KPI that has been added this month and will be reported in IPRs to Trust Board and Quality and Safety Committee. All confirmed outbreaks reported in month will be included in this metric.

In July there was a total of six outbreaks:
* One MRSA outbreak declared 1st July on one ward. This affected one index patient and four patients that acquired MRSA
* Five COVID-19 outbreaks declared across three wards and two staffing areas

Actions

Root cause analysis is currently being undertaken and will be reported to the IPC committee at the end of August. After action review methodology has been used for each outbreak and key areas of improvement and learning have been shared across the organisation. Regarding COVID-19, we are reviewing mask wearing and visiting guidance regularly through IPC committee.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
									1	0	3	6

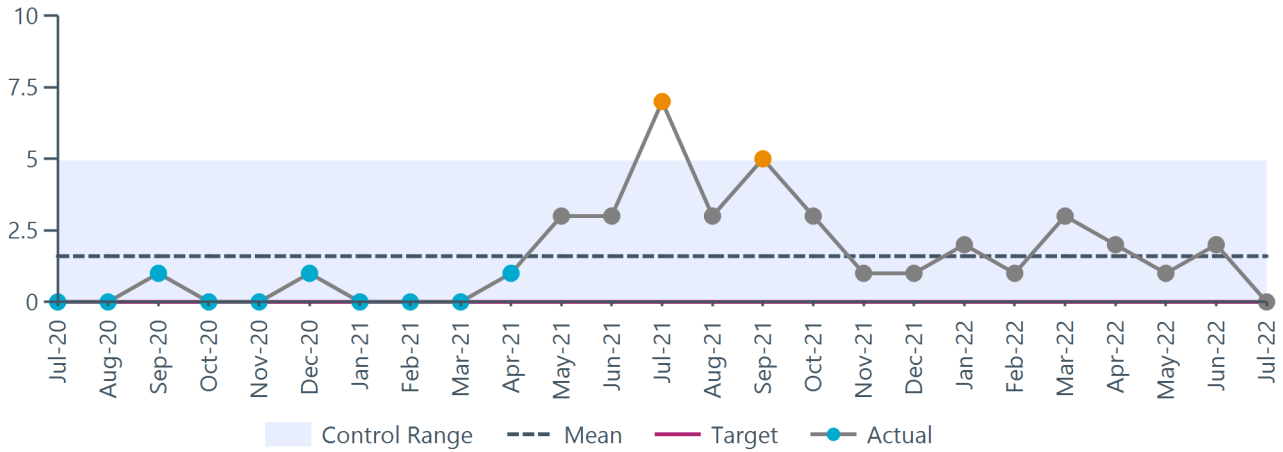
Surgical Site Infections

Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.
217727

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
0	0		

Trajectory



What these graphs are telling us

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

Narrative

Surgical Site infections are monitored for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in the past twelve months. The data represented in the SPC above shows any surgical site infections that have been reported where they're shown on the graph above based on the month that the procedure took place.

In the latest twelve month period, covering August-21 to July-22, there have been 24 surgical site infections. There were two additional infections confirmed in July relating to a procedures that took place in June. A data quality check has been carried out with the IPC team to ensure the latest twelve month period is reported correctly.

For the latest complete quarters a breakdown as follows:
- October 21 to December 21 - 5 SSIs with all Post Infection Reviews Complete
- January 22 to March 22 - 6 SSIs with all Post Infection Reviews Complete
- April 22 to June 22 - 5 SSIs with 4 Post Infection Reviews Complete

Actions

A thematic review of surgical site infections from the last twelve months has been carried out. Recommendations and actions from this will be monitored through the Surgical Site Infection Protection Working Group.

The IPC Nurse Specialist has introduced a Surgical Site Infection Prevention working group, chaired by the MSK matron, that is being held every two weeks. The group is being managed by the MSK unit with membership including Theatres, Pre-Op and Baschurch. The group has clear actions with initial focus on warming and wound care.

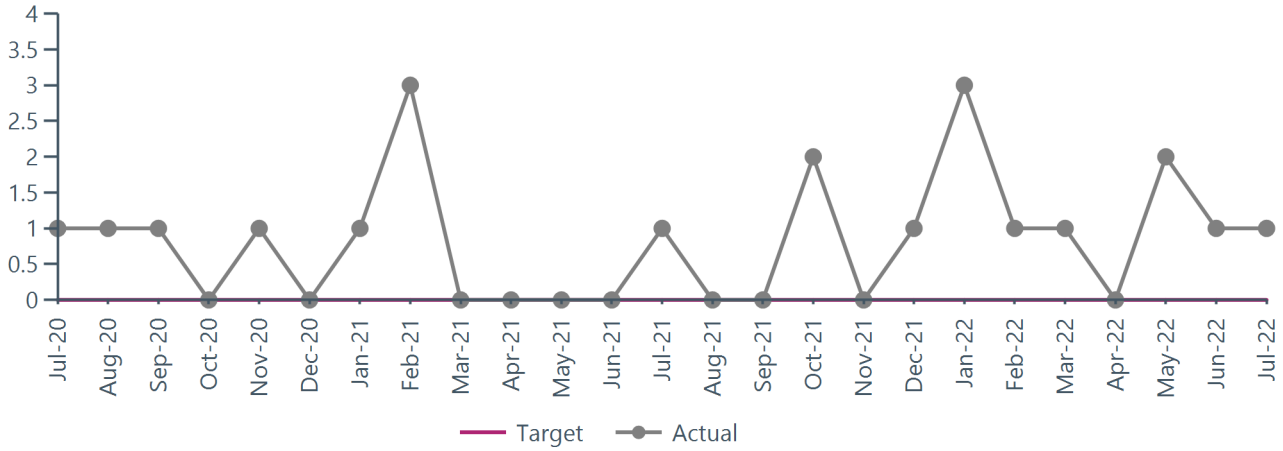
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
7	3	5	3	1	1	2	1	3	2	1	2	0

Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Finance and Planning Officer

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



Trajectory

What these graphs are telling us

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

Narrative

There was one death within the Trust in July that was categorised as an Expected Death.

Actions

With any death, expected or unexpected, root cause analysis is undertaken to ensure there is learning from this incident. The results of this will be taken to Patient Safety and plans to disseminate any relevant learning, where identified, will be put in place.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
1	0	0	2	0	1	3	1	1	0	2	1	1

Cancer Plan 62 Days Standard (Tumour)*

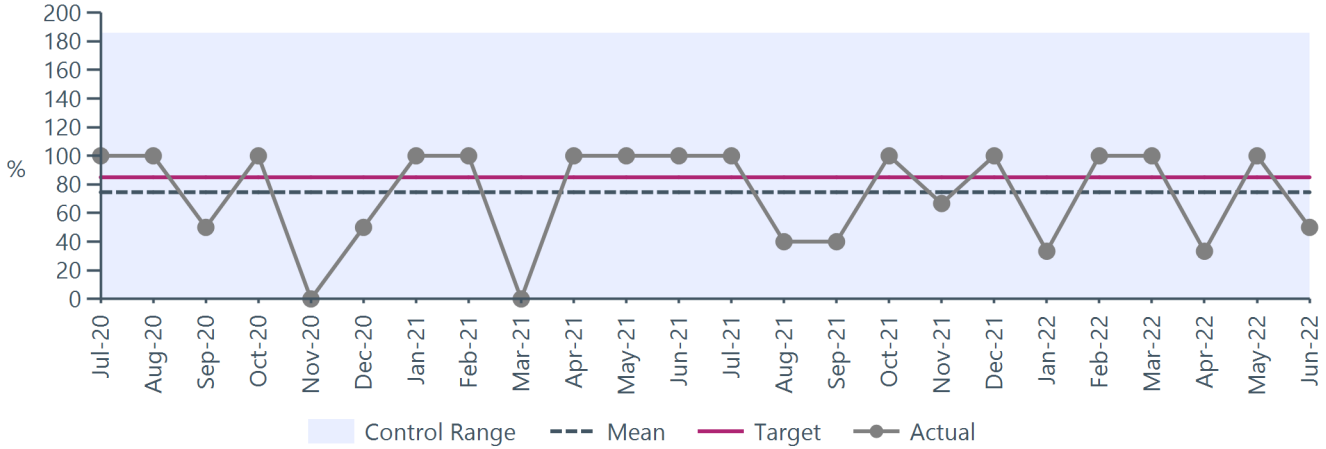
% of cancer patients treated within 62 days of referral (*Reported one month in arrears) 211045

Responsible Unit:
Specialist Services Unit

Target/Plan	Latest Value	Variation	Assurance
85%	50%		

Trajectory

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 Cancer 62 Day Standard was not met in June (reported one month in arrears). RJAH was accountable for two shared pathways in June where one met the standard and the second did not. Reasons for the breach are associated with the need for multiple diagnostic tests due to the complex diagnosis, which meant the patient was not able to be referred out sooner.

Actions

Due to the complexity of this patient's pathway there have been no actions identified.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
100%	40%	40%	100%	66%	100%	33%	100%	100%	33%	100%	50%	

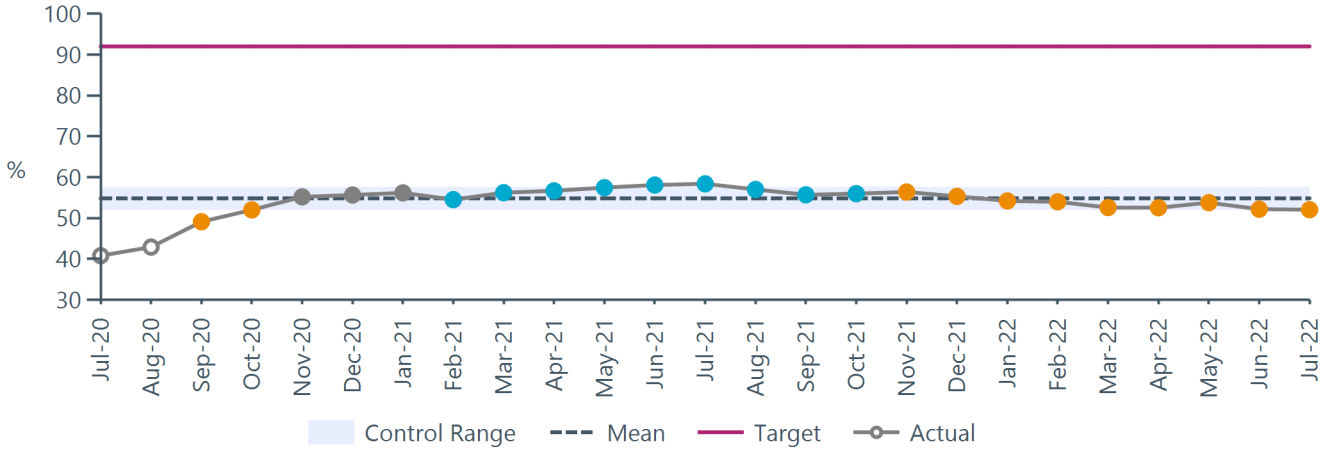
18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Target/Plan	Latest Value	Variation	Assurance
92.00%	52.07%	L	F

Trajectory



What these graphs are telling us

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

Narrative

Our June performance was 52.07% 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 - 7769 patients waiting of which 2327 are breaches
* MS2 - 1489 patients waiting of which 967 are breaches
* MS3 - 4908 patients waiting of which 3496 are breaches

2022/23 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 - exceptions are patients choice/specific specialties
* Eliminate waits of over 78 weeks by April 2023 - exceptions are patient choice / specific specialties
* Develop plans to reduce 52 week waits with ambition to eliminate them by March 2025

Actions

We continue with the Trust's plans and actions to manage demand. These are inclusive of:
- Activity plans for Independent sector and mutual aid capacity
- Outpatient Transformation Programmes
- Develop key lines of enquiry for theatre activity
- External company undertaking Theatre Workforce Review
- Internal Audit carrying out Waiting List Audit to ensure no disparity between English & Welsh pathways

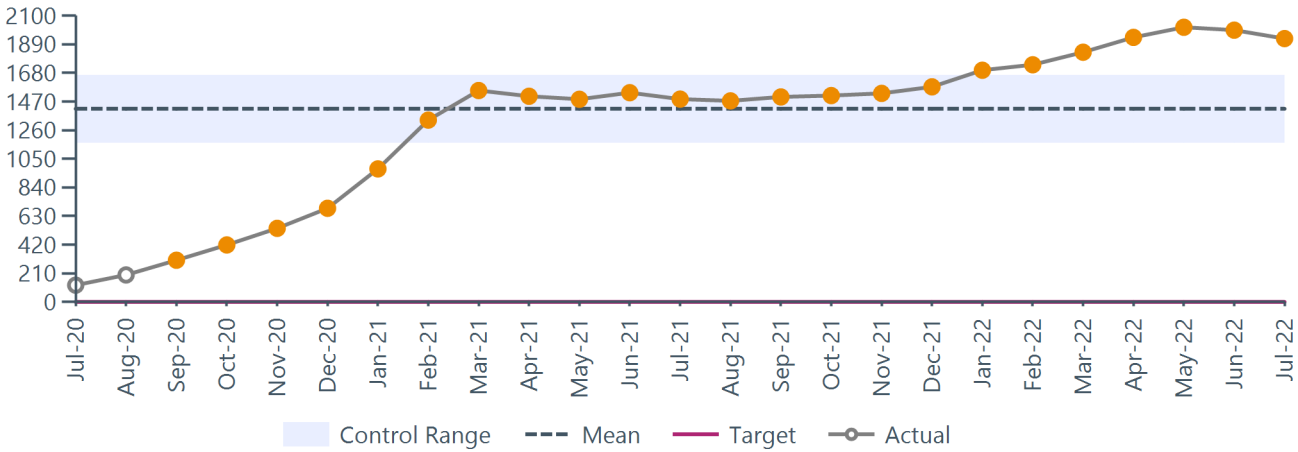
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
58.40%	57.02%	55.71%	55.99%	56.39%	55.33%	54.21%	53.99%	52.60%	52.54%	53.79%	52.19%	52.07%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Target/Plan	Latest Value	Variation	Assurance
0	1,932	H	F



Trajectory

What these graphs are telling us

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

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

Narrative

At the end of July there were 1932 English patients waiting over 52 weeks; below our trajectory figure of 1965 by 33.

The patients are under the care of the following sub-specialities; Spinal Disorders (1007), Knee & Sports Injuries (323), Arthroplasty (193), Upper Limb (151), Veterans (96), Foot & Ankle (83), Spinal Injuries (38), Paediatric Orthopaedics (12), Metabolic Medicine (11), Tumour (8), Neurology (5), Rheumatology (2), Geriatrics (1), SOOS Physiotherapy (1) and Physiotherapy (1).

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1357 patients
- >78 to <=95 weeks - 414 patients
- >95 to <=104 weeks - 101 patients
- >104 weeks - 60 patients

Actions

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

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

In the coming months we are putting a focus on our milestone 1 patients which will help us to identify theatre capacity needed by the end of March.

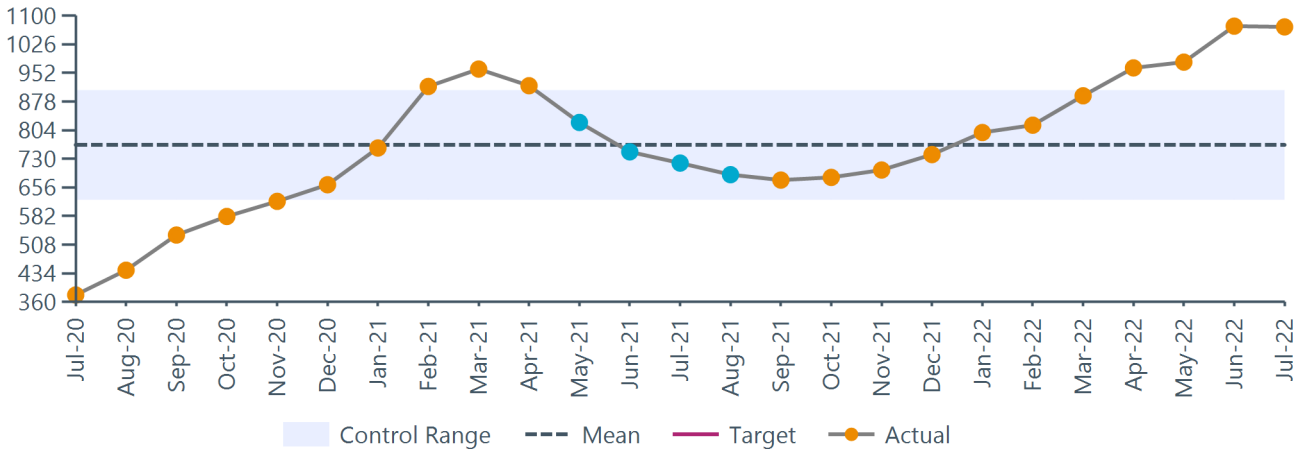
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
1488	1475	1504	1514	1530	1578	1700	1740	1832	1941	2015	1994	1932

Patients Waiting Over 52 Weeks - Welsh (Total)

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

Responsible Unit:
Specialist Services Unit

Target/Plan	Latest Value	Variation	Assurance
-	1,071	H	No Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of July there were 1071 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (706), Arthroplasty (116), Knee & Sports Injuries (99), Upper Limb (75), Foot & Ankle (33), Veterans (14), Paediatric Orthopaedics (9), Spinal Injuries (8), Metabolic Medicine (5), Tumour (3), and Neurology (3).

The patients are under the care of the following commissioners; BCU (587), Powys (473), Hywel Dda (8), Abertawe Bro (2) and Aneurin Bevan (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 752 patients
- >78 to <=95 weeks - 199 patients
- >95 to <=104 weeks - 46 patients
- >104 weeks - 74 patients

Actions

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

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

In the coming months we are putting a focus on our milestone 1 patients which will help us to identify theatre capacity needed by the end of March.

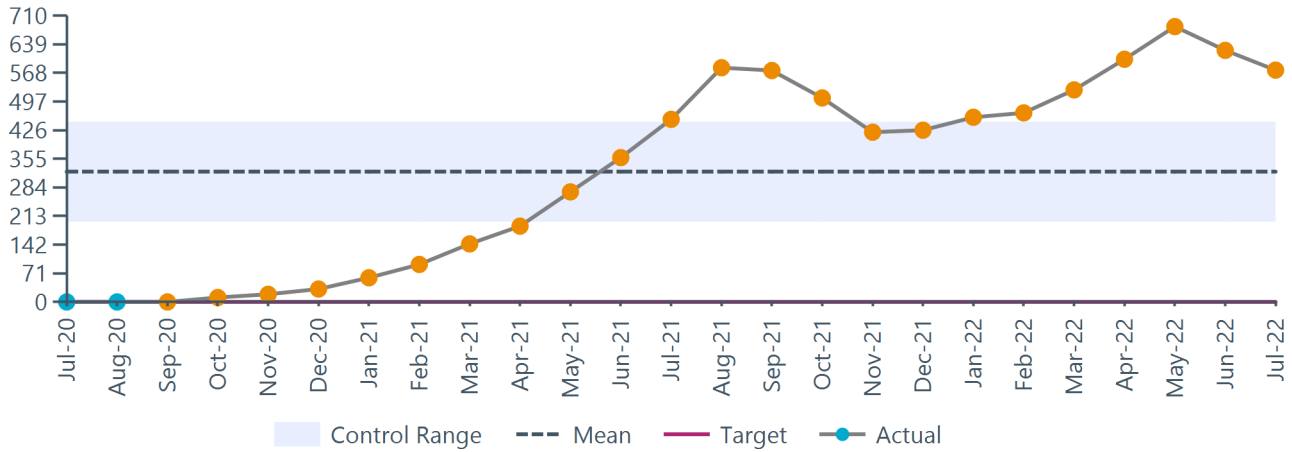
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
719	689	675	682	701	741	798	817	893	965	980	1073	1071

Patients Waiting Over 78 Weeks - English

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

Responsible Unit:
Specialist Services Unit

Target/Plan	Latest Value	Variation	Assurance
0	575	H	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of July there were 575 English patients waiting over 78 weeks; this was 41 patients above our trajectory of 534. Submitted plans are visible in the trajectory line above.

The patients are under the care of the following sub-specialities; Spinal Disorders (429), Knee & Sports Injuries (76), Upper Limb (29), Spinal Injuries (16), Arthroplasty (15), Foot & Ankle (5), Veterans (3) and Tumour (2).

Actions

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

The Trust is constantly monitoring waiting list movements alongside capacity available for our clinically urgent patients. The Trust continues to follow clinical prioritisation national guidance to book patients and has a noted risk for its Spinal Disorders services. In the coming months we are putting a focus on our milestone 1 patients which will help us to identify theatre capacity needed by the end of March.

RJAH has been placed in Tier 2 monitoring. This is regionally led with national support. Weekly escalation calls are in place with NHS EI for monitoring purposes.

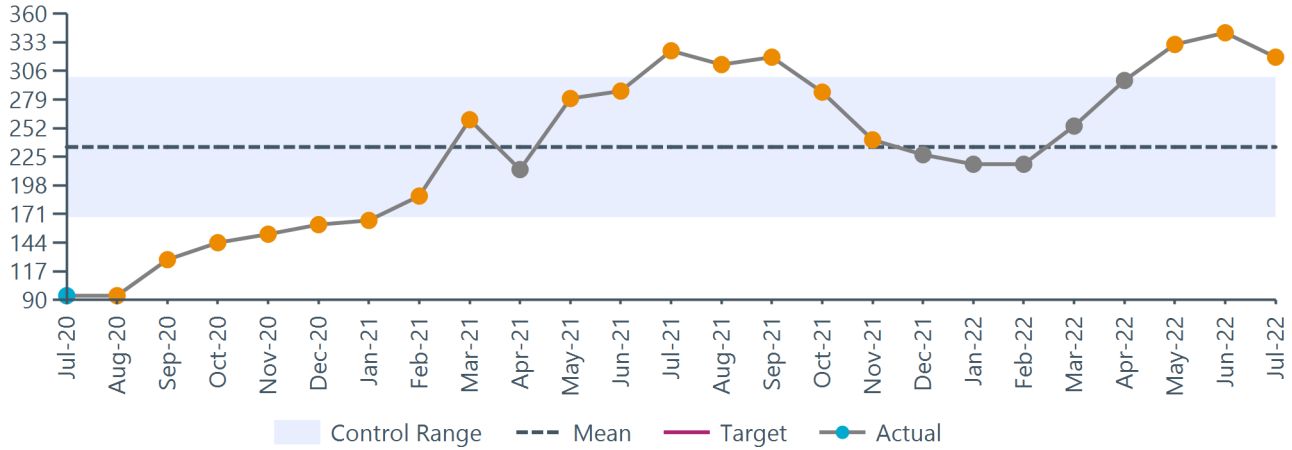
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
453	581	574	506	421	426	458	469	526	602	683	624	575

Patients Waiting Over 78 Weeks - Welsh (Total)

Patients waiting over 78 Weeks - Welsh (Total) 217802

Responsible Unit:
Specialist Services Unit

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



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of July there were 319 Welsh patients waiting over 78 weeks; this was 10 patients below our trajectory of 329. The Trust plans are visible in the trajectory line above.

The patients are under the following sub-specialties; Spinal Disorders (264), Knee & Sports Injuries (31), Upper Limb (12), Arthroplasty (5), Spinal Injuries (2), Foot & Ankle (1), Veterans (1), Tumour (1), Neurology (1) and Metabolic Medicine (1).

Actions

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

In the coming months we are putting a focus on our milestone 1 patients which will help us to identify theatre capacity needed by the end of March.

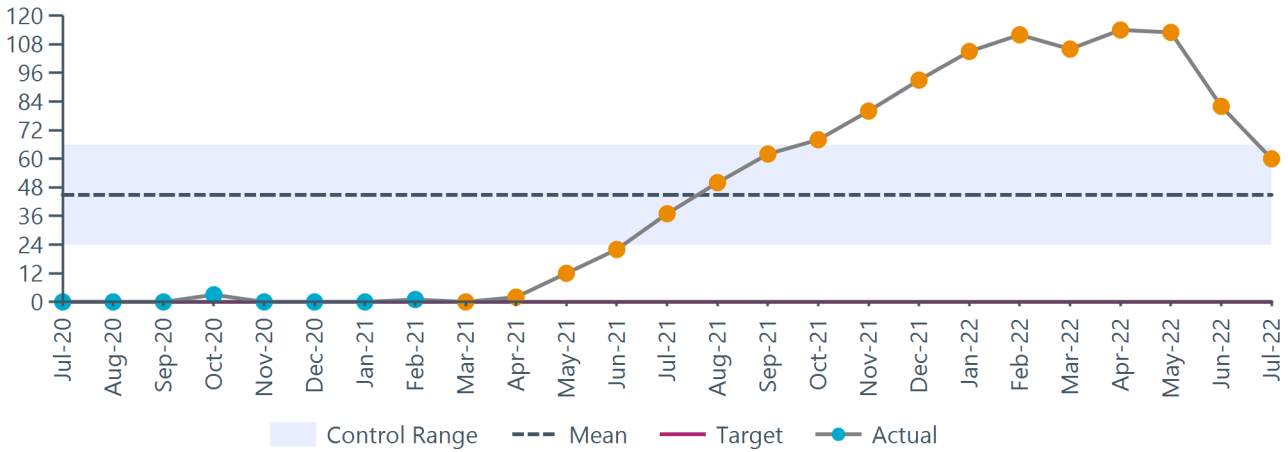
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
325	312	319	286	241	227	218	218	254	297	331	342	319

Patients Waiting Over 104 Weeks - English

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

Responsible Unit:
Specialist Services Unit

Target/Plan	Latest Value	Variation	Assurance
0	60	H	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of July there were 60 English patients waiting over 104 weeks, below our trajectory figure of 61 by 1.

The patients are under the care of the following sub-specialities, with further details on the volume by priority;
- Spinal Disorders (56) - P2 (1), P3 (9), P4 (32), Not on Elective WL yet so no priority (14)
- Knee & Sports Injuries (2 - both P3)
- Spinal Injuries (1 - P4)
- Veterans (1 - Not on Elective WL yet so no priority)

By Milestone, there were:
- Milestone 1 (Outpatients) - 4 patients
- Milestone 2 (Diagnostics) - 11 patients
- Milestone 3 (Electives) - 45 patients

Of the 60 patients, 57 are complex and 3 are patient choice.

Actions

2022/23 NHS England operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 - exceptions are patients choice/specific specialties

The Trust expects spinal disorders 104+ weeks to still be present. This is due to national pressures for this specialist service and continued demand. As acknowledged through the planning guidance, there may also be patients who choose to wait. This formed part of our 2022/23 planning submission and our submitted plans can be viewed in the trajectory line above. The Trust has taken actions to review the volume of patients who fall into the 'patient choice' category with improvements to the volumes now seen and reflected in revised trajectories.

Regarding mutual aid, further capacity has been identified at the Schoen clinic in London. Patients are being identified who would be suitable and agree to transfer. Support with the Royal Orthopaedic Hospital and the Nuffield is ongoing. A mutual aid co-ordinator is now in post with a clear focus on this. Complexity remains a limiting factor for mutual aid support.

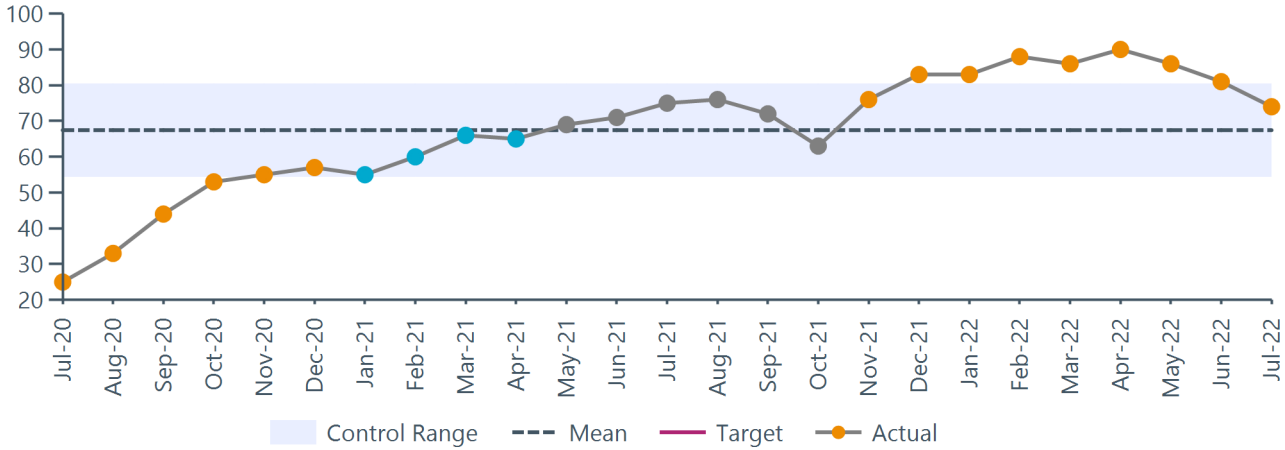
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
37	50	62	68	80	93	105	112	106	114	113	82	60

Patients Waiting Over 104 Weeks - Welsh (Total)

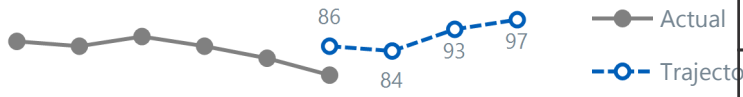
Patients Waiting Over 104 Weeks - Welsh (Total) 217803

Responsible Unit:
Specialist Services Unit

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



Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of a concerning nature.

Narrative

At the end of July there were 74 Welsh patients waiting over 104 weeks; below our trajectory figure of 86 by 12.

The patients are under the care of the following sub-specialities, with further details on the volume by priority;
- Spinal Disorders (73) - P2 (2), P3 (25), P4 (38), Not on Elective WL yet so no priority (8)
- Spinal Injuries (1 - P3)

By Milestone, there were:
- Milestone 1 (Outpatients) - 9 patients
- Milestone 2 (Diagnostics) - 4 patients
- Milestone 3 (Electives) - 61 patients

Actions

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

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

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
75	76	72	63	76	83	83	88	86	90	86	81	74

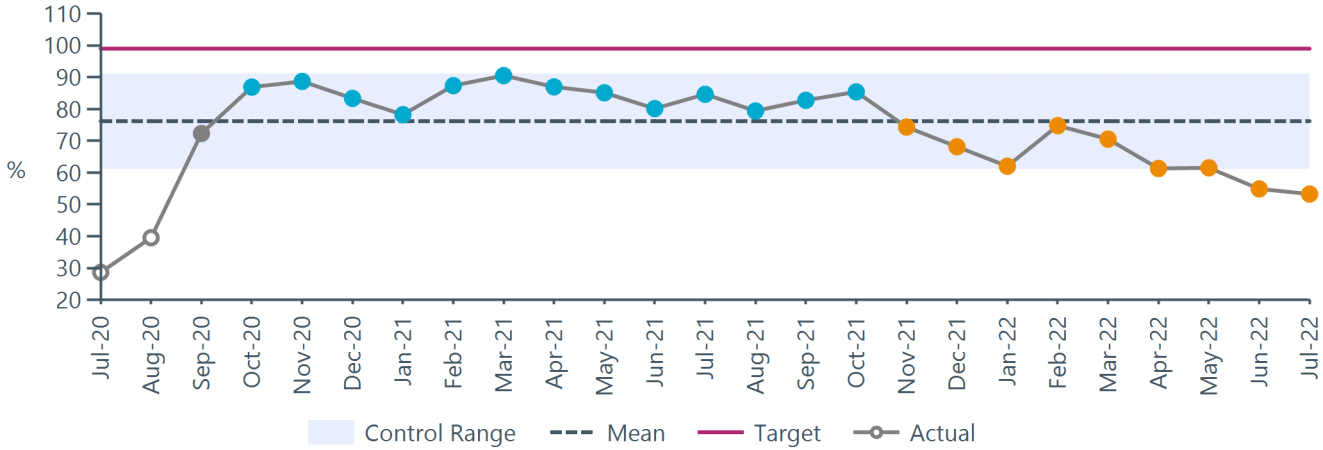
6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Target/Plan	Latest Value	Variation	Assurance
99.00%	53.30%	L	F

Trajectory



What these graphs are telling us

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

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 53.30%. This equates to 899 patients who waited beyond 6 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 43.62% - D2 (Urgent - 0-2 weeks) 4 dated, D3 (Routine - 4-6 weeks) - 15 dated, D4 (Routine - 6-12 weeks) - 781 with 440 dated
- CT - 89.60%% - D4 (Routine - 6-12 weeks) - 11 with 5 dated
- Ultrasound - 76.51% - D3 (Routine - 4-6 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 87 with 81 dated
- DEXA Scans - 100%

The trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were initially referred as D4 (Routine - 6-12 weeks) but were updated to urgent at a later date .

MRI was reported at 43.62% against a trajectory specifically for MRI at 46%. It must be noted that all diagnostic activity plans were met in July.

Actions

Actions include:
- Explore options to source a mobile MRI scanner
- Extended weekend working to be implemented from October 2022, up until then staff to continue to work overtime at the weekends
- Training and utilising established staff across multiple modalities where pressures arise - this has been agreed by ERF

It is anticipated that the actions above will help to improve the current performance although not meet the target. The national expectations are not for this target to be achieved throughout 22/23.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
84.66%	79.43%	82.78%	85.42%	74.35%	68.16%	62.04%	74.81%	70.56%	61.33%	61.54%	54.90%	53.30%

8 Week Wait for Diagnostics - Welsh Patients

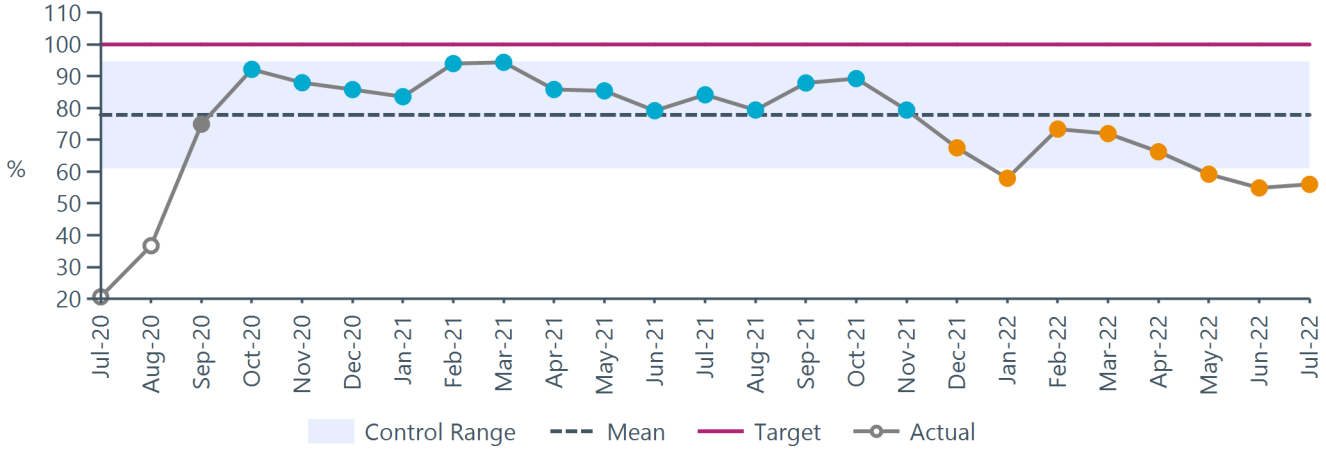
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Responsible Unit:
Clinical Services Unit

Target/Plan	Latest Value	Variation	Assurance
100.00%	56.03%	L	F

Trajectory

Actual
Trajectory



What these graphs are telling us

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

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 56.03%. This equates to 405 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 51.43% - D3 (Routine - 4-6 weeks) - 4 dated, D4 (Routine - 6-12 weeks) - 386 with 238 dated
- CT - 81.08% - D4 (Routine - 6-12 weeks) - 7 with 4 dated
- Ultrasound - 89.74% - D4 (Routine - 6-12 weeks) - 8 dated
- DEXA Scans - 100%

It must be noted that all diagnostic activity plans were met in July.

Actions

Actions include:
- Explore options to source a mobile MRI scanner
- Extended weekend working to be implemented from October 2022, up until then staff to continue to work overtime at the weekends
- Training and utilising established staff across multiple modalities where pressures arise - this has been agreed by ERF

It is anticipated that the actions above will help to improve the current performance although not meet the target. The national expectations are not for this target to be achieved throughout 22/23.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
84.19%	79.39%	87.91%	89.28%	79.38%	67.51%	57.94%	73.41%	71.98%	66.27%	59.22%	54.90%	56.03%

Overdue Follow Up Backlog

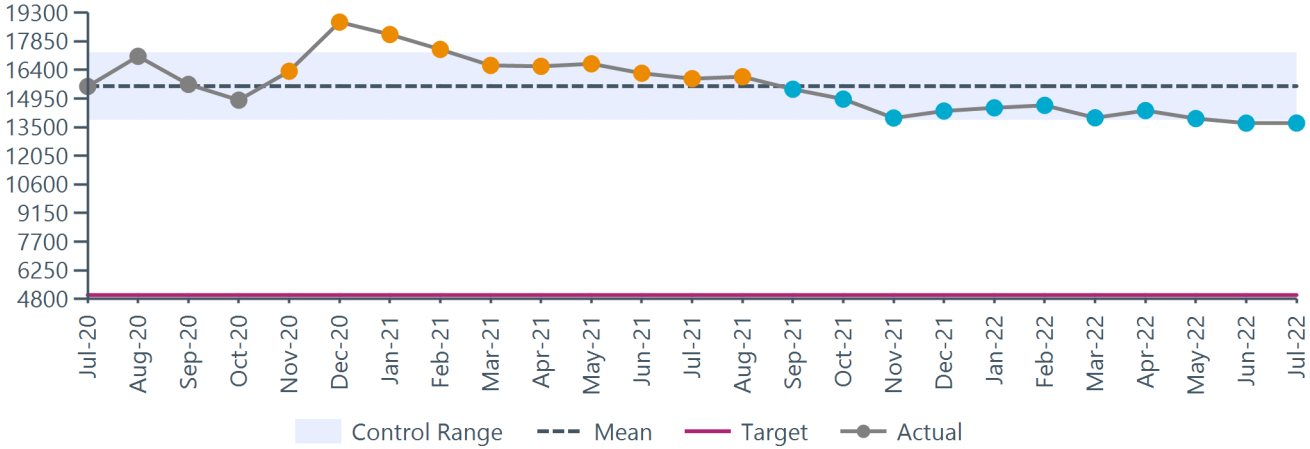
All dated and undated patients that are overdue their follow up appointment 217364

Responsible Unit:
Clinical Services Unit

Target/Plan	Latest Value	Variation	Assurance
5,000	13,710	L	F

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

At the end of July, there were 13710 patients overdue their follow up appointment. This is broken down by:
- Priority 1 is our more urgent follow-up cohort - 8875 with 1558 dated (18%)
- Priority 2 is the lower priority - 4835 with 1220 dated (25%)

There was an increase of 5 patients overdue their follow up appointment.
Sub-specialities with the highest percentage of overdue follow ups:
- Rheumatology - 21.66%
- Arthroplasty - 17.29%
- Spinal Disorders - 9.40%
- Spinal Injuries - 8.72%

Planning expectations for 2022/23 is to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023, however, our plans for 2022/23 do not meet this aspiration as the Trust continues to address its overdue follow-up backlog.

Actions

There are a number of contributable factors that will address the volume of backlog as follows:
- Additional validation posts now in place to address any data quality issues that will ensure we're working to, and reporting on, a cleansed list of patients
- In delivering the Outpatient activity levels that were submitted in our plans, this will impact the overdue follow ups with a proportion of the activity planned for follow ups.
- A trajectory has been agreed for Rheumatology for the next 3 months and work has started on a trajectory for all other specialties which will need input from all operational managers before it is finally agreed
- The Trust has a number of Transformational projects in progress, such as PIFU, that will support in further reductions in this area
- Consultants to increase desk-top reviews for their overdue follow up patients
- Further analysis on-going to understand how overdue follow ups have increased/decreased due to practice changes within different sub-specialties

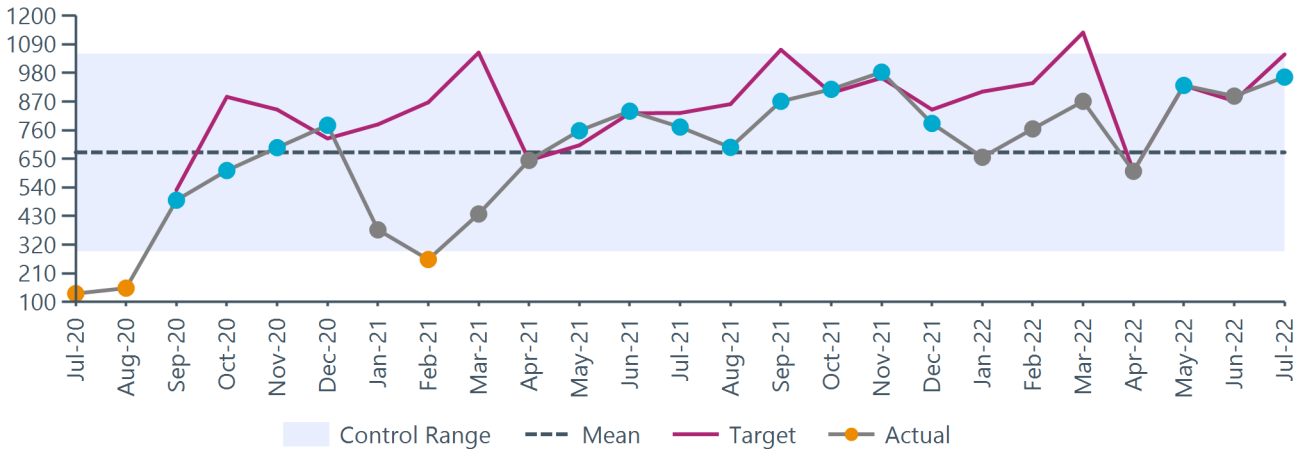
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
15956	16055	15422	14923	13965	14319	14482	14605	13976	14342	13937	13705	13710

Elective Activity Against Plan (volumes)

Total elective activity rated against 2022/23 plans. 217796

Responsible Unit:
MSK Unit

Target/Plan	Latest Value	Variation	Assurance
1,051	964	H	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

The plan for July was 115.6% of 19/20 baseline against a national target of 104%. This metric is included as an exception as it is reporting special cause variation of an improving nature.

Total elective activity undertaken in July was 964, 87 behind the 2022/23 plan of 1051 equating to 91.72%. Some of the shortfall can be attributed to lack of Independent Sector uptake equating to 18 patients, and 43 on the day theatre cancellations. Non-theatre activity is reporting 25.21% of the total and Theatre activity is 74.79% of the total.

In July, the Trust fell short of the sessions and cases per session plan; the Trust achieved 97.30% of its IJP capacity and 47.43% of its OJP capacity; all core staffed Theatre sessions were utilised. See 'Theatre Cases per Session against plan' and 'Volume of Sessions Against Plan' for further analysis.

The aim of the Trust is to ensure elective activity continues according to plan, to reduce long waits and prevent further lengthening of waiting lists.

Actions

In reviewing this KPI by sub-specialty we have noticed an increase in Rheumatology/Metabolic daycases. There are two factors impacting this:
* An inconsistency in the intended management recording identified over a period of time
* More new patients attending for treatment over the last few months and less activity has been seen for returning patients

At the time of IPR production investigations to understand the recording and the impact on performance are ongoing.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
772	694	871	917	983	786	656	765	871	602	932	891	964

Bed Occupancy – All Wards – 2pm

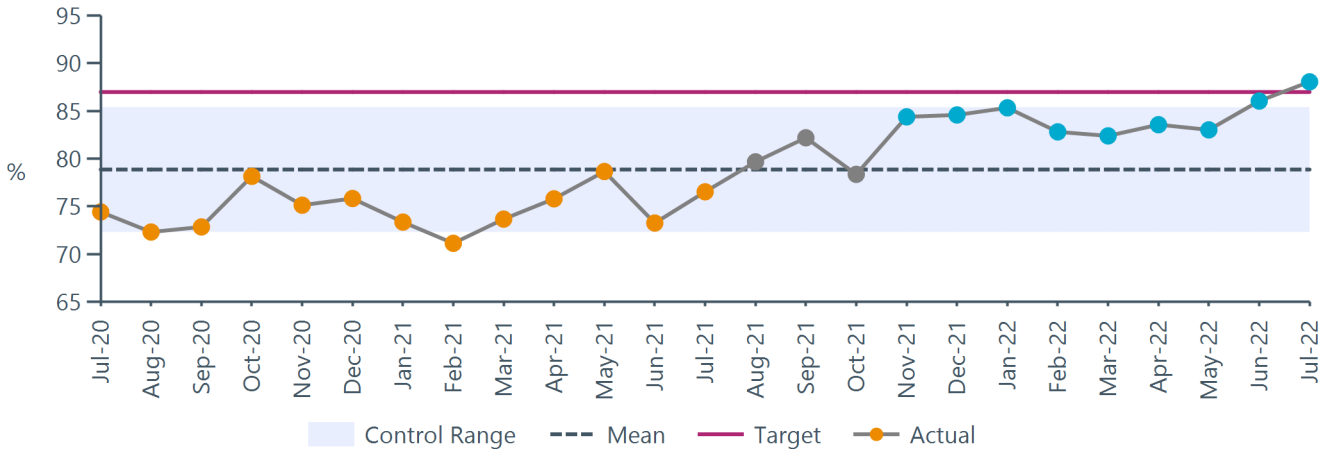
% Bed occupancy at 2pm (NHS & Private Beds) 211039

Responsible Unit:
MSK Unit

Target/Plan	Latest Value	Variation	Assurance
87.00%	88.07%	H	F

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 88.07% for July and remains shown as special cause variation with sustained improvement. Breakdown provided below:
MSK Unit:
- Clwyd - 89.01% - compliment of 22 beds open majority of the month
- Powys - 90.85% - compliment of 22 beds; gradual reduction at start of month to closure from 12th July
- Kenyon - 88.24% - compliment of 22 beds open for majority of month
- Ludlow - 90.87% - compliment of 16 bed open all month

Specialist Unit:
- Alice - 45.52% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 86.20% - compliment of 10 beds open all month
- Gladstone - 94.43% - compliment of 29 beds open all month
- Wrekin - 93.89% - compliment of 15 beds open; 1 bed closed on some days
- Sheldon - 91.38% - compliment of 20 beds open throughout month

Actions

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

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
76.54%	79.68%	82.21%	78.37%	84.40%	84.60%	85.35%	82.82%	82.40%	83.58%	83.03%	86.06%	88.07%

Total Outpatient Activity against Plan (volumes)

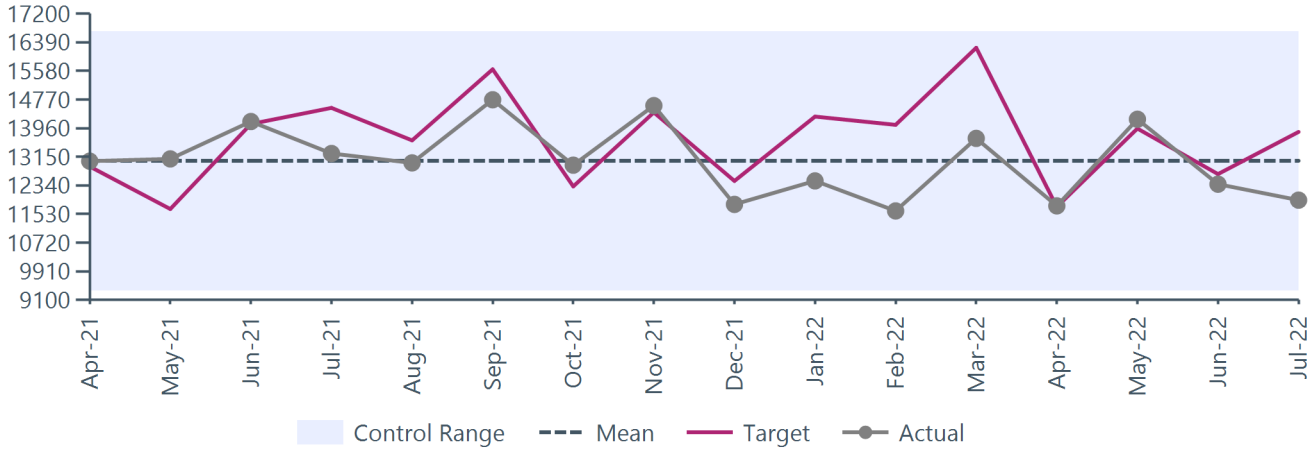
Total outpatient activity (H1 - consultant led, non-consultant led and un-bundled and H2 and 22/23 plan - consultant led and non-consultant led) against submitted plans.

217795

Responsible Unit:
Clinical Services Unit

Target/Plan	Latest Value	Variation	Assurance
13,854	11,924		Moving Target

Trajectory



What these graphs are telling us

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

Narrative

The plan for July was 95% of 19/20 against a national target of 104%. Total outpatient activity undertaken in July was 11924 against the 2022/23 plan of 13854; 1930 cases below - equating to 86.07%.
This is broken down as:
- New Appointments - 3757 against 4459 - equating to 84.26%
- Follow Up Appointments - 8167 against 9395 - equating to - 86.93%

The sub-specialities with the lowest activity against plan in July are:
- Physiotherapy - 1516 against 2138 - 622 cases below - associated with vacancies and unexpected pool closure
- Upper Limb - 714 against 1086 - 372 cases below - associated with unplanned leave, increase in additional duties and covid related absences
- Foot & Ankle - 562 against 787 - 225 cases below - associated with increased levels of leave and covid absences

Other activity was lost due to a shift in follow ups to new appointments in clinic templates, consultant job plan changes and unplanned retirement and transformation schemes not currently achieving required activity levels. It must be noted that there will also be a reduction in follow up appointments as focus on 104 week waiters planned for next three months.

Actions

The CSU Unit closely monitor outpatient activity to ensure activity is booked within all sub-specialities in order for the 22/23 plan to be met. Current Actions include:
- Outpatient Improvement Plan which includes all aspects of outpatient activity including Overdue Follow Ups, DNA's, PIFU, Virtual, IPC etc.
- Various improvement programs have been implemented to increase outpatient activity
- Changes to clinic templates within sub-specialities to maximise number of appointments
- Project underway to ensure all activity is captured under the correct area
- Review of staffing within outpatients to meet current demand
- Recruitment (particularly consultants and therapists)

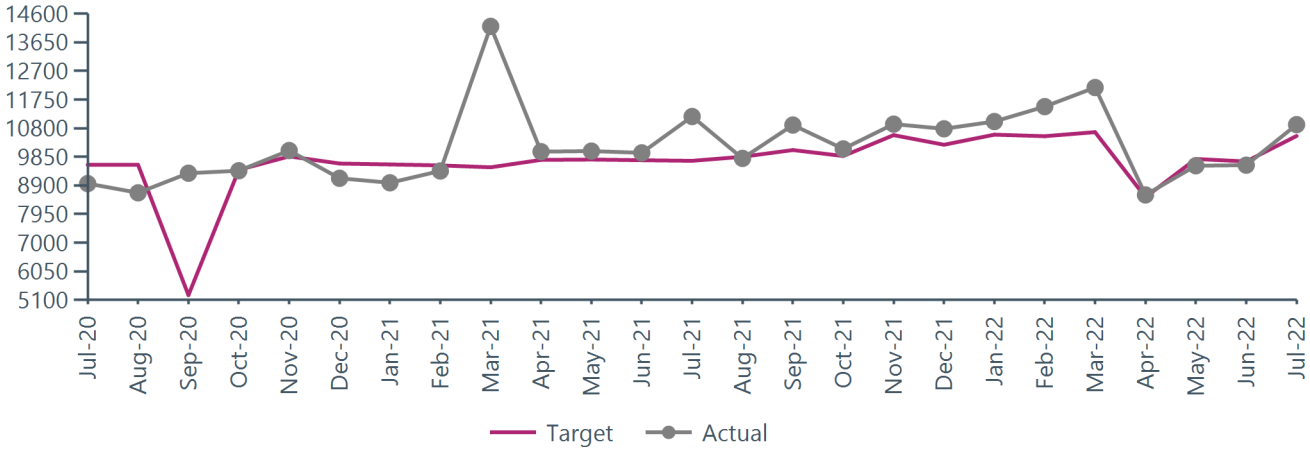
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
13244	12978	14765	12914	14599	11804	12469	11619	13672	11761	14213	12376	11924

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
10,542	10,918	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Income £112k adverse excluding pass through income (offset in expenditure):
- NHS Clinical Income adverse driven by activity
- Other income adverse (Research, Car Parking & TSSU)

Partially offset by :
- ERF rule change favourable
- Private Patient recovery favourable
- Coding review favourable

Actions

Ongoing Private patient activity recovery

Delivery of NHS activity against plan.

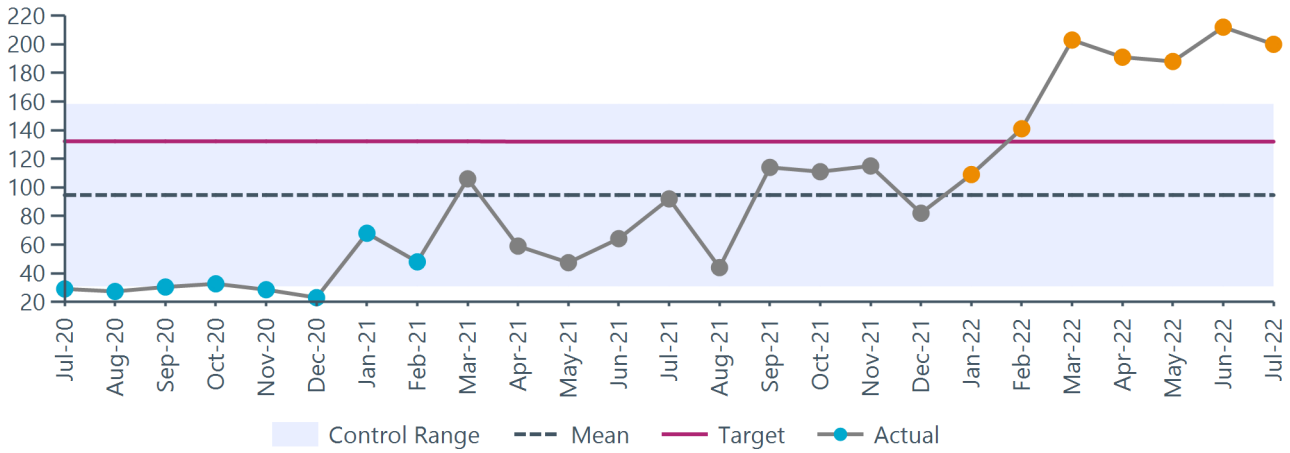
Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
11188	9797	10905	10113	10935	10780	11021	11516	12150	8585	9554	9573	10918

Agency Core

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency only 216336

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
132	200	H	?



Trajectory

What these graphs are telling us

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

Narrative

Core agency above cap driven by Covid absences, recruitment slippage and escalation beds open to support system pressures.

Actions

Request to de-escalate beds through system - reduction from 4 to 2 beds.
Reinforced agency approval procedures and oversight.
Recruitment plans for nursing, HCA's and consultants.

Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
92	44	114	111	115	82	109	141	203	191	188	212	200

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

Performance Against Plan £'000s

Category	Annual Plan	In Month Position			22/23 YTD Position			Forecast Position		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	112,919	9,430	9,277	(153)	33,961	33,819	(142)	112,919	112,284	(635)
Covid-19 Funding	1,411	118	118	0	470	470	0	1,411	1,414	3
Private Patient income	5,868	442	547	105	1,893	1,636	(258)	5,868	5,868	(0)
Other income	6,653	552	653	100	2,203	2,381	178	6,653	6,741	88
Pay	(76,490)	(6,404)	(6,480)	(76)	(25,285)	(25,283)	1	(76,490)	(76,552)	(62)
Non-pay	(43,804)	(3,619)	(3,597)	23	(13,158)	(13,191)	(33)	(43,804)	(43,449)	355
EBITDA	6,558	519	518	(1)	84	(168)	(253)	6,558	6,306	(252)
Finance Costs	(7,962)	(662)	(652)	10	(2,587)	(2,516)	70	(7,962)	(7,710)	252
Capital Donations	3,300	484	324	(160)	1,987	1,220	(767)	3,300	3,300	0
Operational Surplus	1,896	341	190	(151)	(516)	(1,465)	(949)	1,896	1,896	0
Remove Capital Donations	(3,300)	(484)	(324)	160	(1,987)	(1,220)	767	(3,300)	(3,300)	0
Add Back Donated Dep'n	632	52	50	(2)	202	201	(1)	632	632	0
Control Total	(772)	(91)	(84)	7	(2,301)	(2,484)	(184)	(772)	(772)	0
EBITDA margin	5.2%	4.9%	4.9%	0.0%	0.2%	-0.4%	-0.7%	5.2%	5.0%	-0.2%

Statement of Financial Position £'000s

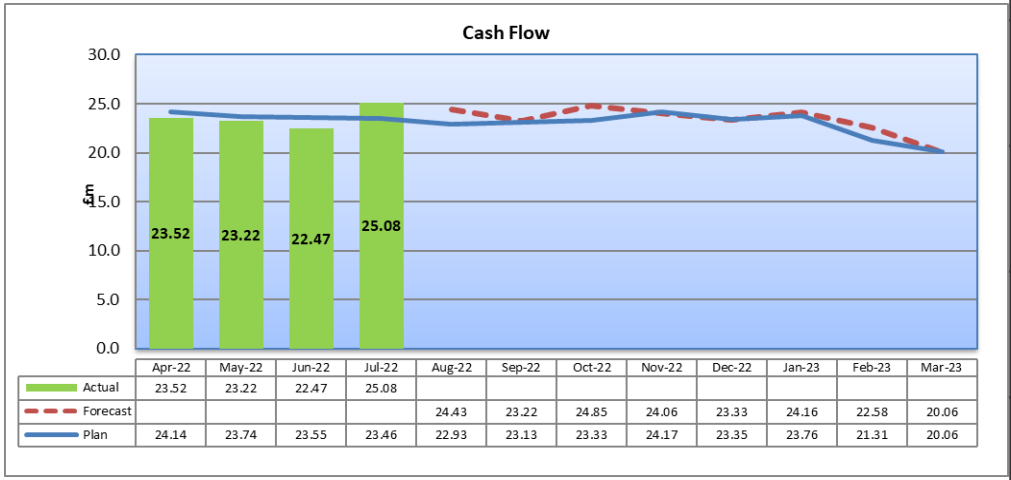
Category	Jun 22	Jul 22	Movement	Drivers
Fixed Assets	90,092	90,031	(61)	
Non current receivables	1,363	1,188	(175)	Higher than normal RTA/CRU withdrawals.
Total Non Current Assets	91,455	91,219	(236)	
Inventories (Stocks)	1,273	1,289	16	
Receivables (Debtors)	6,678	6,694	16	
Cash at Bank and in hand	22,470	25,081	2,611	Phasing of plan driving increase in cash in addition to: lump sum cash received from HEE (deferred income), cash received on account from Headley Court donation.
Total Current Assets	30,421	33,064	2,643	
Payables (Creditors)	(18,776)	(21,009)	(2,233)	Increases in HEE deferred income, cash received on account from Headley Court and accrued payables.
Borrowings	(2,017)	(2,021)	(4)	
Current Provisions	(336)	(336)	0	
Total Current Liabilities (< 1 year)	(21,129)	(23,366)	(2,237)	
Total Assets less Current Liabilities	100,747	100,917	170	
Non Current Borrowings	(4,740)	(4,734)	6	
Non Current Provisions	(1,046)	(1,032)	14	
Non Current Liabilities (> 1 year)	(5,786)	(5,766)	20	
Total Assets Employed	94,961	95,151	190	
Public Dividend Capital	(36,354)	(36,354)	0	
Retained Earnings	(30,598)	(30,598)	0	
Revenue Position	1,655	1,465	(190)	Current period deficit
Revaluation Reserve	(29,664)	(29,664)	0	
Total Taxpayers Equity	(94,961)	(95,151)	(190)	

Finance Metrics (NHS Oversight Framework)

Financial efficiency - variance from efficiency plan	
Financial stability - variance from break-even *	
Agency spending	

* Subject to system position through IFP arrangements

	YTD
Debtor Days	20
Creditor Days	60

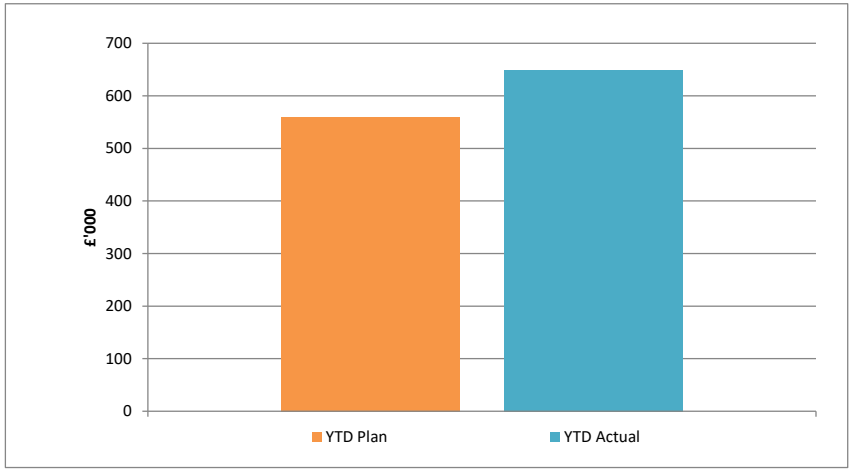


	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	23.52	23.22	22.47	25.08								
Forecast					24.43	23.22	24.85	24.06	23.33	24.16	22.58	20.06
Plan	24.14	23.74	23.55	23.46	22.93	23.13	23.33	24.17	23.35	23.76	21.31	20.06

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

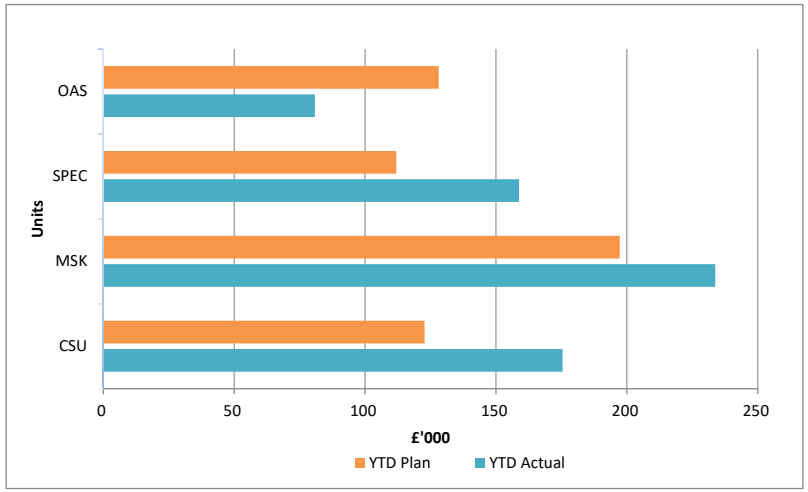
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's



Capital

Position as at	2223-04	Capital Programme 2022-23						
Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
Backlog maintenance	350	20	0	20	45	63	-18	350
I/T investment & replacement	300	10	0	10	20	0	20	300
Capital project management	130	11	10	1	42	42	0	130
Equipment replacement	750	50	14	36	100	14	86	750
Diagnostic equipment replacement	920	0	-3	3	390	246	144	920
IPC & safety compliance	360	80	95	-15	210	158	52	600
EPR planning & implementation	4,500	1,000	3	997	1,000	3	997	4,500
Invest to save	200	0	0	0	50	0	50	200
Enhanced staff facilities	500	0	0	0	0	0	0	500
Additional theatres x 4 (replace barns)	3,000	0	0	0	0	0	0	3,000
Leases (IFRS16)	149	0	0	0	0	0	0	149
Veterans' facility	3,200	484	324	160	1,962	1,220	742	3,200
Veterans' facility (HEE)	0	0	0	0	0	2	-2	58
Donated medical equipment	100	0	0	0	25	0	25	100
Contingency	500	0	0	0	0	11	-11	202
Total Capital Funding	14,959	1,655	443	1,212	3,844	1,760	2,084	14,959
Veterans' facility	-3,200	-484	-324	-160	-1,962	-1,220	-742	-3,200
Donated medical equipment	-100	0	0	0	-25	0	-25	-100
Capital Funding (NHS only)	11,659	1,171	119	1,052	1,857	540	1,317	11,659

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	7 September 2022
Executive Sponsor:	Stacey Lea Keegan, Interim Chief Executive	Paper Category:	Governance
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 the Board and what input is required?

The Board is asked to ***consider and approve*** the proposed risks for the Board Assurance Framework (BAF) aligned to the objectives agreed at the meeting on 4 May 2022.

2. Executive Summary

2.1. Context

The Board of Directors uses the BAF as tool to ensure effective management of any risks which have potential to impact on delivery of the Trust strategy.

The Board agreed new objectives for 2022-23 on 4 May 2022 and the project initiation documentation for these objectives was presented to the Board on 8 June 2022. As part of this work and through Executive Team discussions headline risks for 2022-23 have been identified and the Board Assurance Framework for 2021-22 has been reviewed for closure or carry forward of risks (where still relevant).were identified and approved by the Board in June 2022.

The Executive Team worked through these and have made considerable revision to the proposed list of risks. These were approved by the Executive Team on 11 August and further work undertaken to align these to the objectives and outline the controls and assurances. The Executive Team reviewed and approved the attached BAF on 6 September 2022.

2.2 Summary

The Board Assurance Framework is presented for approval with ongoing review and update via the relevant Committees going forward ahead of submission to the Board of Directors.

Where risks have previously been identified but removed from the BAF, it does not mean that it is no longer a risk that requires action it means that it is a risk that no longer has potential to impact on the delivery of the Trust's objectives. These risks will continue to be managed through the Trust's risk management processes.

For ease of reference the source of assurance ratings used in the BAF are as follows:

Level 0 – It has not been possible to obtain assurance
Level 1 – Assurance obtained at departmental level
Level 2 – Assurance obtained at organisational level i.e supported by HR, Finance etc
Level 3 – External assurance has been obtained through audit / inspection processes

2.3. Conclusion

The Board is asked to:

- Consider and approve the BAF for 2022-23

Board Assurance Framework 2022-23

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

The risks to delivery of the Trust's objectives are detailed on the Board Assurance Framework and presented at Appendix One. Each objective has an identified Assurance Committee for oversight and onward assurance to the Board.

Risk	Headline Risk	Linked Objective(s)	Assurance Committee
1	Effectiveness of engagement with the workforce	1,2,3,4,5	People Committee
2	Workforce capacity and capability	1,2,3,4,5	People Committee
3	ED & I capacity and capability	1,2,3,4,5	Quality and Safety Committee & People Committee
4	Community Infection Prevalence	1,5	Quality and Safety Committee
5	Insufficient capacity to meet demand	1,3,5	Quality and Safety Committee & Finance Planning and Digital Committee
6	IT capacity and functionality to support new ways of working	1,2,3,4,5	Quality and Safety Committee & Finance Planning and Digital Committee
7	Cyber risk	1,3,5	Finance Planning and Digital Committee
8	Constrained resources (incorporating system investment restrictions)	1,2,3,4,5	Finance Planning and Digital Committee
9	Delivery of year on year efficiencies and productivity gains	1,2,3,4,5	Finance Planning and Digital Committee
10	Compliance with strategic oversight framework	1,4,5	Audit and Risk Committee

Board Assurance Framework 2022-23

Appendix One: Extracted risks from the Board Assurance Framework for consideration of the People Committee

Effectiveness of engagement with the workforce NEW — BAF 1

If the engagement with the workforce is not effective there is a risk that opportunities for improvement and innovation will be missed and staff morale will deteriorate with potential to result in loss of staff. Engagement can be hampered by the prioritisation of operational and clinical duties and there is potential for there to be insufficient time given to managers and clinical staff working together.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	3	1
Total	16	12	4

Risk Details:

Opened:	August 2022
Reviewed Date:	September 2022
Source of Risk:	Risk assessment
Corporate Risk Register	

Controls:

- ✓ Rolling half days
- ✓ Monthly Trust Management Group meeting to include Clinical Leads
- ✓ Staff briefing open to all staff
- ✓ Appointment of COO and strengthened operational team
- ✓ Ward / department buddying by Executive Team
- ✓ Communications and engagement strategy – do we have one?
- ✓ Six monthly back to the floor events / virtual visits – still happening?
- ✓ Leadership training and bite-sized modules for wider organisation
- ✓ Performance framework in place
- ✓ Weekly update from CEO
- ✓ Comms bulletin
- ✓ Q&A sessions with members of the Executive Team
- ✓ Staff networks
- ✓ Awards/Health Heroes
- ✓ Freedom to Speak up initiative
- ✓ 'Chats with Harry'
- ✓ Exec and NED board day walkabouts

Assurance: **Source of Assurance** **3**

- ✓ Medical Advisory Committee overseeing engagement with management
- ✓ Regular updates to People Committee and the Board
- ✓ NHSE Quarterly System Review Meetings
- ✓ Staff Survey
- ✓ NHS Oversight Framework
- ✓ Oversight from People Committee
- ✓ Health and Safety Committee oversight of staff health

Gaps In Controls:

C1: Staff experience group not established – consider shared governance model
C2: Quality Forum has not adequately replaced MDCAM
C3: Schwartz Centre Rounds
C4: Staff Survey action plan and communications

Gaps in Assurance:

Lack of real-time measure of workforce engagement levels (all staff)
Responding to staff concerns in a timely manner

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Staff Experience Group not established	Chief People Officer	Oct-22	First meeting will be scheduled for October and Terms of Reference will be drafted for agreement at the first meeting.
C2	MDCAM to be re-established	Trust Secretary / Chief Medical Officer	Oct-22	Agreement has been reached that these should be re-established. Dates being scheduled for the rest of the financial year.
C3	Schwartz Centre Rounds	Chief Nurse & Patient Safety Officer	Dec-22	Two new facilitators are being appointed.

Board Assurance Framework 2022-23

C4	Staff survey action plan to be re-visited and communication plan is being agreed to encourage responses to 2022 survey	Chief People Officer	Oct-22	

Exec Lead	Lead Committee
Chief People Officer	People Committee

Board Assurance Framework 2022-23

Workforce Capacity and Capability CARRIED FORWARD FROM 2021-22 **BAF 2**

Inadequate succession planning and talent management resulting in gaps in levels of expertise. Risk to staff morale resulting in increased turnover. Inability to increase activity safely to meet national targets resulting in further regulatory scrutiny. Poor patient experience and potential patient safety risks. This risk is impacted by potential reduced opportunities for international recruitment due to Covid and lack of a sustainable workforce model. Lack of innovative roles reduces the quality of staff being attracted to the organisation

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	2
Likelihood	4	4	2
Total	16	16	4

Risk Details:

Opened: April 2021

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment plans to target vacancy hotspots
- ✓ Sickness absence management
- ✓ Staff turnover monitoring
- ✓ Leadership training to support effective management and engagement of staff
- ✓ Business Continuity Plans
- ✓ KPI in place for overtime hours by unit
- ✓ IPR includes breakdown of activity for IJP & OJP at point of delivery
- ✓ Recruitment timeline KPIs
- ✓ Vacancy rates by professional staff group
- ✓ Nursing associate roles now in training
- ✓ Nursing strategy on a page

Assurance: **Source of Assurance** **3**

- ✓ Performance report
- ✓ Safe staffing audits
- ✓ People Committee oversight
- ✓ Agency usage monitoring
- ✓ Independent review of e-rostering
- ✓ Turnover and sickness absence rates

Gaps In Controls:

C1: Lack of emergency planning and resilience resource
C2: Nursing strategy implementation Nov 22
C3: Unit level workforce plans aligned to operational activity
C4: PDR compliance
C5: Exit interview completion and themes
C6: Sickness themes
C7: Review of flexible working and flexible working offering
C8: Supernumerary and supervised staff not counted within establishment

Gaps in Assurance:

A1: Alignment of workforce to optimise capacity
A2: Workforce plan monitoring triangulated with activity and quality
A3 Succession plan
A4 Talent management strategy
A5 CPD gaps and allowance of time
A5: Recruitment process assurance -line of sight on milestones
A7: Escalation process for staffing rota concerns

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	EPRR resilience review	Chief Operating Officer	Nov 22	Short term internal options are being explored alongside longer-term options for an ICS wide solution
C2	Nursing strategy implementation	Chief Nurse and Patient Safety Officer	Nov 22	Nursing associates rolled out with second cohort recruited and in training
C3, C4, C5, C6, C7, C8	Workforce Task and Finish Group to be set up and chaired by CPO and CN&PSO. To include full establishment review of wards.	Chief Nurse and Patient Safety Officer and Chief People Officer	Sep-22	Update and recommendations presented to People Committee in August 2022.
A1-A7	Review of workforce assurance	Chief People Officer	Sept 22	Additional resource has been brought in to support the review

Exec Lead

Chief People Officer

Lead Committee

People Committee

Board Assurance Framework 2022-23

EDI Compliance, delivery, accountability and leadership **CARRIED FORWARD FROM 21-22** **BAF 3**

Potential for non-compliance with statutory and regulatory requirements. Poor staff experience impacting on staff morale and lack of inclusion, sickness absence and turnover. Inability to improve staff survey results. Potential for health inequalities to not be addressed impacting on patient experience.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	3
Likelihood	4	4	1
Total	16	12	3

Risk Details:

Opened: April 2021

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ ED&I Committee members taking ownership to drive the agenda forward
- ✓ Appointment of Chief of People and Culture Officer
- ✓ NHS Standard Contract requirements
- ✓ System transformation work (includes consideration of health inequalities)
- ✓ EDS 2022 self-assessment and action plan (in progress)
- ✓ Annual ED&I Workforce report and annual report – includes WRES and WDES
- ✓ 'It's Just Cricket' (BAME), LQBTQIA+ Friends & Womens Network
- ✓ Accessible Information Standards- regular reviews
- ✓ PLACE assessments
- ✓ ED&I training (ICS) and Veteran Awareness training
- ✓ Data quality improvement plan including ethnicity and deprivation index
- ✓ Menopause awareness

Assurance: **Source of Assurance** **3**

- ✓ Staff surveys
- ✓ NHSE oversight/ NHS Oversight Framework
- ✓ People Committee
- ✓ System People Board and establishment of a System People Committee
- ✓ Executive lead in place both for patients and staff
- ✓ ED&I Committee oversight
- ✓ WRES, WDES and EDS 2022 returns
- ✓ Bi-annual report on health inequalities (includes digital exclusion)

Gaps In Controls:

C1: Sustainable ED&I resource to be identified and secured

C2: Health inequalities working group

C3: Talent Management

Gaps in Assurance:

A1: Effectiveness of ED&I Committee

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	~~Dec 20~~ Mar 22	Completed – Internal Audit undertaken and presented to People Committee with associated action plan
C1	ED&I resource to be secured	Chief of People	~~May 21~~ ~~Apr 22~~ ~~Jun 22~~ Oct 22	Internal audit undertaken and action plan developed.
A1, C3	Refresh of ED&I Committee	Chief of People	Sept 22	Meeting in September of Interim Chief People Officer / Director of Governance and Chief Nurse
C2	Health inequalities working group to be established	Chief Nurse and Patient Safety Officer	Oct 22	

Exec Lead

Chief People Officer

Lead Committee

People Committee and Quality & Safety Committee

Board Assurance Framework 2022-23

Community Infection Prevalence (NEW) — **BAF 4**

Impact on staff absence, increased potential for covid outbreaks, adverse impact on patient safety and patient experience, reputational damage, additional regulatory scrutiny, impact on the capacity of the IPC Team

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ External support from NHSE/I
- ✓ Alignment to Clinical Governance from 1 April 2022
- ✓ Investment in the team
- ✓ IPC Governance role established
- ✓ Quality Management System
- ✓ IPC Task Group led at Executive Level
- ✓ IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review
- ✓ Senior IPC/ Deputy DIPC recruited in partnership with Shrop Comm
- ✓ Increased staff training programme
- ✓ Learning from previous SI's – actions completed
- ✓ Compliance with Covid guidance
- ✓ Sickness policy and communication
- ✓ Risk assessments
- ✓ Flu campaign
- ✓ Covid booster

Assurance: **Source of Assurance** **3**

- ✓ IPC Quality Assurance Committee
- ✓ Increased committee reporting
- ✓ NHSE/I oversight of IPC improvement plan
- ✓ External clinical governance review with focus on IPC commissioned
- ✓ People Committee oversight

Gaps In Controls:

C1: Completion of IPC action plan
C2: Community prevalence (outside of Trust's control)

Gaps in Assurance:

A1: EPRR desktop scenarios and testing business continuity plans

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Progress with improvement action plan	Chief Nurse	Oct 2022	Reported through IPC Quality Assurance Committee
A1	EPRR desktop scenarios and business continuity plan testing	Chief Operating Officer	Nov 22	Short term internal options are being explored alongside longer-term options for an ICS wide solution

Exec Lead

Chief Nurse and Patient Safety Officer

Lead Committee

Quality and Safety Committee / IPC Assurance Committee

Board Assurance Framework 2022-23

Insufficient core capacity to meet demand CARRIED FORWARD FROM BAF 21-22 **BAF 5**

Inability to restore activity levels to that provided pre-Covid resulting in increasing waiting times and poor patient experience. Regulatory and system scrutiny and loss of reputation.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	4	1
Total	16	16	4

Risk Details:

Opened: November 2020

Reviewed Date: September 2022

Source of Risk: Corporate Risk Register

Controls:

- ✓ Demand and capacity modelling at local level
- ✓ Monitoring of efficiency KPIs
- ✓ 6-4-2 implemented
- ✓ Recovery programmes in place for Outpatients, Theatres and Diagnostics
- ✓ Weekly tactical restart activity meeting
- ✓ Key restoration of capacity KPIs
- ✓ Weekly meetings for management of delayed discharges
- ✓ Daily dashboards
- ✓ Outpatient room usage report in place

Assurance: **Source of Assurance** **3**

- ✓ Monthly Performance Improvement Board oversight
- ✓ Inpatient Survey Performance
- ✓ System and regulatory oversight
- ✓ Internal audit regarding job planning
- ✓ Patient Experience Committee oversight
- ✓ Finance, Planning & Digital Committee oversight
- ✓ Outpatient Transformation Board restored
- ✓ STW Planned Care Delivery Board Oversight
- ✓ System Governance Framework
- ✓ Integrated Performance Reporting
- ✓ Consultant annual leave reporting through People Committee

Gaps In Controls:

C1: Lack of line of sight on system demand and capacity requirements
C2: Potential for Gaps in job planning and governance processes to ensure full capacity utilised
~~C3: Clear leadership for discharge planning~~
C4: Impact on capacity of increasing complexity of cases due to increased waiting times
~~C5: Lack of line of sight on use of Trust infrastructure (theatres/op rooms) utilisation~~
~~C6: Ward staffing establishments aligned to theatre activity planning~~
C7: Implementation of current job planning policy

Gaps in Assurance:

~~A3: Key performance indicator of job plans reviewed and in date required.~~

N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Development of a system orthopaedic PTL	~~Chief Performance Officer~~ Chief Operating Officer	~~Sep 21~~ ~~Nov 21~~ Sept 22	DPIA completed and awaiting sign off following which the system orthopaedic PTL will go live, this is being led by the System.
C3	Review of leadership for discharge planning with clear escalation structure to be articulated and actioned	Chief Nurse	~~Jul 21~~ ~~Oct 21~~ Nov 21	Completed
C4	Establish reporting on impact of complexity and consider mitigating actions	Chief Medical Officer	~~Jul 21~~ ~~Oct 21~~ Jan 22 Overdue	Complexity review underway with focus on long waiters and P2 patients and establishing the average case per session for these patients. Update to go to Q&S after going through Clinical Effectiveness

Board Assurance Framework 2022-23

				Committee – first meeting of refreshed Clinical Effectiveness Committee has taken place
A3	Creation of KPI's in relation to job planning to be added to people committee IPR.	Chief Performance Officer	Dec 21	Completed
C5	Regular reporting in place of room and theatre usage at room and theatre level	MD for Support Services	Dec 21	Completed
C6	Deep dive triangulating nursing, activity, bed numbers commissioned	Chief Nurse and Chief Performance Officer	Feb 22	Completed – deep dive presented to People Committee in January 22 and recommendations being actioned.
C7	Conversations to take place around review of job plans	Chief of People / MDs	Mar 22	Good progress made with conversations around job plans and being tracked through Trust Performance Board – action can be closed
C7	All job plans to be signed off by e-job planning	Chief Medical Officer	Ongoing	Tracking of this to be looked at so that there is line of sight

Exec Lead

Chief Operating Officer

Lead Committee

Finance Planning and Digital Committee

Board Assurance Framework 2022-23

IT capacity and functionality to support new ways of working NEW — BAF 6

Impact on roll out of EPR, inability to adapt to emerging requirements, opportunities of the system constrained by finances, inability to progress with compliance with accessible information standard resulting in inadequately meeting patient needs and poor patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital Steering Group in place for operational delivery
- ✓ Sub groups as created by Digital Transformation Board to oversee delivery of EPR implementation
- ✓ Programme plan in place
- ✓ Outpatient processes to identify and flag patient needs before admission
- ✓ Accessible Information Working Group established
- ✓ Translation and interpretation services available

Assurance: **Source of Assurance** **3**

- ✓ ICS Digital Strategy Board
- ✓ Digital Transformation Board oversight reporting to FPD Committee
- ✓ Oversight of Accessible Information Group and Patient Panel

Gaps In Controls:

C1: EPR Solution in development to address accessible information standard compliance but not in place

Gaps in Assurance:

A1: Monitoring of additional patient needs to ensure services and facilities are suitable to meet the needs of patients

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Accessible Information Group / Patient Panel to recommend monitoring metrics	Chief Nurse	Dec 2022	
C1	Progress with EPR Solution	Director of Digital	Ongoing	Programme in place with monitoring via Digital Group and FPD

Exec Lead

Chief Medical Officer

Lead Committee

Quality and Safety Committee & Finance Planning and Digital Committee

Board Assurance Framework 2022-23

Cyber Security NEW — BAF 7

Potential for cyber attack impacting on systems and processes required for delivering patient care, information governance breach, poor patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	4
Likelihood	4	4	2
Total	16	16	8

Risk Details:

Opened: August 2022

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Digital Steering Group in place for operational delivery
- ✓ SIRO, DPO and Caldicott Guardians in place
- ✓ DPIAs in place for all systems and register of data flows
- ✓ Business Continuity Plans in place
- ✓ Security policies and equipment in place
- ✓ Proxy servers to limit downloads and access
- ✓ Penetration testing
- ✓ Staff training
- ✓ CISSP professional training undertaken
- ✓ Back up processes in place

Assurance: **Source of Assurance** **3**

- ✓ Information Governance Committee in place with oversight from Audit Committee
- ✓ NHS X oversight
- ✓ Data Security Toolkit submissions

Gaps In Controls:

N/A

Gaps in Assurance:

N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress

Exec Lead

Chief Medical Officer

Lead Committee

Finance Planning and Digital Committee

Board Assurance Framework 2022-23

Constrained resources (incorporating system restrictions) NEW — **BAF 8**

Unable to take forward necessary and identified improvements, inability to comply with quality risk appetite /tolerance, reduction in standards of care and patient experience

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: August 2022

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Case of need business case process
- ✓ Finance BP support for Units
- ✓ Offsetting efficiency / funding stream identification
- ✓ System plan to improve financial position
- ✓ IPC escalation successful

Assurance: **Source of Assurance** **3**

- ✓ SLG Oversight
- ✓ Finance Planning and Digital Committee oversight
- ✓ Investment Panel within ICS
- ✓ Scrutiny at organisation, system and regional level of delivery of the financial plan
- ✓ QEIA process in place

Gaps In Controls:

- N/A

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress

Exec Lead

Chief Finance Officer

Lead Committee

Finance Planning and Digital Committee

Board Assurance Framework 2022-23

Delivery of year on year efficiencies and productivity gains NEW **BAF 9**

Non delivery of financial plan, additional regulatory scrutiny, impact on MSK Programme to include impact on financial viability and inability to design required admin processes

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	3
Likelihood	4	4	2
Total	20	16	6

Risk Details:

Opened: August 2022

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Finance BP support for Units
- ✓ Offsetting efficiency / funding stream identification
- ✓ Cost improvement schemes identified
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Tracking of theatre productivity
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews
- ✓ Agency controls in place

Assurance: **Source of Assurance** **3**

- ✓ SLG Oversight
- ✓ Finance Planning and Digital Committee oversight
- ✓ Scrutiny at organisation, system and regional level of delivery of the financial plan
- ✓ QEIA process in place
- ✓ Monitoring of CIP delivery via performance meetings
- ✓ QIPP monitored by RJAH and CCG at contract meetings

Gaps In Controls:

- C6: Slippage on cost improvement programmes

Gaps in Assurance:

A1: Reset of Big Ticket Item Governance at ICS level

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Embedding of ICS Governance – in relation to efficiency delivery	Chief Finance Officer	Ongoing	

Exec Lead

Chief Finance Officer

Lead Committee

Finance Planning and Digital Committee

Board Assurance Framework 2022-23

Compliance with Strategic Oversight Framework — **BAF 10**

Failure to satisfy NHSE criteria, continued breach of licence and SOF3, increased regulatory scrutiny, reputational damage

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	5
Likelihood	4	3	1
Total	20	15	5

Risk Details:

Opened: August 2022

Reviewed Date: September 2022

Source of Risk:

Corporate Risk Register

Controls:

- ✓ External support from NHSE (Improvement Director)
- ✓ IPC Governance role established
- ✓ Quality Management System - IPC dashboard
- ✓ IPC Improvement Plan in place which incorporates well led improvements identified in the IPC Governance Review
- ✓ Senior IPC/ Deputy DIPC recruited in partnership with Shrop Comm
- ✓ Temperature checks using sustainability tool for IPC improvements
- ✓ Identification of gaps against NHS Oversight Framework
- ✓ CQC action plan and Niche well led review action plan
- ✓ CQC engagement meetings

Assurance: **Source of Assurance** **3**

- ✓ IPC Quality Assurance Committee
- ✓ NHSE oversight and support for delivery of IPC improvement plan
- ✓ Self-assessment against undertakings monthly
- ✓ Formal improvement review meeting with NHSE monthly
- ✓ Formal NHSE IPC reviews to assess compliance against IPC standards
- ✓ IPC standing agenda item at Trust Board
- ✓ Self-assessment against strategic oversight framework completed and submitted
- ✓ Regulatory Oversight Group

Gaps In Controls:

- C1: Improvement action plan to be completed
- C2: Awaiting GGI recommendations
- C3: Executive Team oversight of gaps against NHS Oversight Framework
- C4: CQC stakeholder engagement

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Completion of improvement action plan – meeting undertakings and continuation of IPC improvement plan and sustainability	Chief Nurse and Patient Safety Officer	Oct 22 and Mar 23	Good progress is being made and regular update meetings with NHSE continue.
C3	Delivery of actions in support of moving to segment 2 of NHS Oversight Framework (ambition of segment 1)	Assistant Chief Executive	Oct 22	Gap analysis agreed with Executive Team and leads assigned to metrics.
C4	CQC stakeholder engagement plan	Chief Nurse and Patient Safety Officer	Nov 22	Plans include staff briefings, mock inspections, CQC inspector visits and briefings to Trust Management Group and Board

Exec Lead

Chief Nurse

Lead Committee

Quality and Safety Committee / IPC Quality Assurance Committee

Chair's Assurance Report
Quality and Safety Committee 21 July 2022

0. Reference Information

Author:	Olivia Evans, Executive Assistant	**Paper date:**	7 September 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	2 September 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Quality and Safety Committee meeting held on 21 July 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The Committee was quorate.
- The Committee received the standard agenda items which included the SI and Never Events paper, a Unit quality report, the Harms presentation, and the performance report.
- The Committee approved Getting to a Health Weight SOP.
- Areas to highlight to the Board include:
    - The Uniform Policy has been updated and implemented.
    - Speech and language provision has been added to the risk register.
    - Inpatient ward falls have been consistently off target and work is ongoing to investigate potential causes for this e.g. lack of joint school or physiotherapy sickness therefore patients attempting to mobilise themselves without assistance.
    - One case of C.Diff in June, associated with antibiotic usage.
    - Zero Serious Incidents reported in June.
    - One surgical site infection (SSI) reported in June and a Post Infection Review (PIR) taking place.

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 21 July 2022. The meeting was quorate with 2 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:		
Present:	Chris Beacock	Non-Executive Director (Chair)
	Martin Newsholme	Non-Executive Director
	Penny Venables	Non-Executive Director
	Paul Kingston	Non-Executive Director
	Ruth Longfellow	Chief Medical Officer
	Stacey Keegan	Chief Executive
	John Pepper	Non-Executive Director
In Attendance:	Kirsty Foskett	Head of Clinical Governance & Quality
	John Pepper	Associate Non-Executive Director
	Nicki Bellinger	Assistant Chief Nurse
	Tracy Slater	Assistant Director of Quality, ICB
	Nia Jones	Head of Planning
	Jacqueline Barnes	Director of Improvement
	Heather Pickering	Executive Assistant – Minute Secretary
	Karen Hunter	Good Governance Institute
	Jenny O'Connor	Shropshire, Telford and Wrekin CCG
	Teresa Jones	Research Manager
	Ian Gingell	Health and Safety Officer
Apologies:		
Shelley Ramtuhul, Sara Ellis-Anderson, Ibrahim Roushdi and Dawn Forrest.		

3.2 Actions from the Previous Meeting

The Committee discussed the action plan in detail and an update was provided for each action. There were 0 actions noted as outstanding a forwarded on to the next meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
PV noted themselves as a NED from the BDA.		
2. CNO and CMO Update		
Covid-19 is still present in the community. Weekly risk assessments being undertaken and face masks reinstated in certain areas.	Y	

Updated Uniform Policy has been implemented.	Y	
Speech and language provision in the Trust is insufficient and has been placed on the risk register.	Partial	Mitigation plan in development with SaTH.
Concerns have been raised as to the provision of physiotherapy for orthopaedic patients due to sickness and vacancies within the team.	N	
Concerns also raised in relation to staff shortages overnight due to short notice cancellations from agency staff.	N	
3. Performance Report		
Slight amendments to IPR: - "Total deaths" as replaced "Unexpected deaths". - WHO documentation has been removed from IPR.	Y	
Inpatient falls consistently off target. Potentially driven by the lack of Joint School and lack of inpatient physiotherapists therefore patients trying to mobilise with no assistance.	N	Falls Lead is looking specifically are falls in bathrooms and mitigating actions.
Complaints response rate continues to be off target.	N	
One case of C. Difficile in June associated with antibiotic usage.	Y	
One surgical site infection reported in June and a post infection review is due to be undertaken.	Partial	
One unexpected death which was bought to serious incident panel. Confirmed as not a serious incidents however root cause analysis underway.	Partial	RCA will confirm learnings from death.
Cancellations continue to be off target.	N	
4. Clinical Services Quality Report		
102 incidents reported consisting of 59 no harm, 32 low harm and 11 moderate.	Partial	
Therapies manager is on long term sick leave therefore NB is working closely with Therapies team in his absence for support.	Y	
Recruitment drive taking place within physiotherapy to mitigate the use of bank and agency.	N	Full Therapies service review is planned to commence on 1st September 2022.
There are both capacity and income issues with Research which need addressing.	N	
5. Operational Planning Framework		
E-Rostering attainment level of 0 against a national standard of 4. This is due to the new system embedding and is anticipated to be up to standard shortly.	Partial	
Currently non-compliant against 2 monthly clinical reviews for elective patient standards.	N	

6. CQUIN Update Q1		
Out of 9 CCG CQUINS, 6 have been agreed as relevant to RJAH. More detail will follow at future meetings.	Y	
7. Serious Incidents and Never Events		
Zero serious incidents reported in June 2022. Never Event from 2021 has now been closed following approval from ICS. Really good improvements made in month with 20 actions completed and only 2 actions overdue which are being reviewed daily.	Y Y Y	
8. Harms Presentation		
Of cohort 1, 2259, 23 were defined as moderate harm with 2 requiring an RCA. Cohort 2 has begun with 1100 patients. Harms reviews in discussions for becoming business as usual given the high number of waiting list backlogs.	Y Y	
9. Quality Priorities		
VTE – Progressing well with monitoring of compliance against new policy to begin in quarter 3 and 4. End of Life & RESPECT – Working ongoing and linking in with local hospices to receive specialised end of life training and care.	Y Y	
10. Learning from Deaths Report		
3 deaths within quarter 1. 1 death taken to serious incident panel who confirmed as not a serious incident. Discussions surrounding deaths are had at Mortality Steering Group.	Y	Further information surrounding deaths required in future papers.
11. Legal Claims Update		
Clinical negligence claims: 2 closed in quarter and 8 remain open. Employee liability: 1 closed in quarter and 5 remain open.	Y	
12. Research Committee Chair Report		
The Committee noted the chair report.	N/A	
13. Trust Performance and Operational Improvement Board Chair Report		
The Committee noted the chair report. A decision was made for the chair report to be presented at FPD moving forward.	N/A	
14. Patient Safety Committee Chair Report		
The Committee noted the chair report.	N/A	
15. Health and Safety Committee Chair Report		
The Committee noted the chair report.	N/A	
16. Medical Devices Committee Chair Report		
The Committee noted the chair report.	N/A	
14. Review of the Work Plan		
The Committee noted the workplan.	N/A	
15. Attendance Matrix		
The Committee noted the attendance matrix.	N/A	

3.4 Approvals

Approval Sought	Outcome
Getting to a Healthy Weight SOP	Approved

3.5 Risks to be Escalated

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

4. Conclusion

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

0. Reference Information

Author:	Dr James Neil	Paper date:	7 September 2022
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety 21/07/2022	Paper Ref:	N/A
Forum submitted to:	Board of Directors - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report was presented to the Quality and Safety Committee in July 2022.

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

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

Deaths are reported through the Board of Directors.

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

MSG report discussed at Patient Safety Committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

See Numbers Below.

2.3. Conclusion

No Concerns identified.

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes/Family feedback.	Actions
April 2022	0	0	0	0	No theme/Feedback	None required
May 2022	2	2	0	0	No theme/Feedback	None required
June 2022	1	Awaited: (RCA in progress)	0	0	RCA awaited	

3.3. Associated Risks

None

3.4. Next Steps

Discussions in progress with SaTH concerning a link with their Medical Examiner and Bereavement system. DPIA done but outstanding IG clarification still awaited. This service likely to commence autumn 2022.

Learning from Deaths lead now working as a Medical Examiner at SaTH.

Learning from Deaths lead at RJAH now attends Mortality steering group at SATH.

Also attends Shropshire Learning from Deaths group and West Midlands Learning from Deaths forum (currently west midlands only due to staffing issues at ICS in Shropshire).

3.5. Conclusion

No concerns identified.

Appendix 1: Acronyms

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report

Infection Control & Prevention Quality As

0. Reference Information

Author:	Mary Bardsley	**Paper date:**	7 September 2022
Executive Sponsor:	Chris Beacock and Sara Ellis Anderson	**Paper written on:**	1 September 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Infection Control & Prevention Quality Assurance Committee meeting held on 11 August 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

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

2.2 Summary

- The meeting was well attended and quorate
- The Committee received all agenda items noted within the Committee workplan
- The Committee asked for the meetings to be scheduled up to March 2022, where a formal effectiveness discussion will be held
- Good progress was noted across all action plans
- The Exit Strategy target date remains at the end of September/beginning of October

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Infection Control & Prevention Quality Assurance Committee which met on 11 August 2022. The meeting was quorate with 3 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Paul Kingston	Non-Executive Director
Martin Newsholme	Non-Executive Director
Stacey Keegan	Interim Chief Executive
Sara Ellis-Anderson	Interim Chief Nurse & Patient Safety Officer
In Attendance:	
Susan Sayles	IPC Nurse Specialist
Shelley Ramtuhul	Trust Secretary/Director of Governance
Ian Maclennan	Assistant Chief Nurse for MSK Unit
Apologies:	
Kirsty Foskett, John Pepper, Penny Venables, Ruth Longfellow, Jacqueline Barnes.	

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.

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	Assurance Sought
Declaration of Interest		
There was no declaration of interests shared.	N/A	
IPC Live Data Dashboard		
The following key highlights were presented: ▪ The programme of works is now 81% complete. ▪ 13 criteria are on plan/in progress. ▪ 1 outstanding criteria ▪ Publishing of the revised Covid-19 BAF is imminent and will then need to be reassessed, ▪ IPC Covid audits have been suspended and merged with existing audits. Key themes are cleanliness of the environment and equipment cleanliness, including the labelling of clean equipment. ▪ The new IPC support worker has delivered 24 sessions trust wide on subjects including bare below the elbow and hand hygiene.	Yes	

There was a query regarding a potential solution for the SSI data collection, and how rapidly this may be able to be in place. The Trust reported that the case of need is currently being drafted and confirmation have been received regarding the access to upfront capital spend, however there are some ongoing discussions around the implications of the upkeep costs. It was noted this would be expedited where possible.		
IPC Quality Report		
The following key highlights were presented: ▪ 1 case of E coli, 1 case of C difficile, 1 case of MSSA ▪ SSI figures: 3 hips, 2 spines, 0 knees. A thematic review has been undertaken. ▪ Outbreaks: 4 are noted in the report but this figure has since risen to 5, involving Powys, Clwyd, Kenyon, theatres, implant room and admissions team. Key lessons have been circulated. ▪ Quality Assurance Walks have taken place during July on Kenyon, Gladstone and Clwyd. ▪ IPC training compliance- currently at 87% with hand hygiene training and 62.5% hand hygiene competencies. ▪ Patient feedback is very positive, the exception is feedback regarding outpatient seating. There was a query regarding whether the MRSA cases are showing that RJAH has an issue with nursing MRSA positive patients. The Trust noted it is a concern. The circumstances in this case were a unique combination that have resulted in the outbreak. Following a discussion, the Trust noted there was scope for looking at possibilities for further provision of showering facilities in this area. The Trust discussed the importance of staff being confident to challenge others regarding the Bare Below the Elbow campaign. It was queried whether there was a visitor IPC protocol. The Trust confirmed all visitors to MCSI are educated around hand hygiene and instructed to remain in one area of the ward where possible.	Partial	
IPC Improvement Plan		
Following a review of the action plan in July, the actions have increased from 67 to 82 of which 49 are complete, 28 are in progress and 2 actions have not commenced. There are 3 currently behind plan which are linked to the microbiology SLA. There will be a continued focus on IPC training although the Committee noted the vast improvements made by the team. Following a discussion, the Trust noted all actions do not need to be completed to 'exit' the plan. A self-assessment of the undertakings has been completed and shared with NHSE; therefore, the target date remains the beginning of October. The Trust confirmed launching the IPC strategy is a current key focus point. It was noted the sustainability of the strategy is key to ensuring ways to maintain the momentum amongst staff will be the focus when the inspectorate have left.	Yes	
IPC Hygiene Code Gap Analysis		
The code of practice sets out 10 criteria, with 250 elements which the CQC and Regulators will monitor the Trust against.	Yes	

The Trust undertake a self-assessment every quarter with this paper presented to the IPC Committee in July. Overall compliance increased to 96% due to the actions taken on the IPC Improvement Plan. Next steps are an independent review carried out by an external body to provide the Trust with additional assurance, this is planned for quarter 3. It was queried whether all Trusts undertake this process, and if so whether there is benchmarking available. The Trust confirmed other organisations do complete this, but there isn't a pass mark. Due to the live and rolling nature the document it was thought 100% compliance was unlikely to be achievable within any Trust.		
IPC Q1 Report		
The following key points were highlighted: ▪ First case of c-difficile, patient treated with antibiotics for a chest infection subsequently developed c-difficile. The patient responded to treatment but relapsed taking him over the 30 days, counting as a second case. ▪ Klebsiella bloodstream infection. PIR showed the infection to be 'unavoidable' – lessons learnt were circulated. ▪ Surgical site infections include, 4 total hips, 4 total knee, 1 spinal. Outlier letter has been received for the 4 total hips from NHSA. It was noted that revisions are not separated out in these figures - it could be the revision surgeries (which carry greater risk of infection) are the reason for the high numbers. It was noted it would be worth separating these figures out if possible. ▪ 4 covid outbreaks ▪ 15 Quality Assurance Walks completed. Key themes raised are storage, cleanliness of equipment, floors and inappropriate items in shower rooms. ▪ 2 new staff have joined the IPC team ▪ IPC fair was well attended ▪ Hand hygiene posters have been circulated The Trust is now reduced to amber on NHSE matrix	Yes	
One Together Action Plan		
There are a total of 66 actions - good progress was noted following a review of the action plan. The Trust agreed to expedite the outstanding policies using the One Together resources which include an assessment tool. A specific challenge around medical engagement was noted, this is hoped to be resolved by September when annual leave is less frequent. There was a query regarding how the criteria scored as green are evidenced. The Trust noted much of the criteria were audited as part of the One Together programme. There was a query regarding how newly reviewed policies are followed up to ensure they are being appropriately implemented. The Trust noted all policies have an implementation and monitoring section which sets out the process. The oversight of compliance would then sit with the author of the policy.	Yes	

Chair Report from IPC Committee		
The Committee met on 26/07/2022 and the following key points were highlighted: ▪ VIP scoring has arisen as a theme so spot check audits will be completed in this area. ▪ A significant number of policies have been approved through the committee, so policies are now within their review dates.	Yes	
Committee Workplan		
The Committee reflected upon the work plan. It was noted that the meetings have been scheduled until October 2022, this is to be extended until March 2023.	Yes	
Attendance Matrix		
The attendance matrix is shared with the Committee for information only	N/A	
AOB		
The following items were shared with the Committee for information only: ▪ IRM presentation (July 2022) ▪ Undertakings Self-Assessment Both documents have been presented to NHSE within July and no risks/concerns have been noted to escalated to the Board.	N/A	

4. Conclusion

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

0. Reference Information

Author:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	7th of September 2022
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	5th of August 2022 updated on 31st August 2022
Paper Reviewed by:	IPC Quality Assurance Committee	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

RJAH was escalated to Red on the NHSE/I IPC Matrix in August 2021. Following a visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance and therefore the Trust has been moved into SOF 3 of the single oversight framework and issued with enforcement undertakings. The Trust has an IPC improvement plan in place with seven exit criteria.

2.2. Summary

- Review of improvement plan and evidence in July saw overall number of actions increasing from 67 to 82
- As of the 31st of August:
  - 2 actions behind plan (a reduction of 1 since 5th of August)
  - 56 actions complete (an increase of 7 since 5th of August)
  - 23 actions in progress with clear action owners and timescales
  - 1 action not started - this relates to the planned formal inspection in September.
- Of the 23 actions in progress (12 due for completion in September, 4 in October, 2 in November, 2 in December and 3 in April 2023)
- All actions have priority status assigned
- Formal letter received from NHSE following the IPC visit on the 22nd of June, acknowledging the outcome of the visit and improvements made, meaning that the Trust has now moved from red to amber on the NHSE IPC matrix
- Monthly self-assessment of progress against undertakings presented at NHSE Improvement Review Meetings. (appendix one)
- Next steps regarding formal assessment against undertakings outlined in section 3.2.3

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

On the 22nd June 2022 there was a formal IPC review from NHSE, the trust received a formal letter acknowledging the outcome of the visit and significant improvements made, meaning that the Trust was moved from red to amber on the NHSE IPC matrix a further visit and formal IPC review from NHSE is planned for September 2022 with a focus on demonstrating sustainability of the improvements made to date.

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

3.2. IPC Improvement Plan

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

In response the IPC improvement plan has been developed to ensure actions are embedded trust wide and improvements are sustained. The plan has been developed to include all actions and recommendations from various sources.

The IPC improvement plan has been split in to nine themes. A review of the IPC improvement plan completed in July 22 saw a total of 67 actions increasing to 82. The themes and actions have been aligned to overarching seven objectives (exit criteria).

Table 1: Overview of progress against actions IPC Improvement Plan on 31/08/2022

No.	Objective (Exit Criteria)	Not Started	Behind Plan	In Progress	Complete	Total
1.	Evidence of board assurance, senior leadership, and delivery of actions	0	0	3	3	**6**
2.	Trust staff have the necessary improvement skills to sustain improvement	0	1	2	13	**16**
3.	Trust IPC audits demonstrate improvement	0	1	12	21	**34**
4.	Trust reporting on HCAIs, outbreaks and SSIs	0	0	3	17	**20**
5/6.	Improvement in external IPC inspections	1	0	0	2	**3**
7.	Agreement between regulators, commissioners and the System that there is evidence of significant progress and confidence in the Trust leadership Team	0	0	3	0	**3**
	Total	**1**	**2**	**23**	**56**	**82**

The final two columns on the improvement plan describes the evidence required to close the action and methods of ongoing assurance. A priority column has been added to determine the priority status of each action – this will be reviewed monthly at IPCC as priorities may be subject to change. Associated risk numbers for each of the high priority actions are also referenced within the plan.

There are currently two actions behind plan:

No	Priority	Area for Improvement	Target completion date	Accountable Exec	Responsible Lead	RAG status
2.2	High	Review microbiology provision and update of current SLA	30/07/2022	Chief Nurse	Dawn Forrest	Red
5.7	Medium	Install glass doors on Kenyon and Gladstone	30/07/2022	Chief Nurse	Phil Davies	Red

- The microbiology SLA update was provided to the executive team on 2/8/22 – SaTH have been unsuccessful in appointing into the team – this is being escalated by COO to COO conversation.
- Installation of doors has been delayed due to estates access to the areas and is being reviewed weekly at IPCWG.

There continues to be a focus on IPC training with the report being produced every 2 weeks, whilst there has been significant improvements the areas of focus remain physical assessment of hand hygiene competency across all disciplines.

SSI surveillance needs to be expanded across all specialties, Foot and Ankle surveillance commenced 1st of August 2022. The IPC team are working with IT to enable interim solutions whilst a case of need is written for implementation of ICNet or other digital solution.

3.2.1. Key successes and achievements in July/August

- NHSE visit to Theatres, Baschurch and High Dependency Unit showed continued improvement and good staff engagement (see appendix two)
- Sustained improvement in General environmental IPC audits
- Sustained improvement in Hand Hygiene and BBE audits
- Hygiene Code of Practice gap analysis reviewed with overall increased compliance from 92% to 96%
- Introduction of After Action Review learning sets following outbreaks to facilitate timely shared learning across the organisation
- IPC quarterly dashboard summary developed and supported revised format of quarterly IPC report to board.
- Successful re-launch of IPC champion role
- IPC NHSE masterclass delivered to Clinical Leads
- Agreement signed with ShropComm for deputy DIPC to commence in post 19th of September

3.2.2. Next Steps for September/October

- Targeted focus on improvement in staff training for IPC with for Hand Hygiene assessment
- Continued estates improvement – Clwyd ward sink replacement
- Cleanliness resource implementation – Housekeeper posts to be recruited to on open day 12th of September
- IPC Summit with launch of IPC strategy due in early October
- Final self-assessment against undertakings with evidence collection in progress
- Sustainability questionnaire to be sent to all staff week commencing 5th of September as a temperature check across the organisation
- Formal NHSE IPC inspection 26th of September with assessment against the NHSE IPC escalation matrix

During September and October there are a series of actions that will take place to assess the progress made for the undertakings. Formal assessment will culminate in a 3 way Board to Board with NHSE, RJAH and the STW ICS on 27th October 2022

- Prior to this date, the following will take place:
    - Sustainability tool assessment — 5th of September
    - NHSE formal IPC review — 26th September
    - ICB assurance review and visit — End of September/Beginning of October
    - Review of ongoing plan for IPC delivery — End of September
    - Review of on going support required — End of September
    - NHSE desk top review of evidence — Mid to 27th October

3.3. Associated Risks

Risks to be escalated:

- Microbiology provision and impending retirement of Consultant Microbiologist
- Digital capability to support increased SSI surveillance

IPC Improvement Plan

3.4. Conclusion

The Trust has now moved to AMBER on the NHSE Midlands Infection Prevention and Control escalation matrix. A further follow up inspection is scheduled with NHSE in September 2022, focusing on sustainability of the improvements that have been made.

The improvement plan will continue to be monitored through internal IPCC, IPC Quality Assurance Committee with system oversight at the STW System Quality Group. The Trust Improvement Plan is being used to track evidence delivery for the undertakings. A monthly review meeting has been established with NHSE and ICS members.

During September and October there are a series of actions that will take place to assess the progress made for the undertakings. Formal assessment will culminate in a 3 way Board to Board with NHSE, RJAH and the STW ICS on 27th October 2022

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

Appendix 1: Acronyms

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

NHS England Midlands

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

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

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

30 August 2022

Dear Sara,

NHS England Visit 28 July 2022

I would like to thank you for organising the review visit of the Trust Theatre department on 28 July 2022. This visit was part of the informal review process, as such we did not review the Trust against the NHSE Midlands Infection Prevention and Control (IPC) internal escalation matrix. Following the visit on 22 June the Trust were moved to **AMBER** on our matrix the Trust remains at amber at this time. Across the day we visited Baschurch, High Dependency Unit (HDU) and Theatres.

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

I would like to pass my thanks to the teams who were happy to show us around their areas, share the improvement works that have been undertaken and identified the areas that they are now working on, the engagement across the teams was evident throughout the day. At the end of the visit, Trust level feedback was provided to yourself, the Trust Medical Director, Improvement Director, estates and facilities team and IPC team.

Below is a summary of the key findings shared on the day. Generally, there was improvement noted across the organisation and within each area that was visited throughout the day. Improvements were identified with the levels of engagement across the organisation and across the multidisciplinary team.

Key areas of improvement identified:

- Estates work:
    - Flooring has been completed in parts of the theatre department
- Wipe clean keyboards are now in place in the theatre suite, this is an improvement from the previous visit, and it was noted that the keyboards were clean.
- The lead gowns were reported to be cleaned daily, this was evidenced with clinell strips and observed to be clean at the time of the visit.
- The stock levels within the theatres have improved since the previous visit and similarly there was a vast improvement noted in the storage areas in Baschurch.
- We observed that the portering team were not wearing gloves to push the beds through the hospital on this visit, as a result we also observed an improvement in the hand hygiene for this staff group as they were able to effectively decontaminate their hands at the correct times.

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

- We observed fewer staff wearing theatre hats and scrubs outside of the theatre areas, I am aware that work is ongoing to address this as part of the new uniform policy which has now been signed off.
- PPE use needs continued work, this included one of the theatre support workers wearing a singular glove.
- The open bin frames were observed to be clean, however the wheels had started to rust, these were only three months old, we discussed the need to review the product and consideration of leaving them upside down to dry so as the cleaning product does not pool around the wheels.
- Further estates works are needed in the theatre, the Trust is aware of this and have reviewed the feasibility in undertaking the works whilst theatres remain functional, this was not a feasible option and the full works will need to be planned in to minimise the disruption to the organisation. The works that have been done have been completed to a high standard, however there is a large refurbishment required, especially to the recovery room. In the meantime, there is work required in the recovery sluice to fix box work and in the “bridge store” to add wall protection for the rolling shelves.

- The suction unit on the resus trolley was observed to have the single use items in sealed packaging, this is an improvement from previous visits and was observed on all of the areas visited. However, the suction units were all set up in the recovery area, I would recommend that there is a risk assessment completed on this as staff report that it is a requirement and that it would be a greater risk if it was to be assembled at the point it was required.

Key themes where improvement is still required:

- Attention to detail when cleaning, including underneath chairs, high levels and ensuring that all items are moved for cleaning. In addition to this, the underneath of the paper towel dispensers and soap dispensers required further attention. Consideration is required as to whether the teams have the correct attachments and equipment to easily access all areas that require cleaning.

- There is attention to detail needed for the underneath of the equipment, for example there was blood identified on the base of the Allen table in the theatre corridor, the underneath of the silver trolley in theatre 10, the frame of the couch in the consultation room on Baschurch and the underside of the bedtable in bed space 1 in HDU. There was dust identified under the transfer trolley in HDU, staff reported that a new cover is on order for the transfer trolley. In addition to this there was a stained mattress cover identified on Baschurch that requires disposal and the Bair Hugger pipe had an unexplained substance that was easily removed with a wipe but was labelled as “clean”.

- There were waste bags observed to be attached to the side of the anaesthetic trollies, these waste bags are right next to the sharp’s bins on the side of the trolley. It was noted that the bags were stuck with tape making cleaning the surfaces more difficult. There were bins available to the anaesthetist to safely dispose of waste and following a discussion with one of the anaesthetists in the department they did not identify any concerns with disposing of their waste directly into the waste bins. The Theatre team had also reported needlestick/sharps injuries because of sharps “missing” the sharps bin and ending up in the waste bag.

- A new patient wash trolley is required for theatre recovery and the old one requires disposal.

Next Steps

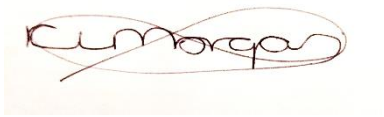
The next full review will be completed at the end of September 2022 and will assess against the NHSE IPC escalation matrix and the exit criteria for the undertakings. This will include a full documentation review, with documents to be shared at least two weeks prior to the visit.

We have delivered the IPC roles and responsibilities session to the clinical leads, if this would be deemed useful a logical next step of the engagement process could be to do a walkthrough the site with the clinical leads to show them what to look for when they are visiting. In addition, we could look to deliver a similar session to the therapy staff and AHP leads. Please let me know if this is something that you would like me to deliver this and we can arrange a suitable date.

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

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

Yours sincerely,



Kirsty Morgan
Assistant Director of IPC – Midlands

NHS England

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

NHS England
Cardinal Square
10 Nottingham Road
Derby
DE1 3QT

22 August 2022

Dear Mr Turner,

Re: Robert Jones Agnes Hunt NHS Foundation Trust Improvement Review Meeting held 28 July 2022

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

The second IRM took place on 28 July 2022. As co-Chairs of the meeting, we write to share the discussions held and any actions agreed as the formal record of the meeting.

1. Actions from the previous meeting

There was one open action from the previous meeting relating to the clinical review report performed by the Good Governance Institute. It was explained this this report has been delayed because fieldwork is not due to be completed until the end of August. We understand that initial verbal feedback is expected in August and the full report due to be presented to the Board in September.

2. Delivery update

Colleagues from RJAH provided a comprehensive update on the delivery of the improvement plan. The presentation was helpful and effectively articulated the status of the improvement plan, with just one action being behind plan, which related to the Tendable IPC Ward to Board reporting. Work is in place to address this action.

Key achievements were shared which included: training performance; IPC audit compliance; the updated uniform policy; and the business case approval for the £440k investment for 15.2 WTE housekeepers and deep cleaning team.

The update also included the recent MRSA outbreak; and whilst this in itself was disappointing, we were pleased to hear of the positive response that had been taken from the team, including the quick response and identification of learning, including the potential for sharing regionally. We noted the risks, challenges and focus for the next month and are supportive of the Trust's approach.

3. Self-Assessment Against Undertakings and Exit Criteria

Colleagues from RJAH completed a self-assessment against the undertakings and exit criteria. This was the first time that the self-assessment had been undertaken and it was deemed a useful exercise, which will continue on a monthly basis.

The self assessment was positive, with an assessment of good progress being made against three of the nine undertakings; and six reported as good progress but with further improvements required. For one of these areas, a risk was noted in relation to the timeframes for procuring a digital solution to fulfil the reporting of the voluntary Surgical Site Infection (SSI) rates. This could potentially mean that this action isn't completed by the target exit date, with the timeframe likely to extend beyond September due to both logistical and funding requirements. Reporting these rates would put the Trust in an exemplar position, all mandatory SSI's are reported currently. An interim solution is being investigated.

It was also agreed that where undertakings were self-assessed as not current/live actions on the tracker, for example the escalation meetings, that action was already being taken and the self assessment next month would be adjusted to reflect this.

ACTION: Self assessment to be amended to reflect the additional activity.

4. System Update

The following system updates were given:

- The AMR and IPC system groups are now in place;
- Further consideration is needed to ensure that the ring is held at a senior enough level;
- Confident that with the new ICB structure has the right system oversight arrangements in place;
- There is a keenness to focus on how to share and disseminate the learning.

5. Support identified / actions

As outlined above, the self assessment will be amended to reflect the additional activity.

6. Next Steps

Jacqueline Barnes outlined her initial thoughts on the process for reviewing the evidence and undertakings during September and October. It was agreed a meeting would be arranged for further discussion with Fran Steele, Oli Newbold, Alison Bussey and Kirsty Morgan to schedule a timeline for the reviews required and to agree how the formal assessment of the progress made for the undertakings would best take place.

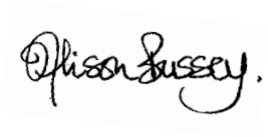
ACTION: Jacqueline Barnes to arrange the meeting to agree the timeline and process for the formal assessment of progress made for the undertakings.

Jacqueline Barnes also suggested the use of a Sustainability Tool, possibly to be used as a temperature check across the organization for how embedded and owned the IPC work is. One had been sourced from NHS England's Improvement Team. It was agreed that this would be discussed with colleagues at RJAH and brought back to the next meeting to present how it would be used.

ACTION: Jacqueline Barnes to arrange to meet RJAH colleagues to agree how the sustainability tool would be best used and present at the next meeting.

Once again, this was an encouraging meeting and it is great to see the positive approach that is being taken by the Trust to the undertakings**.** In advance of the next meeting, we will consider the process up until the end of September, which is the potential exit date.

Yours sincerely,



Fran Steele
Director of Strategic Transformation
North Midlands

Alison Bussey
Chief Nurse
STW Integrated Care System

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

NHS England

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

NHS England
Cardinal Square
10 Nottingham Road
Derby
DE1 3QT

30 August 2022

Dear Mr Turner,

Re: Robert Jones Agnes Hunt NHS Foundation Trust Improvement Review Meeting held 25 August 2022

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

The third IRM took place on 25th August 2022. As co-Chairs of the meeting, we write to share the discussions held and any actions agreed as the formal record of the meeting.

1. Actions from the previous meeting

- Self-assessment amendments – noted as complete and covered separately in the meeting.
- Meeting for the formal assessment progress against the undertakings – confirmed a formal final IRM is arranged for 27th October.
- Use of the sustainability tool – confirmed that the NHSE sustainability tool has been adapted to relate to the IPC work. Noted this is due to be launched at the beginning of September for all staff and will be repeated quarterly.

2. Delivery update

Colleagues from RJAH once again provided a comprehensive update on the delivery of their IPC Improvement Plan.

As of 5th August, 3 actions are behind plan but are making progress; 49 are complete (an increase of eleven since 14th July); 28 actions are in progress with clear actions and timescales. 2 actions have not yet started, these relate to the new estates action following the June NHSE visit and the planned formal inspection by NHSE in September.

Key achievements were shared which included: continued reduction in surgical site infections; continued improvement on IPC training; hand hygiene and bare below elbow and environmental audits remaining above the 95% target.

Updates were provided on the Powys Ward refurbishment with a planned reopening of the ward on 12th September and recruitment to the housekeeper and deep cleaner roles that are in progress.

It was noted that the MRSA outbreak was re-opened following identification of a fourth acquisition of a colonisation case. Following further monitoring, this outbreak closed on 23rd August with no further transmission identified.

The risks, challenges and focus for next month were noted, which includes the next NHSE formal inspection on 26th September.

Stacey-Lea Keagan finally updated that the clinical governance review being conducted by the Good Governance Institute continues to progress. The site visits have now taken place and the final report is expected mid-September. This is planned to go to the October Trust Board meeting.

ACTION: Clinical governance review report to be shared when available.

3. Feedback from NHS England IPC Visit 28th July

Kirsty Morgan provided verbal feedback on her IPC review on 28th July of theatres, the Baschurch day unit and the high dependency unit (HDU).

Kirsty reported that the visit was positive overall. Within the theatres she had seen good improvements including wipeable keyboards and improved storage. There are some outstanding estates work e.g. the recovery room, but noted it is not feasible to undertake these works currently due to operational impact. Kirsty observed good practice from staff in terms of hand hygiene and stock management. Some areas of improvement were noted in relation to cleaning areas that weren't visible e.g. underside of trollies; this was also the case for Baschurch and HDU. It was noted that the business case for extra housekeeping staff will provide more capacity for cleaning. Improvements to the storeroom, patient areas and linen trollies were noted within Baschurch. Kirsty recommended that when there is further new build, to make sure that the plans include sufficient storage space. The formal feedback letter will be issued imminently.

Kirsty Morgan and Fran Steele also carried out an informal visit on 22nd August. This informal visit was also positive; and Fran highlighted the good practice of housekeepers involved in the daily ward huddles. An incident of an agency member of staff wearing a watch was observed, but this was effectively challenged and agency induction arrangements are to be strengthened, which could be developed with SaTH. Alison also suggested that clinical placement facilitators should ensure that Universities are aware of the bare below elbow policy for placement students, following an incident with a student who was unaware of the policy.

ACTION: IPC visit letter to be issued asap.

ACTION: Ensure agency and student placements aware of IPC policy.

4. Trust Self-Assessment Against Undertakings and Exit Criteria

Colleagues from RJAH completed their second self-assessment against the undertakings and exit criteria. The self-assessment had been updated in line with the action from the last meeting to reflect the additional activity. Further suggestions were also noted to make the process more effective, which included: having previous self

assessments within the same file; clearly capturing activity undertaken this month and planned for next month; and developing the risks column to include mitigations and scoring.

ACTION: Self-assessment to be developed to include previous months assessments; current months activity; next month's activity; and risk mitigation and scoring.

5. System Update
Alison Bussey and Jacqueline Barnes are having conversations on support for the Trust as the NHSE support reduces. Alison and Nick White are planning to visit the Trust October. Visit details to be agreed.

ACTION: Support arrangements to be confirmed.

ACTION: Alison Bussey and Nick White to visit the Trust in October.

6. NHSE process and timescales for formal review of progress against the undertakings

It has been agreed that the following will take place in advance of the formal final IRM with NHSE, RJAH and the STW ICS on 27th October 2022:

- Sustainability tool assessment with staff at RJAH	Start of September
- NHSE formal IPC review	26th September
- ICB assurance review and visit	During October
- Review of ongoing plan for IPC delivery	End of September
- Review of ongoing support required	End of September
- NHSE desk top review of evidence	Mid to 27th October.

ACTION: Desk top review process details to be agreed by NHSE and shared wider.

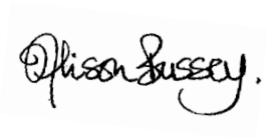
ACTION: Formal final IRM with NHSE, RJAH and the STW ICS to take place on 27th October 2022

7. Support identified / actions
None identified.

6. Next Steps
As outlined above.

The co-Chairs thanks the RJAH executive team for their ongoing progress in IPC imporvements.

Yours sincerely,



Fran Steele
Director of Strategic Transformation
North Midlands

Alison Bussey
Chief Nurse
STW Integrated Care System

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

0.0 Reference Information

Author:	IPC Team E&F Team	Paper date:	7th of September 2022
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	IPC Quality Assurance Committee	Paper Ref:	
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Annual Report provides assurance in terms of compliance with the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008). The Board is asked to approve the annual report.

2. Executive Summary

2.1. Context

The Annual Report provides assurance in terms of compliance with the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008).

2.2. Summary

In 2021/22 the IPC Team continued to adapt in response to the extraordinary COVID-19 circumstances since 2020. The department has worked hard to maintain robust measures and implement the precautions expected in order to keep our staff, patients and visitors safe.

In synchronicity, the department is proud to show another year of improvements in the continuing campaign to reduce avoidable Health Care Associated Infections (HCAI) at the RJAH Orthopaedic NHS Foundation Trust (See figure 1).

The following HCAIs were reported for 2021/22 with further details provided throughout the report:

- 3 C.*difficle* infections
- 1 MSSA
- 3 E.coli
- 2 klebsiella

Ten COVID-19 outbreaks and one MRSA outbreak were declared for 2021/22 (see pg. 32)

There were 34 surgical site infections reported for 2021/22 (see pg. 27)

Figure 1

2.3. Conclusion

The Board is asked to approve the annual report

3. The Main Report

3.1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of Healthcare Associated Infection (HCAI) in the organisation for which she is responsible and release it publicly according to the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008). The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes the activity of the Infection Prevention and Control Team (IPCT) during the year, including progress made against the work plan and targets identified in the Infection Prevention and Control Annual Programme. It also includes performance against key areas in Infection Prevention & Control. Ward specific audits are reported on a monthly basis through Trust wide key performance indicators (KPI's).

The Trust has maintained low infection rates. We ensure ongoing monitoring and surveillance of all infections, as well as regular monitoring of ward and department level practices. During an unprecedented year we continued to focus on delivery of safe, high-quality services for our patients, underpinned by robust business management. A key focus area for the Trust is the Infection, Prevention and Control Improvement plan. Following an MRSA outbreak during the Summer 2021, which involved eight hospital acquired infections, the Trust continued to work hard to implement changes outlined by NHSE/I. Unfortunately, following a visit in February the Trust were in discussions with the regulators regarding a potential breach of licence. In May 2022 the breach of license was confirmed and Trust were to be moved to segment 3 on the single oversight framework (SOF3). The Trust have implemented a IPC Quality Assurance Committee which reports directly to the Board of Directors to enhance oversight over all aspects of IPC. The Trust is committed to implementing the improvements identified, along with welcoming support from NHSE/I and the System. The Board thank the staff for the continued hard work throughout a challenging time and noted the positive outcomes following the issues identified which has supported a improved direction of change for the organisation. It is important to note that no patients were harmed during the MRSA outbreak.

Health & Social Care Act Code of Practice

The Robert Jones & Agnes Hunt Orthopaedic Hospital has registered with the Care Quality Commission and have acknowledged full compliance with the Health and Social Care Act (2008) Code of Practice (commonly known as the Hygiene Code). A self assessment against the IPC Programme of Works has been undertaken with a planned review in 2022/23.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
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.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Health and Social Care Act Compliance Assessment		
Compliance requirements		RAG (% compliance)
Overall Summary of Compliance		
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	98%
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	91%
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	94%
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	90%
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.	100%
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	100%
7	Provide or secure adequate isolation facilities.	89%
8	Secure adequate access to laboratory support as appropriate.	100%
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	99%
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	100%

Key to RAG rating	
	91-100%
	61-90%
	<60%

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

IPC Structure

The **Chief Executive Officer** has overall accountability for the control of infections at RJAH.

The **Director of Infection Prevention & Control (DIPC)** is the Executive Lead for the IPC service, and oversees the implementation of the IPC programme of work through her role as Chair of the Trust Infection Prevention and Control and Cleanliness Committee (IPCC). The DIPC approves the Annual IPC report and releases it publicly. The DIPC reports directly to the Chief Executive and the board on IPC matters. The DIPC has the authority to challenge inappropriate practice.

The **Infection Control Doctor (ICD)** is the Clinical Lead for the IPC service.

The ICD is employed by SaTH but is contracted by RJAH for four sessions a week to include clinical microbiology advice and reporting, microbiology ward rounds, antimicrobial stewardship and infection prevention and control advice. The ICD:

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

The ICD reports to the DIPC on IPC matters.

The Infection Prevention and Control Team (IPCT)

The Infection Prevention and Control Team (IPCT) are the medical and nursing infection prevention and control specialists responsible for carrying out the work described in the infection control programme of work.

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

- Infection Prevention and Control (IP&C) Lead Nurse: (1 WTE) Band 7
- Infection Prevention & Control Nurse Specialist: (1 WTE) Band 6
- Surgical Site Surveillance Nurse: (0.4 WTE) Band 5
- Infection Control Data Analyst (0.8 WTE): Band 4
- The Infection Control Doctor (0.4 WTE)
- Infection Prevention & Control Modern Apprenice (1 WTE until February 22)

In July 2021, the IPC Data Analyst stepped up into the IPC Governnace Lead role as an interim arrangement. Following commencement in post, the IPC Governance Lead designed a local IPC Quality Management System (QMS) to refine and strengthen governance within the department.

It was highlighted following a full IPC governance review in November 2021 that the QMS must be maintained for contuing assurance and strenghthen governance processes for IPC and therefore a business case was approved to uplift the current Infection Control Data Analyst post to a band 6, Assurance Lead post of 37.5 hr and band 2 Administrative assistant/secretarial post to replace the IPC Apprentice position in February 2022.

In addition to the contracted sessions from the Infection Control Doctor we also have 24hr infection control advice available from the on-call Consultant Microbiologist at SaTH as part of the Pathology SLA.

The Antimicrobial Pharmacist

The Trust employs a part-time Antimicrobial Pharmacist who works closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. The role of the antimicrobial pharmacist includes:

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

Infection Prevention Control Committee

The RJAH Infection Prevention & Control Committee (IPC&C) is a multidisciplinary Trust committee with outside representation from UKHSA and the CCG. The IPCC oversees the activity of the IPCT and supervises the implementation of the infection control programme of work. The IPCC meetings were increased to bi-montly from July 2021, and from February 2022, the frequency of this meeting was increased to monthly for additional assurance and increased oversite at board level.

Attendance at IPCC committee

	Apr 2021	*July 2021*	*Sept 2021*	*Nov 2021*	*Jan 2022*	*March 2022*
DIPC	✓	✓	✓	*apol*	✓	✓
ICD	✓	✓	*apol*	✓	✓	*apol*
IPCN	✓	✓	✓	✓	*apol*	✓
Ass Chief Nurse MSK	*apol*	*apol*	*apol*	*apol*	*apol*	*apol*
Ass Chief Nurse SSU	✓	✓	✓	✓	✓	✓
Ass Chief Of Professions CSU	✓	✓	*apol*	*apol*	✓	*apol*
Antimicrobial Pharmacist	*apol*	*apol*	*apol*	*apol*	*apol*	*apol*
IPC Assurance Lead/Data Analyst	✓	✓	✓	✓	*apol*	✓
Facilities Manager (Estates & Facilities Representation)	✓	✓	✓	✓	✓	✓
Matron (Specialist)	✓	✓	✓	*apol*	✓	✓
Matron (MSK Wards & HDU)	✓	*apol*	✓	*apol*	✓	*apol*
Matron (Theatre & OPD)	✓	✓	✓	✓	✓	✓
Head of IPC SCCG & TW CCG	✓	✓	✓	✓	✓	✓
Clinician Rep	✓	✓	*apol*	✓	✓	*apol*
TSSU Rep	*apol*	*apol*	*apol*	*apol*	*apol*	*apol*
Team Prevent Occupational Health	*apol*	✓	✓	✓	✓	✓
UKHSA	X	X	X	✓	✓	✓

The IPC Programme of Work

The IPC programme of work 2021-22 was specifically designed to focus on achieving full compliance with the standards identified in the Code of Practice, and the achievement of national and local infection related targets. In order to accommodate the fluctuations in guidance and change in processes in the management of COVID-19, the Team opted to adopt an annual plan.

The Trust demonstrated good compliance to the code of practice but further works are required to:

- Increase surgical site surveillance to incorporate all othropaedic specialities.
- Formalised environmental IPC audits of Orthopaedic satelite clinics
- No automated system in place to identify abnormal trends of infections

A Trustwide tender process was undertaken in 2021 for the introduction of a new electronic patient record system (EPR). A fit for purpose system was purchased and will include an alert tagging system for the infection status of patients.

The Trust was unsuccessful in the recruitment of a part time Surgical Site Surviellance nurse. Therefore, further funds were secured in February 2022 to increase the hours to a full time post with a change of title to Surgical Site Surveillance practitioner.

Quality Management System

A bespoke Quality Management system was designed in-house and implemented in July 2021 to strengthen assurance to processes and compliance to national requirements. The system was designed to consolidate all IPC related data and a central space for correlation of themes and trends. The system contains a dashboard providing a live position for IPC governance.

The system has been since expanded to include:

- Policy matrix and review tracker
- Redesigned IPC unit reports linked to the system for auto-population of data. Reports are presented at Infection Control & Cleanliness Committee
- Interactive audit dashboard containing audit scores circulated on a monthly basis to all ward and departmental managers.
- Rolling audit plan to include all IPC Assurance audits
- Live reporting to surgical site infections

Infection Prevention and Control Working Group

Infection Prevention and Control Working Group met on a bi-monthly basis with poor attendance throughout 2021. This group reports to the Infection Prevention & Control and Cleanliness Committee. In February 2022, the frequency of this meeting increased to weekly to align with the IPC&C Committee. Full review of the Terms of reference was undertaken to strengthen attendance. The meeting provides effective communications between Infection Control, operational areas and Estates & Facilities by identifying and resolving issues in line with Trust priorities.

IPC Link Staff System

The Infection Control Link Practitioner group meets bi-monthly to provide advice and support and disseminate information regarding Infection Prevention and Control to their peers within their wards/departments. Link staff, IPC team and the link staff ward/department managers agree to roles and responsibilities which clearly define the expectations of the link staff role.

Link Staff Attendance

In adherence to social distancing requirements, face to face meetings continued to be prohibited in 2021/2022 with virtual meetings held. Attendance to these meetings continued to deteriorate since the beginning of the pandemic due to poor staffing levels in wards and departments, and also difficulties in accessing MS Teams in order to join the virtual meetings. In response to this, the IPC team will be relaunching the Link staff practitioner programme to include roles and responsibilities with additional support in the form of hand hygiene champions.

3.1.2 Criterion 1 b): Monitoring the prevention and control of infection

CQC Assessment/ COVID-19 Board Assurance Framework

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

Two further versions of the BAF were released in 2021/22 with Version 1.7 released in April 2021 (with a revised version in July 21) and version 1.8 released in December 2021 containing 80 new key lines of enquiry (KLOE).

Version 1.7 April & July 2021

Key changes made to version 1.7 focused on compliance to COVID-19 national screening requirements and monitoring of compliance to Personal Protective Equipment (PPE) for staff and patients.

The Trust undertook its first audit in April 21 to assess compliance to the following COVID-19 national screening requirements introduced in 2020.

- 72 hours pre admission swab
- Swab on day of admission
- 72 hour/3 day post admission swab (where applicable)
- 5-7th day swab (where applicable)
- 13th day swab (where applicable)

Results showed good Trust compliance to four of the national screening requirements with exception to the 3 day swab. The Information department developed an automated alert system highlighting due dates for patients swabs. Following implementation, a further audit was undertaken in December 21 where results showed significant improvements to the compliance of the 3 day swab. To provide ongoing assurance, the IPC Governance Lead will continue to audit Trust position to COVID-19 screening compliance and IPC Annual audit programme to be expanded to include twice yearly audits.

Changes made in relation to PPE focused on the compliance of mask wearing for staff and patients in all settings. Early 2021 the Department of Health (DoH) deployed two members of staff to the Trust to assist with fit testing. A Trustwide SOP was introduced to ensure:

- Fit testing is provided for all FFP3 users using at least two different masks (ideally three)
- A range of FFP3 masks to be made available to staff and overall should not exceed 25% usage on any one type of FFP3 mask

FFP3 users and fit test results were also uploaded in ESR with individual usage reviewed every quarter.

Further SOP was introduced for patients wearing surgical face masks (IIR). IPC audits were expanded to monitor compliace to face mask wearing for staff and patients

Version 1.8 December 2021

Changes introduced within this version focused on encouraging Trusts to step down on IPC precautions to assist in the restoration of the services. Further changes included:

- Risk assessments undertaken where deviations in national guidance is adopted.
- Documented risk management process for Trust management of COVID-19
- Review of adequate ventilation requirements
- BAF governance process.

On its release, regional prevalance of the Omicron strain of COVID-19 had increased significantly and therefore Trust made the decision to delay the implementation of the recommendations and continue to enforce high level IPC precautions.

A risk was added to the risk register at the start of the pandemic to include risk to staff, patients and visitors. Risk was separated to align with recommendations made within the BAF.

Eight air scubbers were purchased following a review of ventilation in all areas.

An electronic file system of was set up to store all documented evidence to all KLOEs and hyperlinked to the the framework with a governance tracker added to the BAF to track board level oversite and approval with dates shown below:

Version	Date Review at Infection Control & Cleanliness Committee	Date Presented at Quality & Safety Committee	Date Presented to Trust Board
1.7	April 2021	May 2021	May 2021
1.7	July 2021	September 2021	Nov 2021
1.8	January 2022	March 2022	April 2022
1.8	March 2022		

Progress for the BAF is montored via the IPC Quality Management System and live dashboard data presents Trust position at Infection Control & Cleanliness Committee.

IPC Timeline 2021-22

April 21 – June 21

April 21: Procurement of the SureWash Hand Hygiene device.

May 21: First COVID-19 national swabbing requirement audit undertaken showed good Trust compliance. Guidance poster devised for staff.

June 21: National IPC Guidance released providing support for maintenance of Services and Coronavirus Policy updated to reflect changes.
Implementation of Tendable internal auditing system with staged roll out to all areas.
Introduction of new PHE guidance 'COVID-19: Guidance for maintaining services within health and care settings' The Trust continued to restore elective services across the hospital in conjunction with updated NICE guidance

July – September 21

July 21: IPC Ward & Departmental Audits uploaded to Tendable
Introduction of a bespoke IPC Quality Management System (QMS) to collect all data and monitor assurance.
Redesign of the IPC Quarterly Unit reports to communicate with the QMS
MRSA Outbreak Wrekin Ward. All lessons learnt and recommendations were shared Trustwide for learning.

Aug 21: Audit undertaken by BDO - good feedback received in relation to IPC QMS.

Sept 21: IPC Assurance audit process was enhanced, shifting to a rolling programme of IPC Quality Assurance Walks monitored by the IPC QMS outcome aligned with a robust escalation process. Rise in SSI's reported for April – June period escalated to DIPC/Chief Nurse and MD's. Additional analysis showed majority of infections caused by MSSA.
COVID-19 outbreak Therapies & SOOS. RCA completed. Lessons learned were shared at SNAHP 19th October 2021

October – December 21

Oct 21: Further rise in SSIs reported for July – Sept 21 period. Individual RCAs and thematic analysis completed for each infection.

Dec 21: OneTogether Assessment undertaken as a response to rise in SSIs by the IPC Nurse Specialist
COVID-19 Outbreaks declared on Clwyd, Pharmacy, Gladstone & Sheldon. RCAs undertaken lessons learnt shared at local safety huddles, SNAHP, IPCCWG and IPCC Committee.
Version 1.8 IPC Board Assurance Framework released containing 80 new KLOEs.

January 22 – March 22

Jan 22: COVID-19 Outbreaks declared on Alice Ward, Wrekin Ward & Doctors Residence.

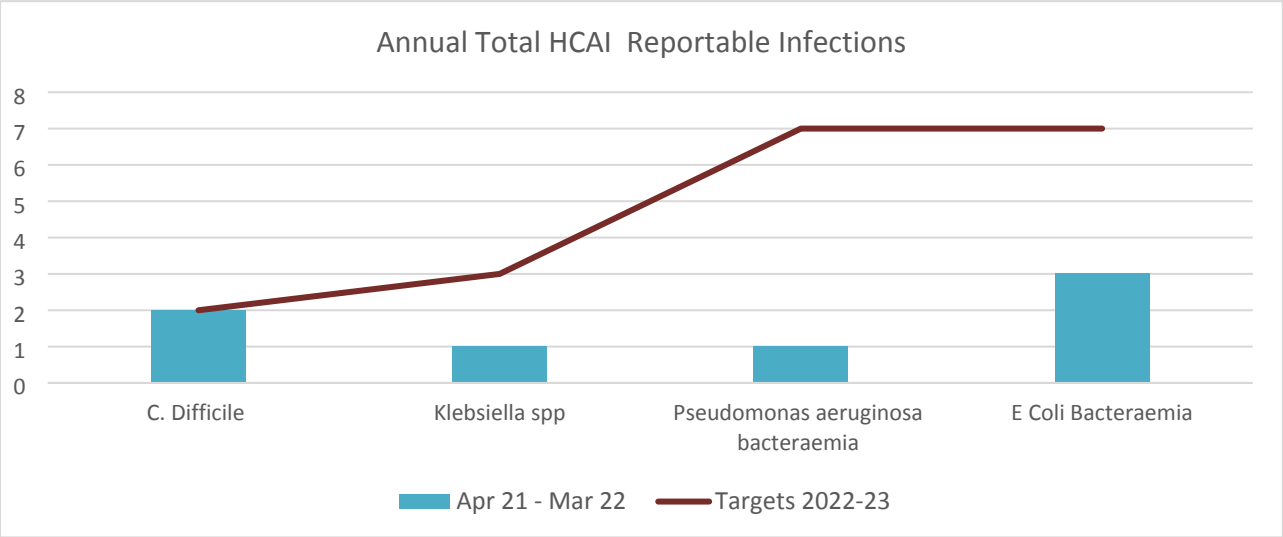
Feb 22: Quality Assurance Walks uploaded to internal auditing software Tendable
Trust agreed to utilise Tendable to centralise actions in response to NHSEI & CCG external visit. Validation exercise undertaken to review all action plans prior to change in process. IPC General inspection audit was used a mechanism to move all open actions onto Tendable.

Mar 22: Shower chair and commode audit undertaken with iems not complying to standards replaced.
SSI Prevention Working Group introduced. Membership from across the surgical pathway and chaired by the MSK Matron. Action plan devised and monitored on a bi-weekly basis. Progress on actions will be monitored through IPCC committee.

Mandatory Surveillance

Healthcare Associated Infections

Reducing health care-associated infections (HCAIs) remains high on the Government's safety and quality agenda. In 2016 a long term plan to reduce the number of Gram-negative bloodstream infections by 50% by 2024/25 was introduced.



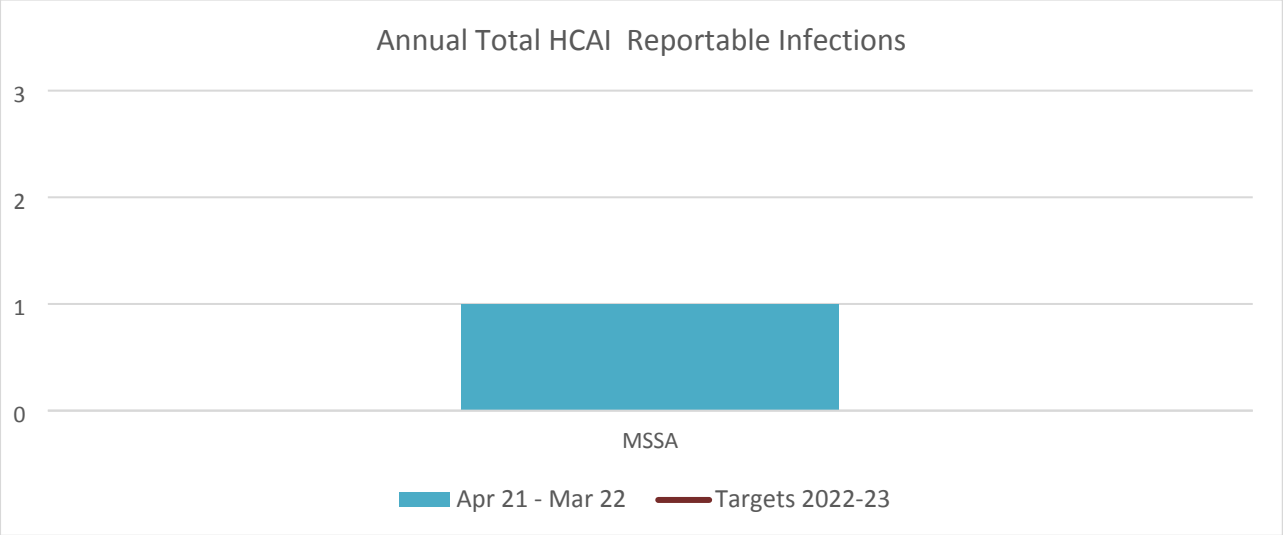
The graph above shows the total of Healthcare Associated Infections (HCAI) blood stream infections reported from April 2017 to March 2022.

The Trust continued to maintain low cases of RJAH acquired HCAI's for 2021/22. It should be noted that there was a significant reduction in elective surgical activity due to the COVID-19 pandemic.

Methicillin Resistant Staphylococcus Aureus Bacteraemia (MRSA)

The Trust is in its 16th year of reporting zero cases of MRSA bacteraemia and continues to comply to the governments 'zero tolerance' strategy set out in the NHS England Planning Guidance released in 2013 and provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA have significantly reduced.

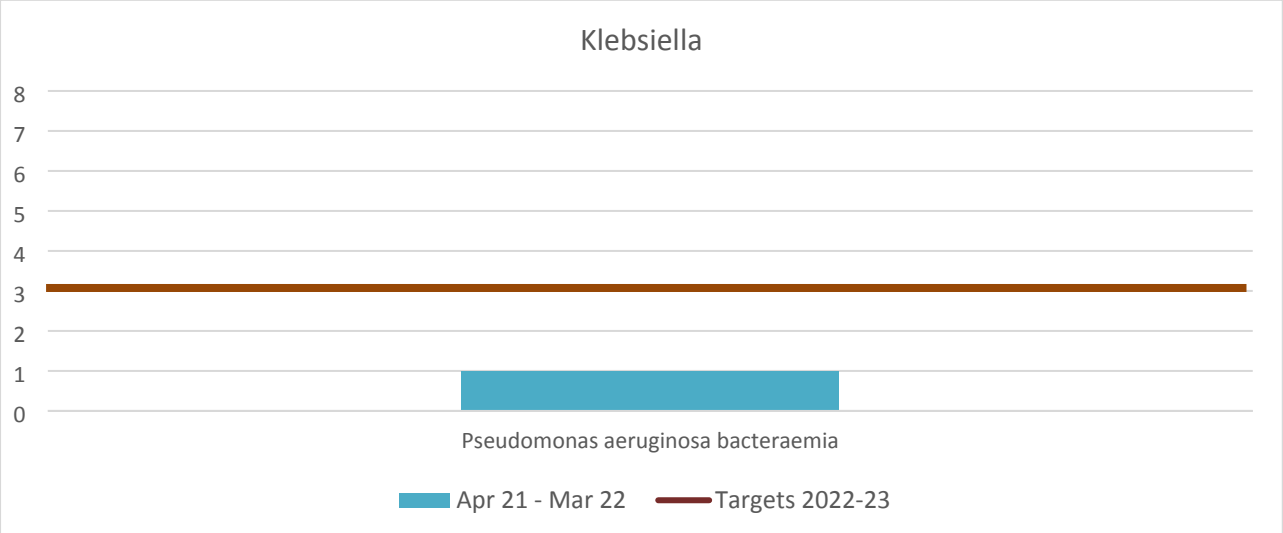
Methicillin Sensitive Staphylococcus Aureus (MSSA)



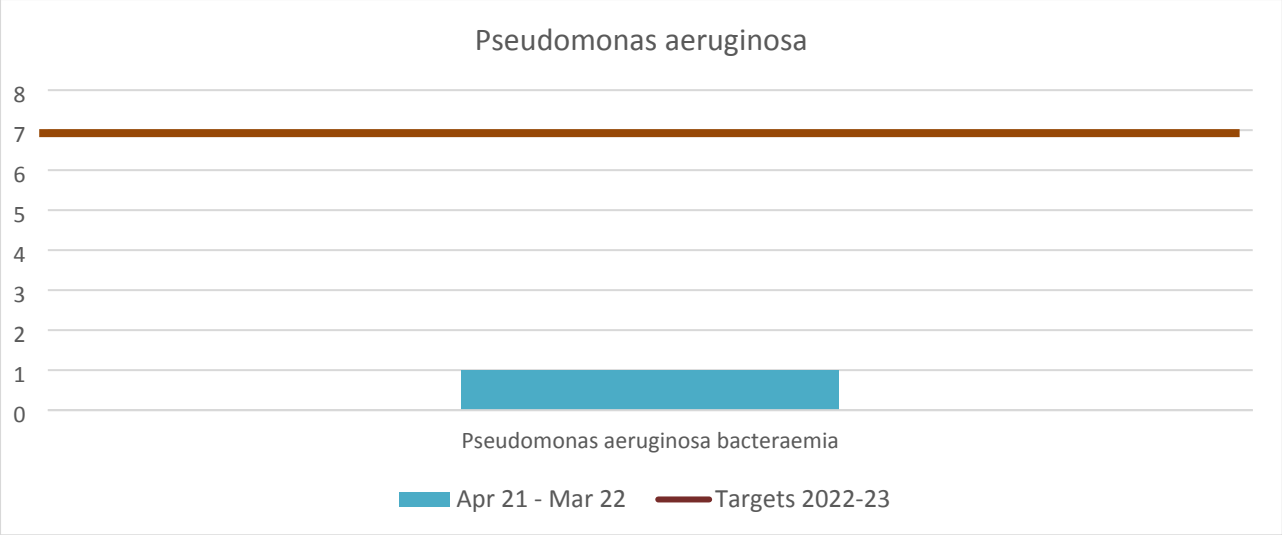
In 2021-2022 there was 1 Trust apportioned MSSA bacteraemia reported in August 2021 which remained consistent to 2020-2021. A post-infection review (PIR) was undertaken which identified a surgical site infection as the source. Themes were identified in relation to poor documentation around catheter insertion and blood cultures. Progress from the PIR action plan were monitored through the Quality Management System and reported to IPCC Committee.

Gram-Negative Blood Stream Infections

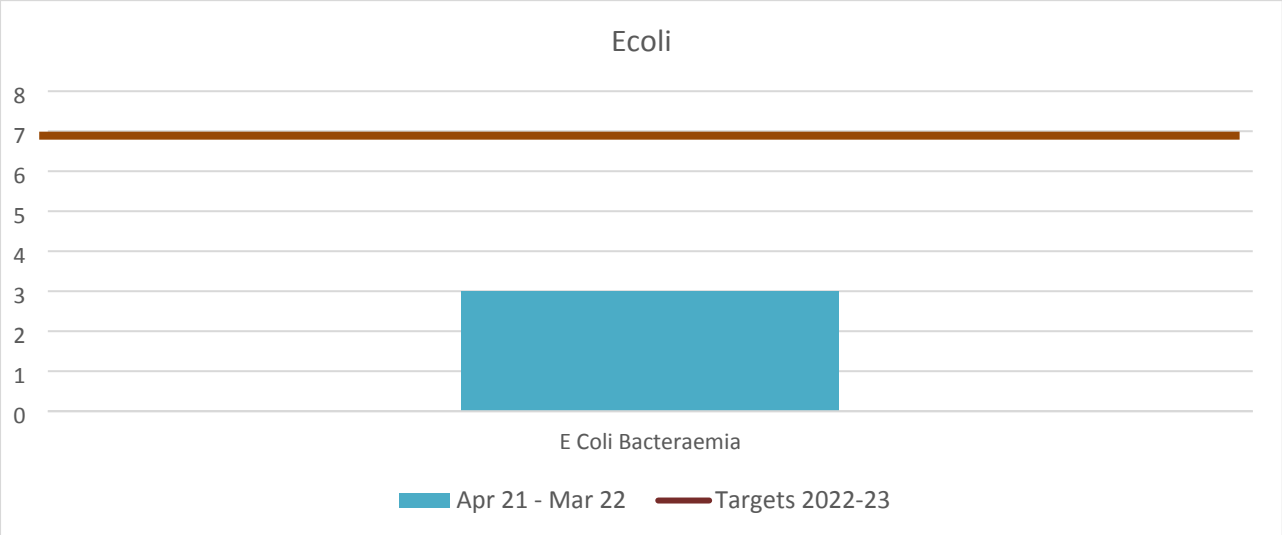
Gram-negative blood stream infections (BSIs) are a healthcare safety issue and from April 2017 there has been an NHS ambition to reduce the number of healthcare associated Gram –negative BSIs. For this purpose the gram-negative organisms are Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa) and Klebsiella species (Klebsiella spp.). Psuedomanoas aeruginosa and Klebsiella species bloodstream infections have only been reportable since April 2018.



In 2021/22 there were 2 cases Klebsiella sps reported with one 1 case apportioned to the Trust.



In 2021/22 there was 1 RJAH acquired positive BSI sample for Pseudomonas aeruginosa.



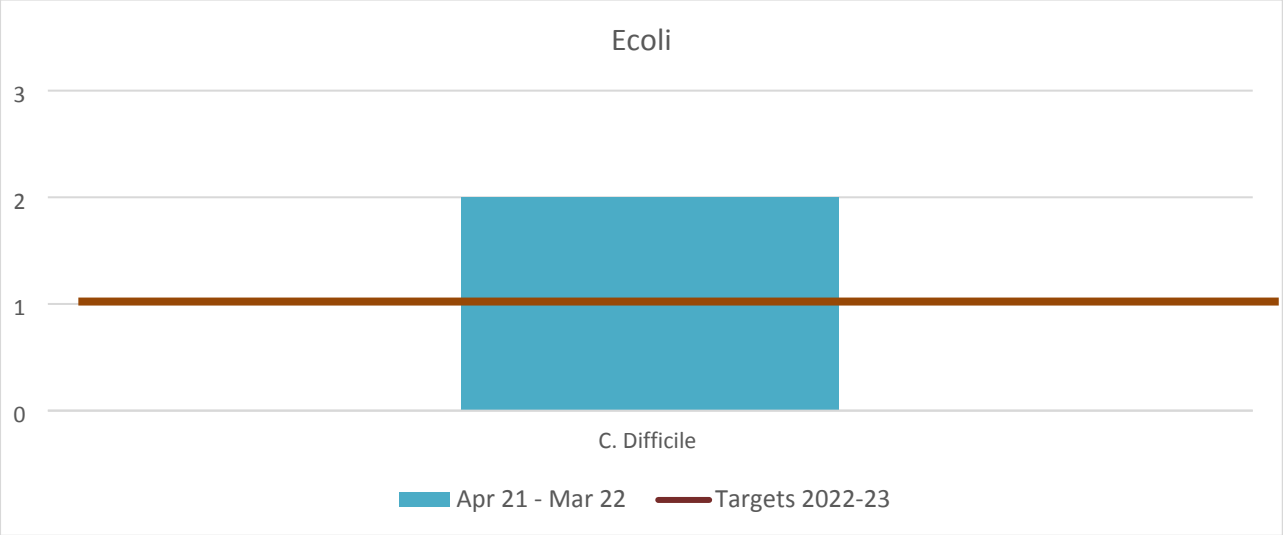
The graph above shows a continued reduction in E.coli cases for 2021/22 with 3 Trust apportioned cases compared to 6 in 2020/21.

The common theme of all 3 cases were related to catheter associated UTIs (CAUTI). There are plans for a review of the catheterisation policy and associated documentation to be undertaken.

The Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.

Post-infection review meetings were undertaken for all RJAH acquired bloodstream infections in order to identify the root causes and any actions required. All lessons learned were presented at ward safety huddles, link staff meetings and SNAHP for wider learning and improvement.

Clostridium Difficile Infection (CDI)



To date we have had 3 RJAH acquired apportioned cases of C.*difficile* infection against an objective of 1 case. One case was apportioned to us from SaTH in November 21, this patient went on to develop further symptoms and relapsed in December 2021.

Case 1 – May 2021:

A post-infection review (PIR) was undertaken which highlighted long-term antibiotic therapy as the most likely source of the infection. Areas of good practice were identified, such as the timely decontamination of the side room. This case was considered to be an unavoidable infection due to the patient's requirements for antibiotic therapy.

Case 2 – November & December 2021:

The patient had been diagnosed with C.*difficile* on the 19/11/21 during a short admission to Royal Shrewsbury Hospital from RJAH due to cholecystitis.

On the 22/12/21 the patient developed further diarrhoea symptoms; a sample obtained identified a relapse in C.*difficile* infection. The patient was reviewed by the Consultant Microbiologist and was treated with Fidaxomicin.

Lessons learned were identified which included:

- Guidance to be provided to ward staff regarding the screening of other patients on the ward
- A-Z of infections to be available on the Intranet for staff to follow management of infections
- Patient had a stool sample taken before being isolated – education provided to team
- Patient felt isolated and alone in side room – discussed importance of regular communication with patients im isolation. This was shared in June's link staff meeting.

Infection Prevention & Control Ward/Department Audits

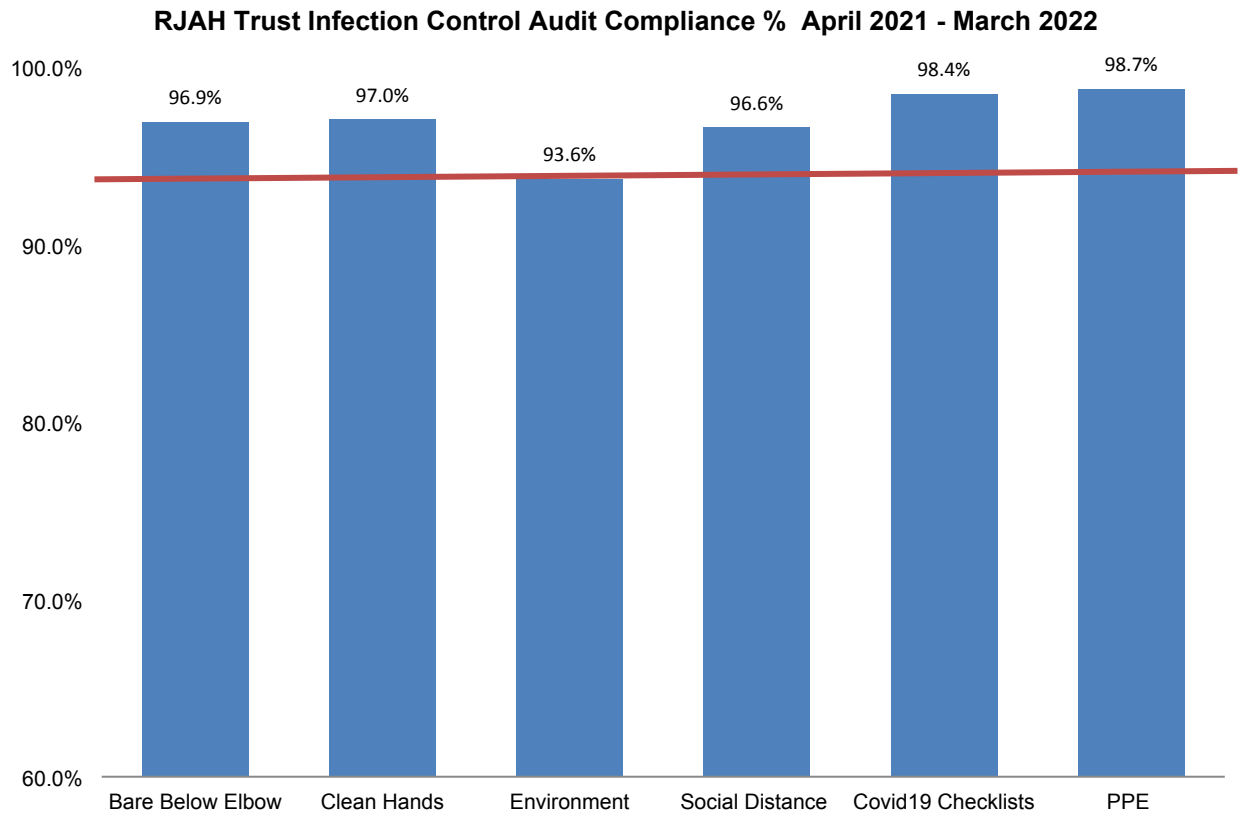
Wards and departments complete a package of infection prevention and control audits across the year. The suite comprises of environmental auditing, Hand Hygiene, Bare Below the Elbows (BBE) Personal Protective Equipment (PPE) COVID-19 checklist and Social Distancing Audits. In July 2021, The Trust introduced an electronic app based auditing software named Perfect Ward, (renamed to Tendable in November 2021) with phased roll out to all wards and departments. Paper system was withdrawn with all areas undertaking aduits via an Ipad preloaded with the auditing software. By September 2021 all but the following areas were had been sep up and utilising Tendable to undertake their audits:

- ORLAU
- Montgomery
- Orthotics
- Menzies

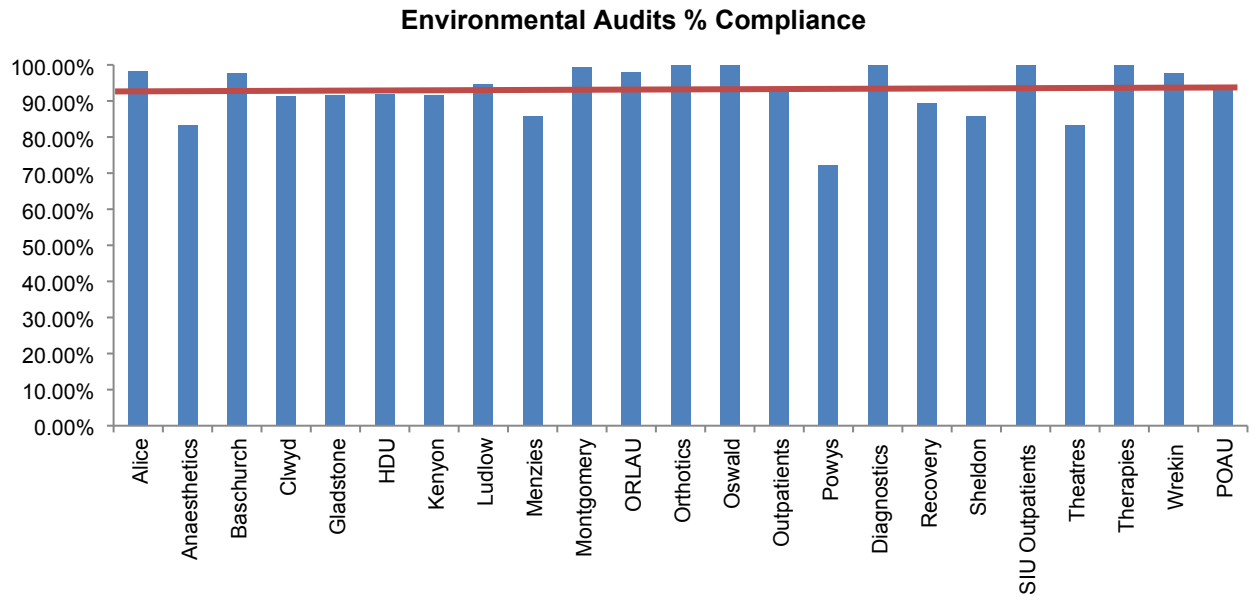
- Therapies

In February 2022, the Trust moved to manage all action plans via Tendable and as a result, further QR codes were obtained to allow full implementation in the above areas. Roll out will continue in 2022. These areas will continue to undertake paper based audits in the interim. All data is analysed by the Interim IPC Governance Lead/Data Analyst and monitored via the IPC Quality Management System.

The following graph shows the Trust's compliance against each of the individual audits. Tendable contains an algorithm that negatively weights scores against repeat episodes of specific issues for non compliance. As a result, scores began to fluctuate signficantly following its implementation.
The results show that despite this change, the Trust consistently achieved the 95% target in all areas for Bare Below the Elbow, Hand Hygiene COVID-19 Precautions and social distancing. Scores for environmental IPC audits fell below the 95% target due to a large number of Estates works identified on wards. All areas are now able to obtain scores and full details of non compliance via Tendable. All actions generated from an audit are sent directly to the ward/departmental manager for their oversite, action and resolve. All Estates works identified continue to be reported via the QUBE portal and will be assigned a requisition number.
For the areas awaiting roll out of Tendable, scores continue to be circulated via the interactive audit dashboard.



Environmental Audits



Scores for environmental audits fluctuated throughout the year with averages falling below the 95% target for many areas. As stated above scores must be viewed with consideration to Tendables scoring system and the variables highlighted above.

The Estates department have commenced a programme of works to address remedial works required within the Trust. The department is also working to strengthen its helpdesk processes for requisitions received. All areas continue to submit Estates related job requests via QUBE.

Hand Hygiene & Bare Below the Elbows

The following graphs show variation of scores to hand hygiene and bare below the elbow audits for 2021/22 with some areas reporting scores below the 95% target by end of March 22.

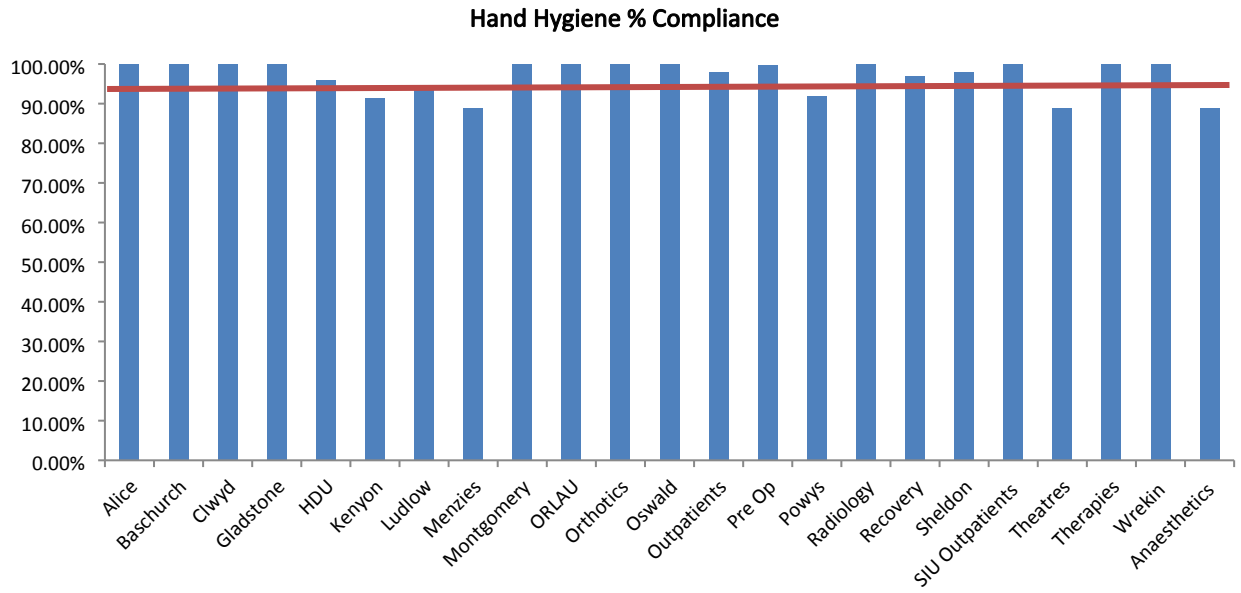
Poor scores related to the question set for this audit. In November 2021, in order to monitor compliance to hand hygiene competencies the following question was added:

" Are hand hygiene competencies in date? Please produce a picture of the register/paperwork"

Although this helped to alert managers to their update, the question posed challenges upon completion of the audit due to registers being kept locally and stored securely. Access to this paperwork was not always available therefore penalising scores.

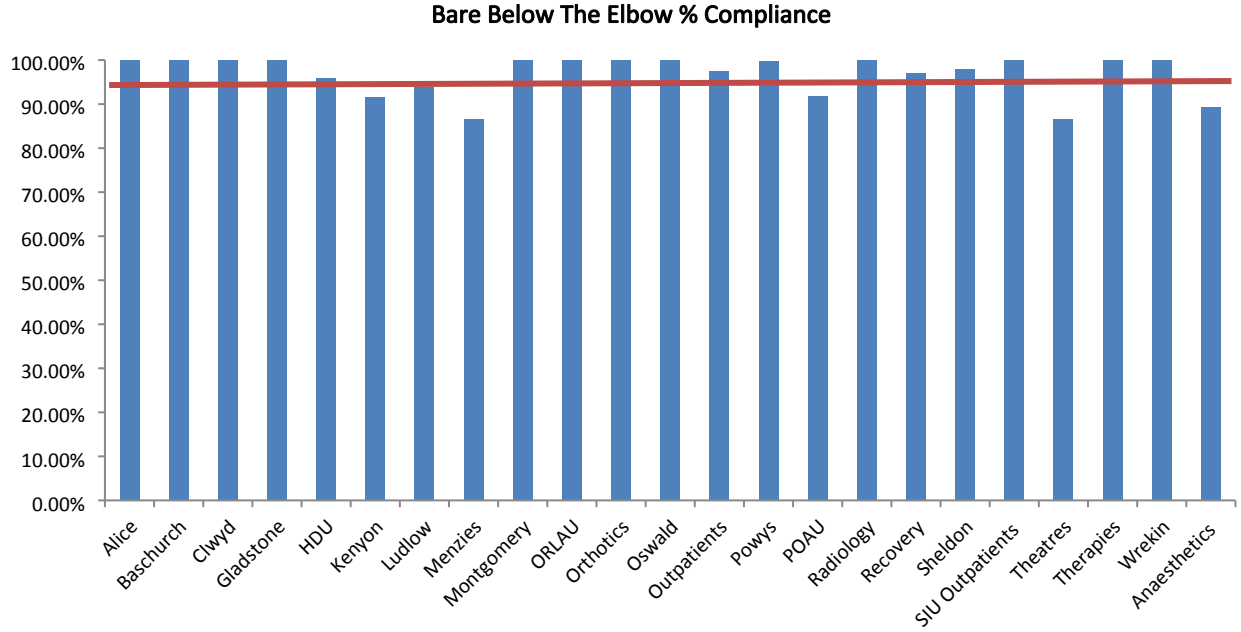
Following a training needs analysis it was agreed that hand hygiene training module will be uploaded to ill be uploaded to ESR. This training will be made mandatory in order to monitor staff competencies. Compliance to this training will be monitored in line with all mandatory training modules with a full report being presented to the Infection Control & Cleanliness Committee.

All audit question sets on Tendable are regularly reviewed to monitor the effectiveness of data with tailoring sessions planned throughout the year with the Tendable Project Team.



Scores for bare below the elbow also fluctuated due to repeated incidents being observed of non compliance to bare below the elbow principles.

Further analysis showed the most common theme for non compliance was due to staff wearing smart watches with medical staff wearing long sleeves jackets being the second. This issue was escalated to the Chief Nurse and Chief Medical Officer who has communicated regular reminders to all staff around the importance of maintaining bare below the elbow. Moving into 2022/23 – a full review of the Trust's uniform policy will be undertaken in order to provide clarity to staff and also new BBE posters will be created and placed around the Trust. The team forecast an improvement in BBE compliance as we move forward. The IPC team's audit process will continue to capture compliance around BBE and an escalation process is in place.



IPC Quality Assurance Walks

The IPC Assurance Audit process was reviewed in line with the introduction of the Quality Management System in July 2021

In August 2021 the team shifted to the new IPC Quality Assurance Walk system. To ensure prompt identification and resolution for issues the system was enhanced to include a rolling porgramme of audits driven by a RAG rated escalation process.

The escalation process determines the timescale for follow up audit.
Existing toolkits were reviewed and updated to include monitoring to national requirements.
Quality Assurance walks are undertaken via the internal auditing system (Tendable) and scored in line with other IPC audits within this system.
The programme is monitored via the IPC QMS with scores mapped in accordance with the escalation process as shown below:

Quality Assurance Walks

Ward/Department	2021 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Alice								82%		93%			92%		100%						P			
Clwyd								91%				93%			95%						P			
Gladstone								92%		89%						94%					P			
Wrekin								96%		89%			91%		94%						P			
Kenyon								WC					88%		92%						P			
Ludlow								81%								94%						P		
Oswald								90%								98%						P		
Powys								86%			91%						P							
Sheldon								81%				91%						P						
HDU								82%							93%						P			
Recovery								82%	87%							93%						P		
Montgomery																100%					P			
TSSU																								
Theatres									81%		87%				73% OD		P							
Outpatients									81%						86%	P								
Radiology								81%								83%	P							
Baschurch																94.7						P		
Pre-op																								
Vac Hub. One off QA Audit following set up						99%																		
Physio						91%										81%	P							
Pharmacy																								
Hydro Pool																								
Louise House																								
Maternity																								
ORLAU																								
Orthotics																								

General Key			
D	Due	OD	Overdue
P	Planned		Audit pre process

Frequency of QA walks is based on the RAG rating score key below:
If score is >90% Green Compliant Repeat Audit 6 monthly
Partial Compliance 81-90% Repeat audit following month with ACN
Non compliance <80% Escalate to Matron for weekly visits
Audit undertaken but not scored

From April 2021 – March 2022 a total of 33 walks were undertaken.
upon follow up audits for many areas.
Common themes for non-compliance are detailed below:

- High volume of Estates works required for many areas triangulating with the IPC environmental ward and departmental audits.
- Patients non compliance to mask wearing not being documented.
- Clutter in many areas prohibited housekeeping teams to undertake cleaning tasks.
- Cleaning Checklists are being completed but format of the document does not allow for sign off.
- Environmental issues remain a correlating theme throughout the quarter

Additonal walks were undertaken in areas with declared outbreaks of COVID-19 as per the outbreak management process.

The auditing system is configured to ensure all actions generated via these audits, are sent electronically to the ward and departmemental managers for their action/resolution.

The IPC team continue to undertake regular quality assurance walks across clinical ares and the QMS will track follow up audits and provide a live position to all walks undertaken.

4. Criterion 2: Provide and maintain a clean and appropriate environment

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

Cleanliness

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

Since July 2021, as part of the wider actions identified by NHSE/I audits, this internal team has been supported by externally contracted cleaning technicians who have focused on deep cleaning of clinical equipment.

Outcomes for cleaning continued to be monitored internally throughout the year. External and patient led monitoring, including PLACE assessment, did not take place during this time, however the Trust has implemented a programme of internal PLACE assessments, utilising NHS England's PLACE Lite tool, to ensure that there is continued oversight the environment from a patient perspective.

Cleanliness – Deep Cleaning

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

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

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

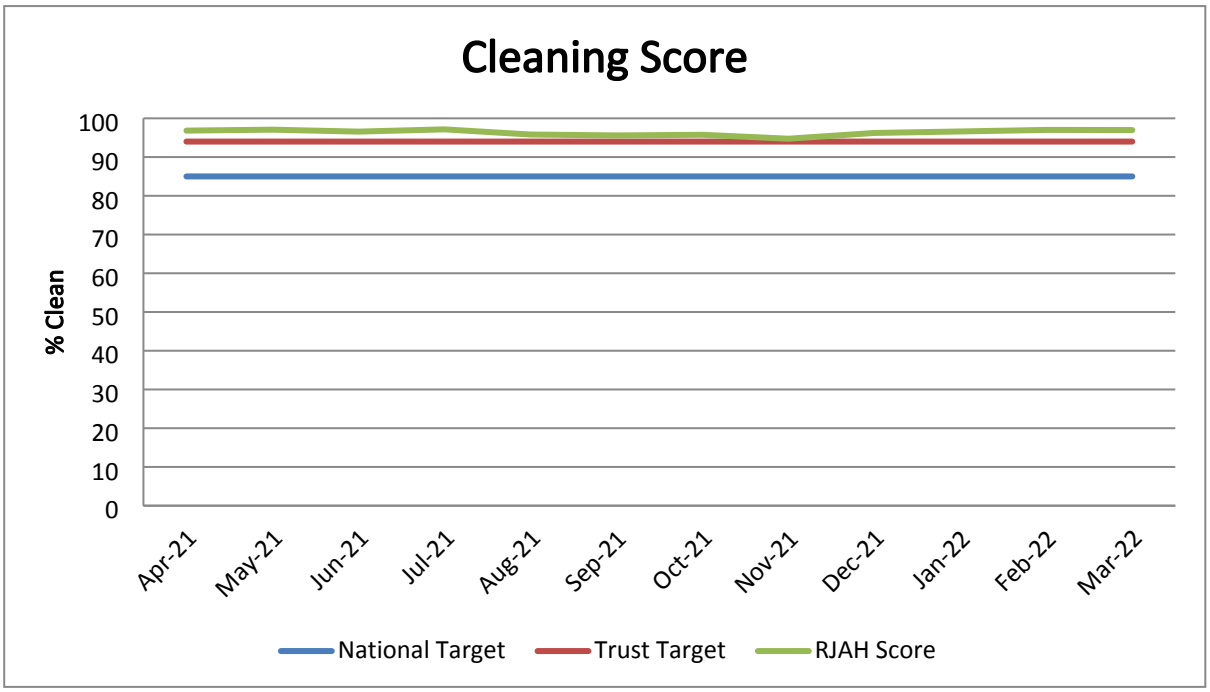
This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

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

12 individual rooms and 1 complete bay and a full ward have required a red terminal clean in 2021/22; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

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



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

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2021/22 the Trust achieved an average score of 96.36%.

National Standards of Cleanliness 2021

The National Standards of Healthcare Cleanliness were published in May 2021. Developed in collaboration with an expert multi-disciplinary team including Infection Control, Health and Safety, Nursing, Clinical and Microbiology leads and healthcare cleaning professionals, the standards have been introduced to drive improvement whilst allowing maximum flexibility to suit the needs of all healthcare organisations.

Adherence these standards is mandatory, and defined through the NHS Standard Contract 2022/23, with acute Trusts given a deadline of May 2022. Following the implementation guidance provided by NHS England, the Trusty undertook a multi-disciplinary review of the requirements – which included a gap analysis considering the correct 2007 NHS Cleaning Specification, engagement with colleagues internally and externally to apply functional risk ratings, evaluation of cleaning responsibilities and a Trust wide communication strategy.

The standards are on schedule to be launched at RJAH on April 1st, 2022, with support and approval at each stage of implementation through the IPC working group, and committee.

Cleanliness and Environment - Kitchen

The Trust kitchen retained its 5-star food hygiene rating at last inspection in June 2021, which in particular, called out the high standards of cleanliness within the Trust kitchens.

Supporting this inspection, the Trust procures a separate externally accredited food safety audit which produces a detailed action plan, undertaken in September 2021 which recommended appropriate measures were in place to retain a 5-star rating.

CQC Inpatient Survey

The CQC Inpatient Survey 2020 results were published in October 2021, with the Trust scoring top in the country under the metric 'how clean was the hospital room or ward that you were in' with an average score of 98.62%. The consistently good results achieved through this survey are a testament to the dedication and exacting standards shown by the entire housekeeping team.

PLACE – Patient Led Assessment of the Care Environment

The 2021 National PLACE assessment was cancelled in response to the pandemic.

With this vital external patient experience audit paused since early 2020, a programme of internal 'mini-PLACE' audits has been completed throughout 2021/22, as a multi-disciplinary spot check, with actions fed through the Infection Control Working Group. A focus for these inspections has been learning where best practice is already in place and replicating this where possible in other areas of the Trust. National assessment criteria were revised despite no requirement to audit, and therefore these internal checks have ensured that patient comfort and experience within the clinical environment continues to be prioritised.

Linen

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

Linen services are provided by an alternative external supplier, who continues to provide assurance to the infection control working group through monthly compliance reporting against HTM 01 04.

Clinical Waste

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

Clinical waste services are provided by an alternative external supplier. Assurance this waste is being managed, both at Trust level and by the external contractor, in line with HTM 07 01 is provided to the infection control working group though annual pre acceptance audits.

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

Estates Department Contribution to the Clean and Appropriate Work Environment

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents: -

1. Health Building Note 00-09 (Department of Health, 2013 -which supersedes and replaces all versions of Health Facilities Note 30) and covers the importance of a clean, safe environment for all aspects of healthcare.

2. Health Technical Memorandum 04 01, The Control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems."

Part A: Design, installation, and testing, and

Part B: Operational management. (Department of Health (DOH) 2006). CWP's 'control of Legionella' closely adopts the requirements of the above HTM.

Matters of estate that impact the clean environment are escalated through the IPC working group for prioritisation and oversight.

Water

The control of water is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Water safety is managed and controlled by the estates department to guidance L8 ACoP, HSG274 and HTM 04.

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

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

The Trust has an Authorising Engineer (Water) (AE(W)) appointed in writing. The AE(W) is a 'critical friend,' a requirement of HTM 04-01b and offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

Estates Operational Service continually undertake water tests throughout the Trust estate. This water testing is carried out under legislation and guidance set out by The Health & Safety Executive and the Department of Health (BS8680, HTM 04 01b, HSG 274, L8 ACoP). Testing is standard practice at RJAH to ensure robust control of waterborne infections such as legionellosis; it is a method of using qualitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. During April 21 – March 22 a total of 589 water sample tests were undertaken, this is a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

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

This year, the estates department have addressed critical backlog issues for the main water supply, infrastructure and will complete by Q4 22/23.

Decontamination Group

Decontamination covers the theatre and sterile services environment under the guidance of HTM 03-01.

Decontamination is led and monitored by the estates department supported by their third party accredited Authorising Engineer AE(D).

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

The RJAH estates team maintain a local testing regime of decontamination equipment on a monthly basis to proactively manage any issues with compliance.

Further, there is a three-monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at a sub- committee of the Infection Prevention & Control & Cleanliness Committee.

Annual revalidations continue to be completed by approved contractors, with the AE(D) sighted on reports, and any follow up maintenance.

Estates & Facilities COVID19 Response

The department has provided support to the wider Trusts pandemic response, contributing to strategic, tactical, and operational matters with a focus on adaptation and maintaining a safe environment during challenging circumstances.

Personal Protective Equipment (PPE)

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

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

Enhanced Cleaning

Implementing the National SOPs for cleaning in line with each risk level, which included additional touch point cleaning, enhanced cleaning in staff only areas (such as staff rooms), and increased frequency of cleaning in clinical areas. Additional documentation, in line with these SOP's has provided valuable evidence for the outbreak control team.

Supporting Social Distancing & Staff Safety

Whilst working from home and reduced site footfall has been advocated throughout the year, the Estates & Facilities team have supported on site teams to work as safely as possible.

This has included advising on risk assessments and action plans; supporting clear communication of restrictions through signage, posters and physical barriers, updating regularly in line with relevant guidance; providing additional rest areas with appropriate social distancing and cleaning measures in place; reconfiguring offices and departments to support new ways of working and ensuring all on site teams have access to hand hygiene facilities and appropriate cleaning products.

IPC Related Estates & Facilities Actions & Improvements

External review of RJAH in response to an MRSA outbreak prompted, amongst a number of actions, a focus on cleanliness and the environment.

Responding to cleaning related actions, deep cleaning was increased to support those staff with cleaning responsibilities. A case has been made to the ICS in relation to options for sustained standard maintenance.

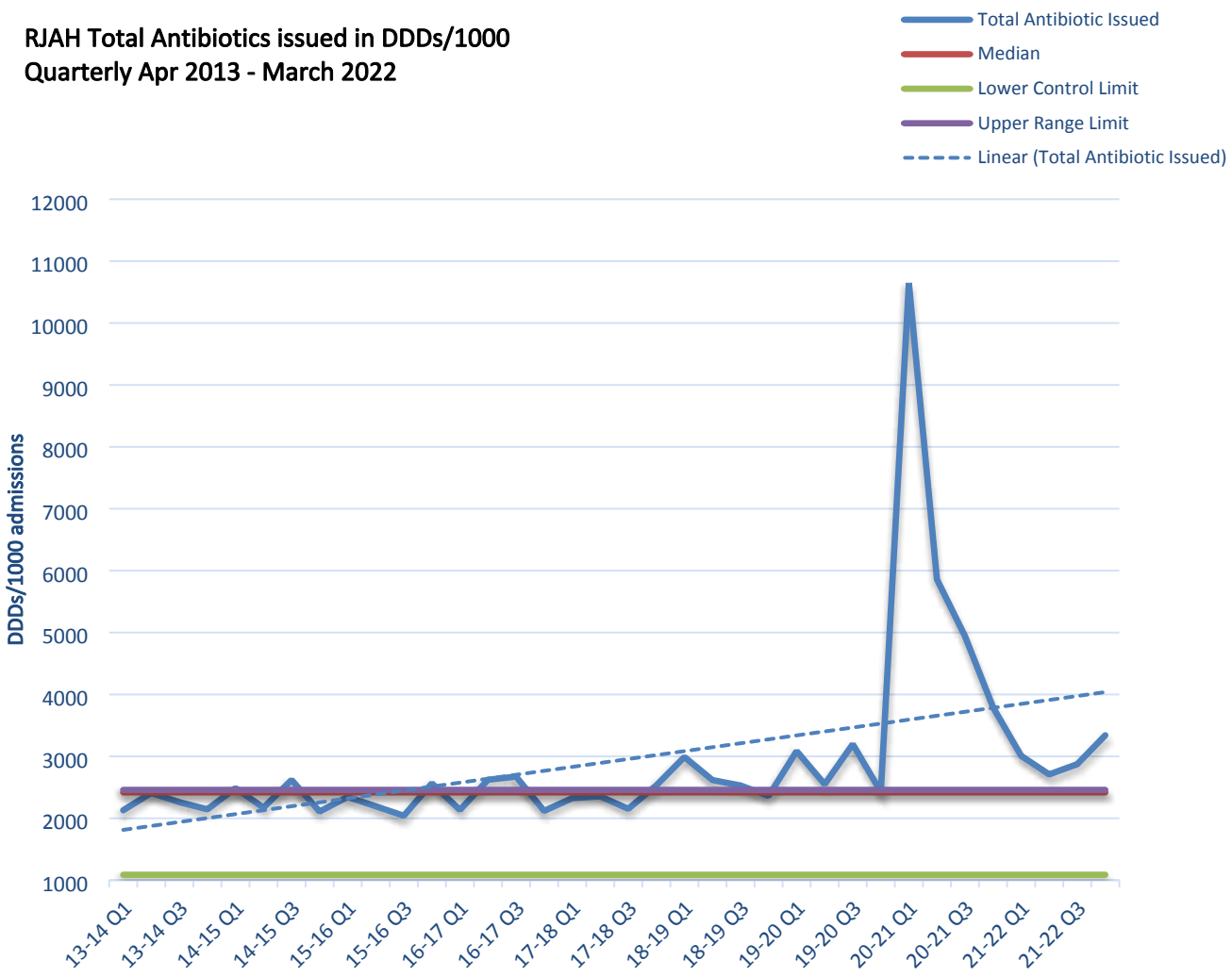
Alongside this facilities response, focus on the estate has led to a number of refurbishment programmes with the outcome being significant investment and improvement to the hospital environment. This programme is continuing into 2022/23.

The multi-disciplinary team, including estates and facilities, continue to drive standards collaboratively ensuring they align to the IPC agenda and are supported by good governance.

4.1.1. Criterion 3: Ensure appropriate antimicrobial use

Antimicrobial Stewardship (AMS) The trust antimicrobial management group (AMG) includes representatives from pharmacy, microbiology, nursing and medical staff. This group manages policy with regard to antimicrobial stewardship,formulates policy with regard to antimicrobial stewardship and responds to concerns in this area. The group feeds back actions and concerns to the executive board via the drug and therapeutic committee and reports in to the Infection Prevention and Control Committee. The action of AMG continues to be hampered by the lack of attendance of the medical representatives. This means that the group meetings are often non-quorate. Actions by the group can therefore be difficult to implement this has been escalated to the Chief Nurse to be addressed with changes being implemented in 2022/23.

Total antimicrobials

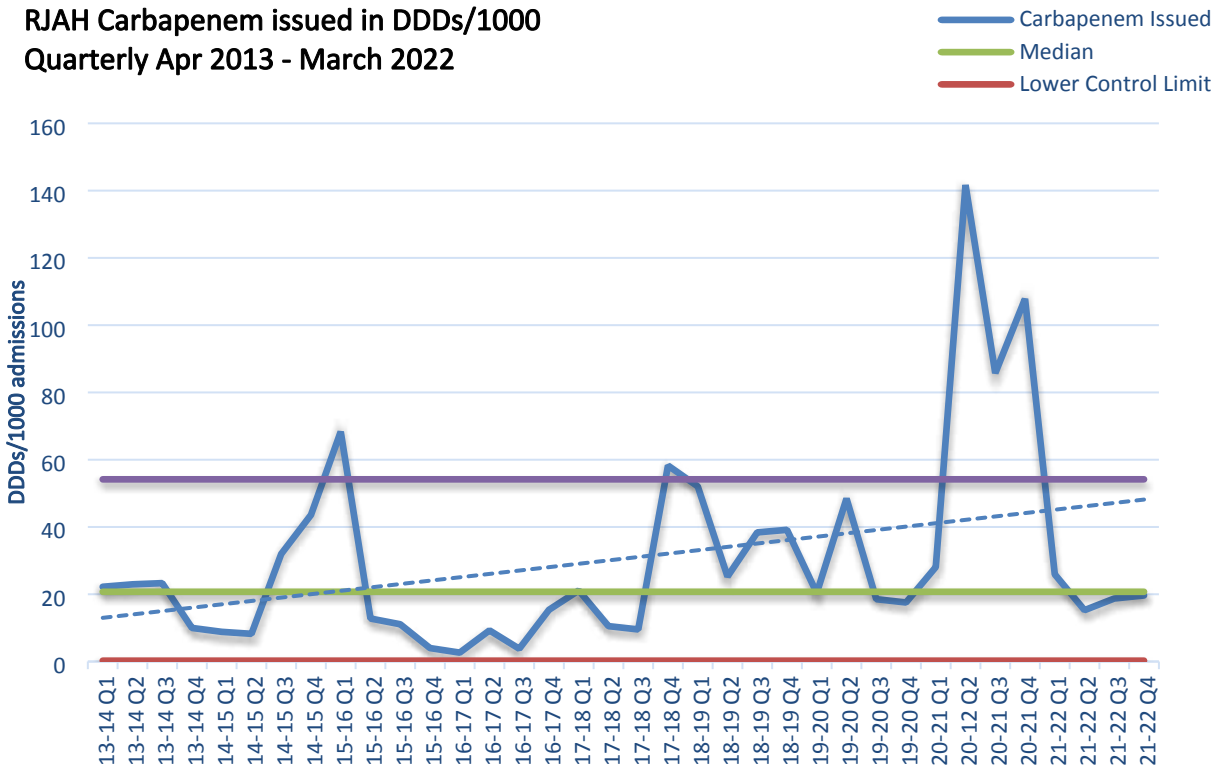


The graph above shows the total antibiotics issued in pharmacy, between April 2013 and March 2022, in DDDs per 1000 admissions. The peak seen in Q1 2020/21 was due to RJAH becoming a trauma centre during the COVID-19 pandemic, however, the usage declined up until Q2 2021/22. Since Q2 2021/22 the usage has begun to slightly increase, and it is thought that this may be due to the following reasons:

- Number of spinal injuries patients in proportion to rest of hospital
- Tend to see a greater number of antibiotics prescribed in the winter months – chest infections etc.
- We are seeing more patients who are requiring longer courses of antibiotics (some exceeding 3 months)

Overall, when looking at the total antibiotics issued, there is an upward trend from around 2000 to 4000 DDDs/1000 admission. It is, therefore, vital that antibiotic usage is continually monitored.

Carbapenems



This graph shows the total carbapenems issued from pharmacy, between April 2013 and March 2022, in DDDs per 1000 admissions. As you can see the usage seems to have plateaued over the last few quarters. Especially last quarter, when reviewing the patients prescribed either ertapenem or meropenem they were all appropriate and as per microbiologist advice which is positive. If a microbiologist advises ertapenem this can usually be switched to meropenem which is a more cost-effective option – the doctors will need to be made aware of this.

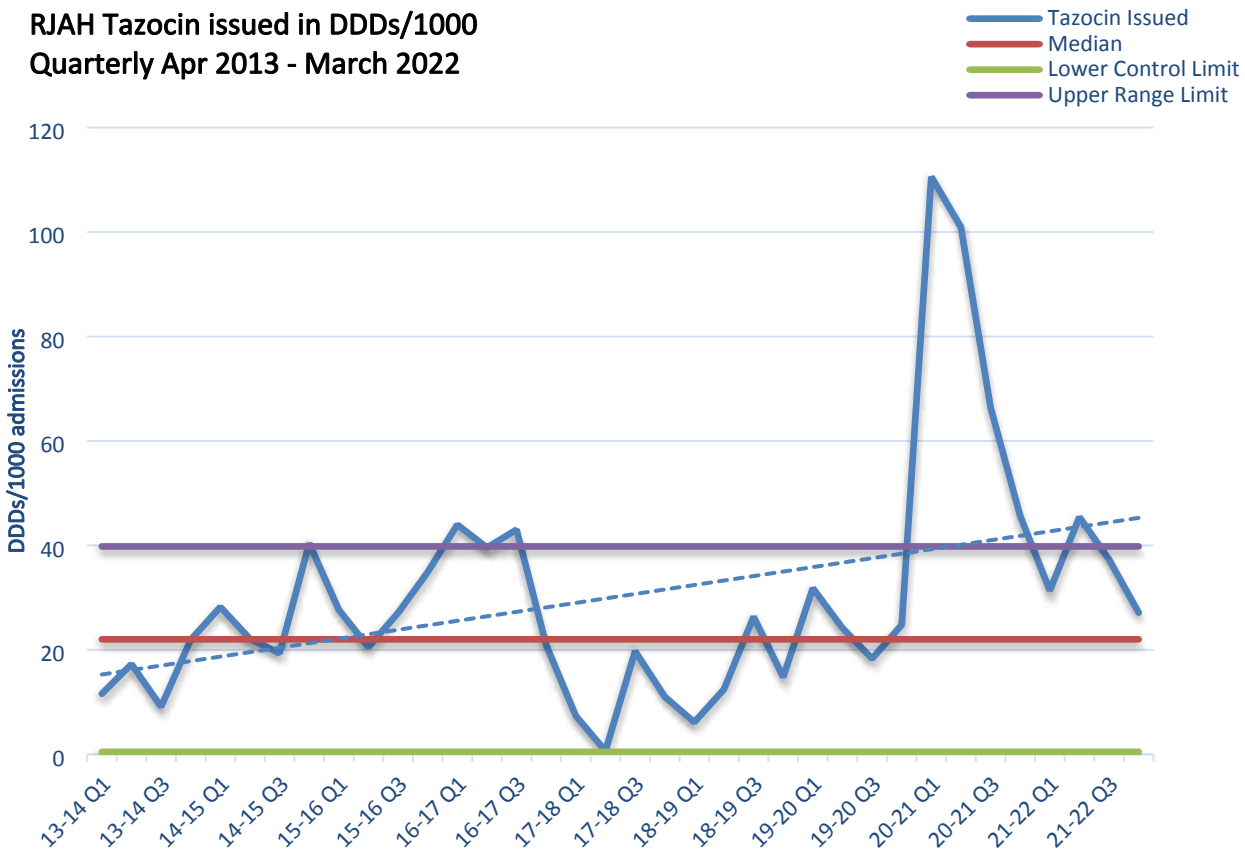
We need to continue to try to limit the use of carbapenems by ensuring that they are only prescribed if indicated in the antibiotic guideline or as per advice from a microbiologist.

Piperacillin/tazobactam (Tazocin)

Spike in usage of tazocin in Q1 2021-22 is attributed to the fact that RJAH became a trauma centre during the COVID-19 pandemic. The usage then declined but, there was another peak in usage of tazocin in Q2 2021-22 when looking at DDDs/1000 admissions although it is not clear why. Due to this a record was made of all those patients prescribed tazocin in the months following to check the appropriateness of prescribing. Although some cases were prescribed tazocin in accordance with the antibiotic policy or as per microbiology advice, the indication and rationale for some of the others were not clear. Due to tazocin being a restricted antibiotic it is vital that there is a clear and appropriate indication for its use and this will need to be fed back to the doctors.

Fortunately, the usage is starting to fall again but this will continue to be monitored.

It is important that tazocin is prescribed appropriately for the indication either according to the antibiotic policy or as per advice from a microbiologist.



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

Communication Programme

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

The IPC and Communications Teams work together to:
- Promote IPC events.
- Update the Trust website and intranet.
- Issue media statements during outbreaks.
- Support the annual flu vaccination campaign

Trust Website and Information Leaflets

Redesign of the Trust Intranet was completed in February 2022. It features a favourite character in our hospital history, Percy the Peacock. Research showed that adopting a persona for the Intranet improved engagement. A new feature is soon to be introduced called 'Ask Percy' to help staff find information.

Further review of the Trust webpage is planned to ensure information provided to patients and visitors reflects Trust expectations to IPC precautions, in line with national guidance.

Internal and external webpages will promote infection prevention issues and guide people to performance information on MRSA, Clostridium difficile and other organisms. The IPC team have updated a range of information leaflets on various organisms that are available for patients and visitors. Paper copies are also available.

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

All patients with alert organisms are seen by the Infection Control Nurse and information leaflets are provided. The consultant microbiologist will also provide advice and support to patients and their relatives upon request.

The Trust promotes best practice in the infection prevention and control to its patients, relatives and visitors; highlighting the roles they can play in preventing infection through the website, targeted poster campaigns, and promotional events such as hand hygiene day.

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

The IPC team receive a daily report (between Mon-Fri) which identifys all positive samples sent to the laboratory as part of the Oswestry Infection Control (OIC) reporting system. This system enables the IPC team to advise and support on patient placement and management.

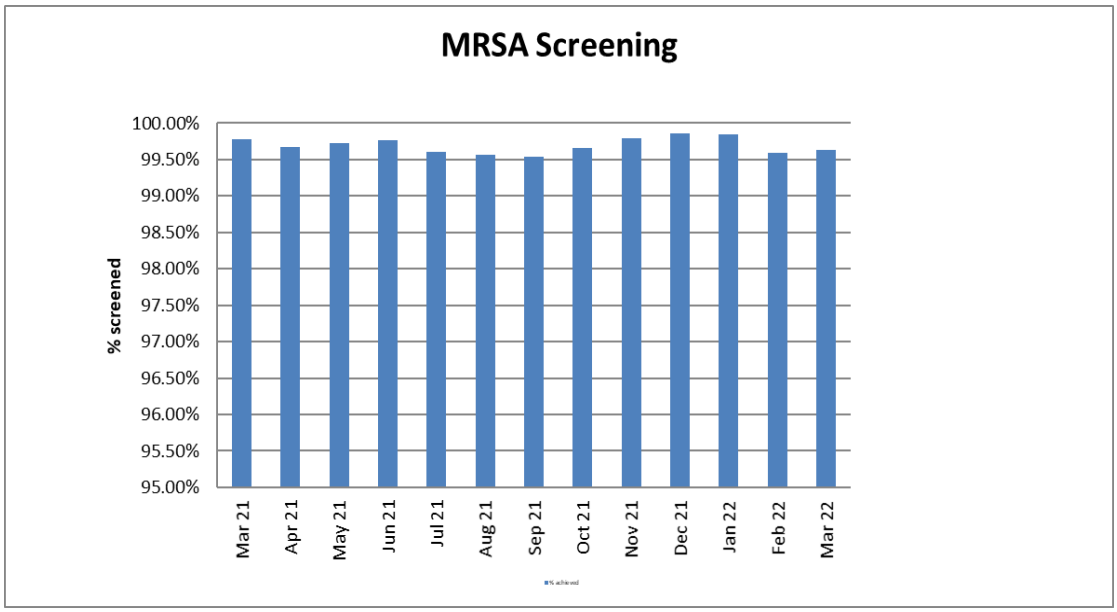
The pre-op assessment process identifies patients who are at risk of infection or require extra attention – this includes those unable to maintain their own levels of hygiene, or those with compromised skin integrity.

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

MRSA positive cases are alerted to the IPCT daily as part of the laboratory reporting system, which are disseminated to the relevant departments; this ensures that positive cases can be decolonised within a timely framework preventing prolonged postponements of patient surgery.

CPE screening is performed on any patients who have been transferred from inner city hospitals or have been hospitalised abroad as per national guidance.

The Infection Control Nurse/Surgical Site Surveillance Nurse provides advice and support to patients/relatives in the event of acquiring infection.



	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Eligible patients	460	610	728	856	763	697	868	878	963	711	646	739	800
Screened for MRSA	459	608	726	854	760	694	864	875	961	710	645	736	797
% achieved	99.78%	99.67%	99.73%	99.77%	99.61%	99.57%	99.54%	99.66%	99.79%	99.86%	99.85%	99.59%	99.63%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Further analysis was undertaken of the decolonisation of patients who are identified as MRSA positive at preop assessment. A breakdown of pre-admission decolonisation is provided on a quarterly basis via the IPC Quarter report.

Surgical Site Surveillance (SSI)

Since July 2008, all hospitals are required to have systems in place to identify patients who are included in the surveillance and later develop a surgical site infection.

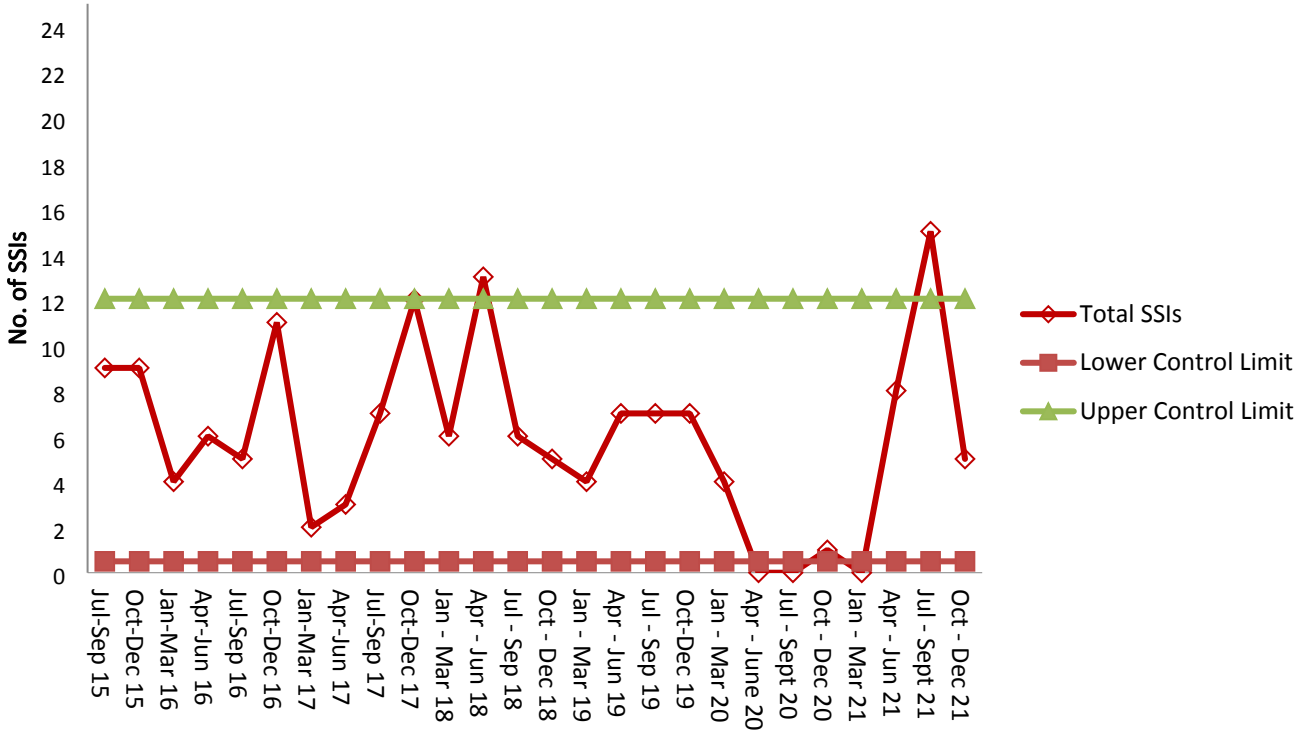
The Trust submits surgical site infection data to the UK Health Security Agency (UKHSA) database on a quarterly basis.

UKHSA (Formerly PHE) analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence falls above the 90th or below the 10th percentiles nationally for a given surgical category, enabling the Trust to benchmark itself against the national rate of infection.
Surgeon specific data allows the surgical site surveillance team to provide analysis of infection rates to individual surgeons as part of their revalidation and appraisal process.

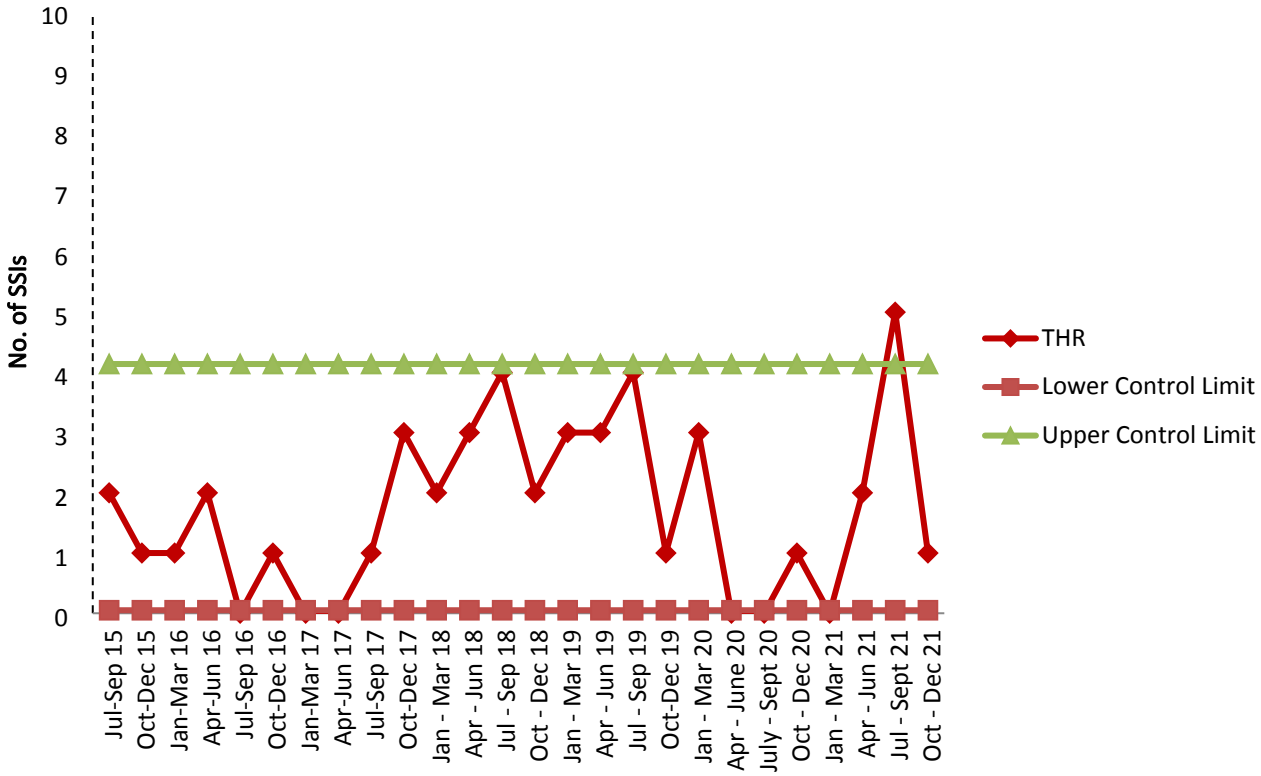
From April 2021 – March 2022, data on 937 operations – 385 Total Hip Replacements (THR), 345 Total Knee Replacements (TKR) and 207 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 34 SSIs reported, 11 THR, 12 TKR, and 11 spinal surgeries.

The following graphs show the breakdown in the total number of SSIs reported to UKHSA between January 2015 and December 2021.

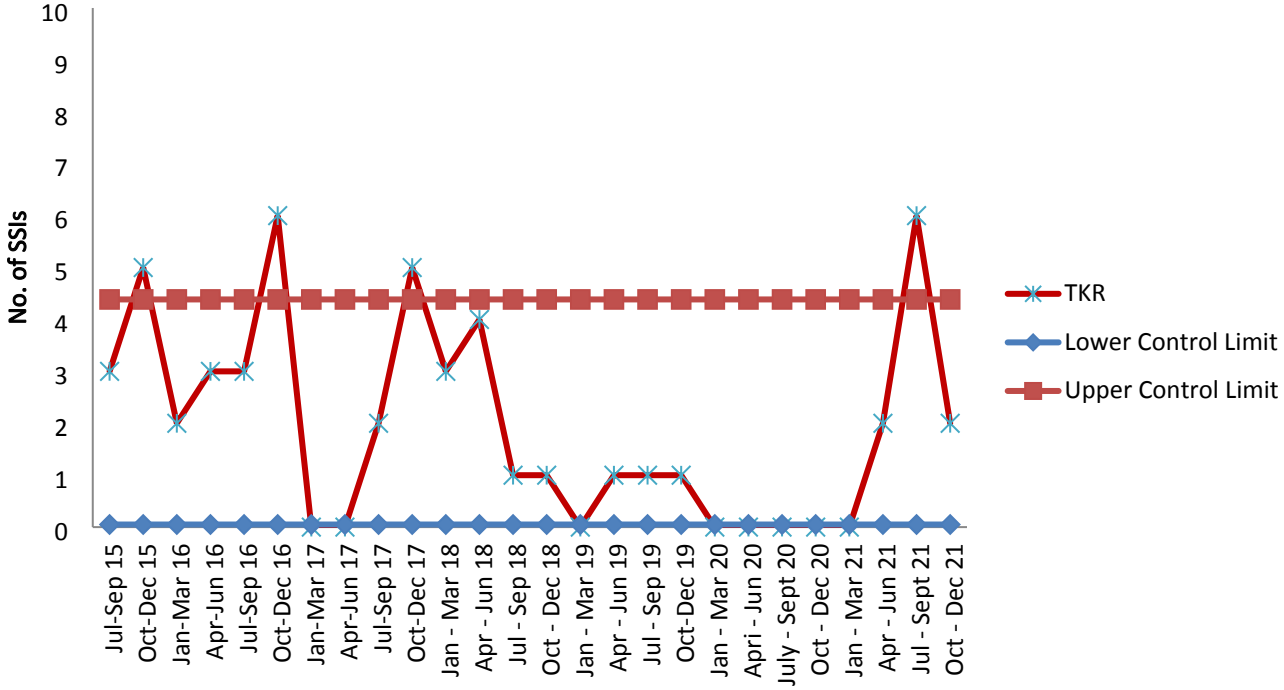
SPC Chart showing the Number of RJAH Total SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr Jul 2015 - Current



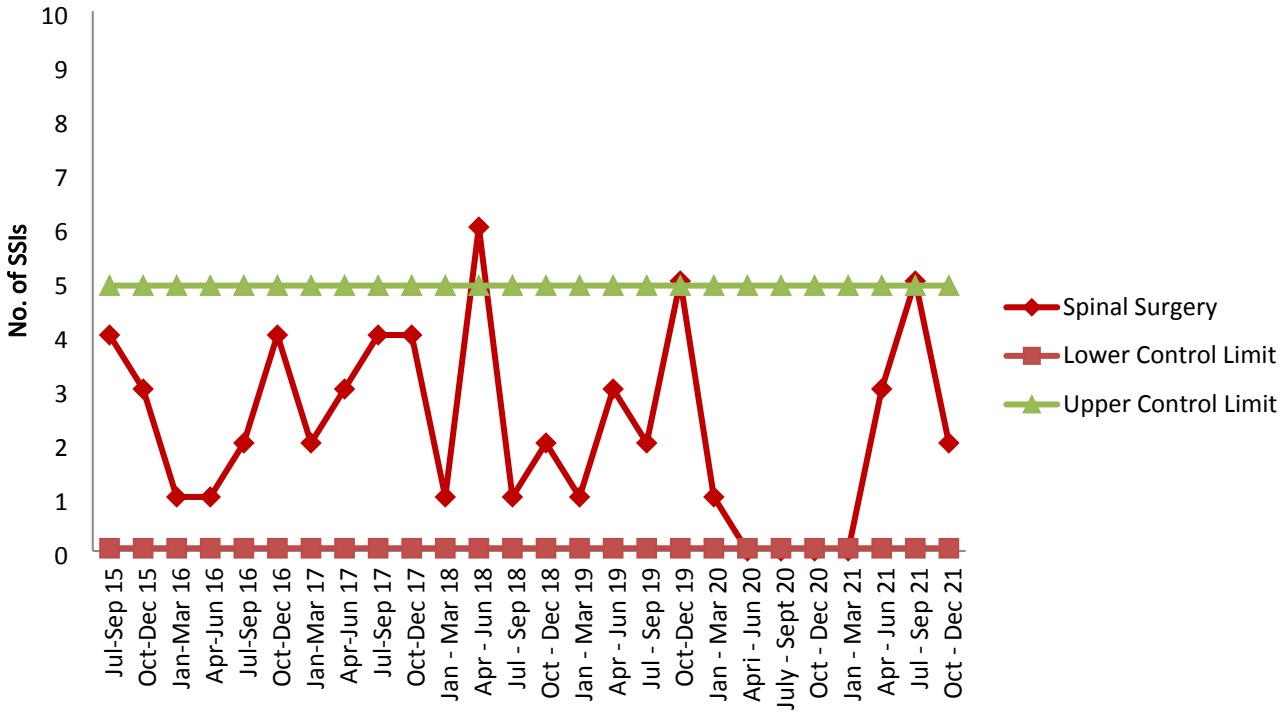
SPC Chart showing the Number of RJAH (THR) Hip Replacement SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr Jul 2015 - Current



SPC Chart showing the Number of RJAH (TKR) Knees SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr Jul 2015 - Current



SPC Chart showing the Number of RJAH Spinal SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr Jul 2015 - Current



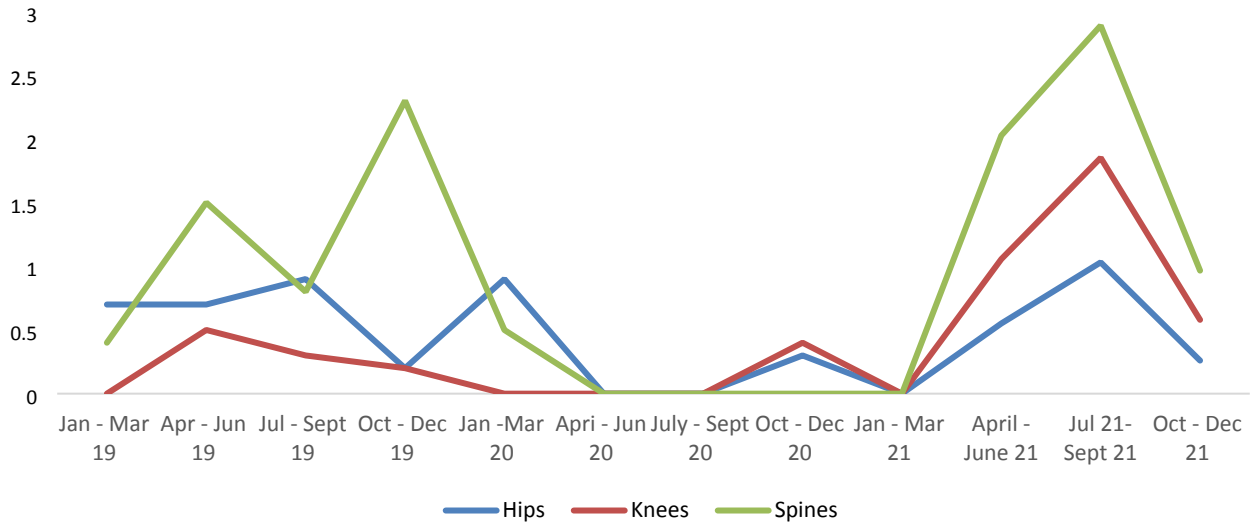
The Trust reported an increase of SSI infections for surgeries undertaken within the April -June 21 period with a total of 8 reported.
A deep dive of the SSI data since 2015 was undertaken and it was determined that this rate remained consistent with historical trends.

A further 15 infections were reported for July – September period instigating a full investigation to determine cause and contributory factors.

Investigations showed that out of 23 SSI infections reported from April 21, 15 of these were found to have MSSA growth. Specimens were sent for typing but results showed no consistent strain.

Rise of infections for July – September period resulted in rates being calculated above the national average for all three specialities generating outlier letters from UKHSA.

SSI Rates



Full review of the Surgical Site Surveillance process was undertaken by the Trust with the following improvements implemented:

- Confirmed numbers for SSIs aligned to the Trust KPI reporting for Board level oversite
- Funding secured to increase vacant Surgical Site Surveillance Nurse post increased to full time post.
- Embedded Post Infection Review process to identify critical points and contributory factors throughout the process. Promoting lessons learnt and recommendations for improvement.
- IPC QMS was expanded to capture live data for SSI's as they are confirmed.
- The OneTogether Programme was undertaken by the IPC Nurse Specialist.
- Surgical Site Infection Improvement Working Group to support Trustwide commitment to prevent surgical site infection.
- Consideration to MSSA decolonisation treatment for patients pre admission.

Infection Multi-Disciplinary Team (MDT)

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

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

A full review of the governance process for this meeting is being undertaken.

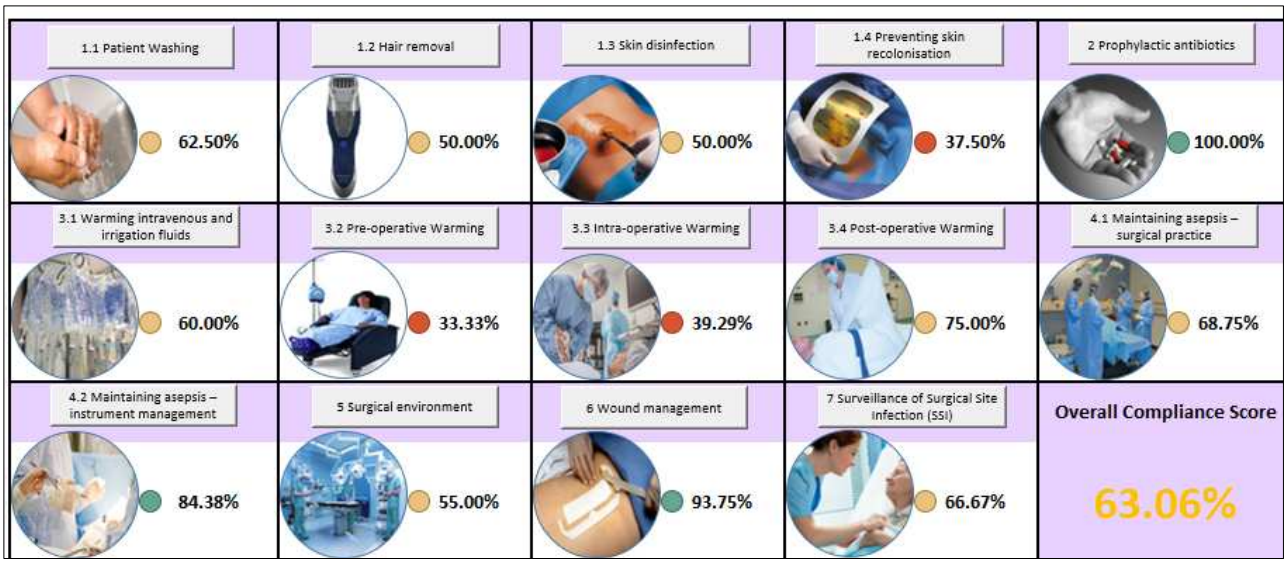
One Together

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

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

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

The assessment was carried out in December 2021 and results showed an overall compliance of 63.06% and are summarised below:



General findings included:

- There is no defined local policy in relation to assisting patients to wash who cannot wash themselves prior to surgery. There is no shower facility on Baschurch
- No standardised practice for skin preparation. Several options being used – SOPs do not align with COSHH.
- No local policy for the use of incise drapes
- No local policy about patient warming or the warming of irrigation fluids. This is across pre-op through to post-op phase of surgical pathway. Patients are not assessed for risk of hypothermia at pre-op and are not given information about keeping warm prior to surgery.
- No regular assessment of surgical practice i.e., surgical hand antisepsis, gowning and gloving etc
- No defined process for the management of staff traffic throughout theatre and ensuring that doors to theatres are closed whilst surgery is in progress.
- Patients do not get information about the risks of SSIs at pre-op, only info relating to wound issues at discharge.

A Surgical Site Infection Prevention Working Group (SSIPWG) was set up in March 2022 which includes membership from across the surgical pathway and will be chaired by the MSK Matron. The group have developed an action plan that will be monitored on a bi-weekly basis. The group have prioritised pre-operative and intra-operative patient warming as these were the lowest scoring areas – mainly due to the lack of defined local policies. A repeat audit will be undertaken during Quarter 3 2022. Progress on actions will be monitored through IPCC committee.

Outbreaks

Each outbreak was investigated by the Outbreak Control Team, which consisted of a multi-disciplinary team that reviewed all available evidence, and reported to UKHSA and the CCG. A summary of the outbreaks for 2021-2022 is tabled below:

2021

Dept	Date declared	Outbreak Type	How many involved (staff and pts)	Themes identified/Contributory Factors	Actions Taken
Wrekin Ward	20/07/2021	COVID-19	10 Patients 0 Staff	The importance of maintaining a clutter free environment Importance of hand hygiene in between each patient interaction Doors to isolation rooms should remain closed unless risk assessment is in place i.e compromised patient safety issue from keeping doors closed	Review Trust MRSA policy Clear cleaning responsibilities between clinical and domestic to be defined Audit of MRSA decolonisation regimes IPC quality walkabout audits undertaken using the RAG rating system to determine frequency of audits dependant on the overall score Immediate identification and resolution of all environmental and estates repairs
Clwyd Ward	03/12/2021	COVID-19	7 patients 2 staff	Improved process required for checking patient mask wearing compliance No process for ventilation (opening windows regularly) One patient not vaccinated	Updated patient mask wearing flowchart created Review of ventilation by H&S Officer Ventilation chart created – clinical areas opening windows 10 mins per hour. Regular action item for future outbreak action logs
Pharmacy	27/12/2021	COVID-19	5 staff	Social gathering during Christmas period Staff working within the same area in Pharmacy department Poorly ventilated break room	Review of social distancing in break room and signage displayed Review of ventilation Encourage staff to work from home where possible
Gladstone	27/12/2021	COVID-19	11 patients 16 staff	SI RCA completed and actions monitored through Q&S committee Increased prevalence within the community a contributory factor	Declutter of ward New lockers installed for patient belongings Donning and doffing training for staff Declared as a serious incident
Sheldon	30/12/2021	COVID-19	11 patients 10 staff	SI RCA completed and actions monitored through Q&S committee	Purchase of more Air Sentry devices to aid ventilation Declared as a serious incident

				Increased prevalence within the community a contributory factor	

2022

Dept	Date declared	Outbreak type	How many involved (staff and pts)	Themes identified/Contributory Factors	Actions Taken
Doctor's Residence	7/1/2022	COVID-19	5 staff*	*Linked to Gladstone (declared during Q3). Not treated as separate outbreak	Designated on call rooms per shift now available
Wrekin	12/1/2022	MRSA	3 patients 1 patient admitted with MRSA 2 patient acquisitions	No clear rott cause identified – several contributory factors including IPC compliance issues	
Wrekin	3/1/2022	COVID-19	1 patient 2 staff	No clear root cause identified	
Alice	24/01/2022	COVID-19	2 patients 1 parent 7 staff	Poor PPE compliance from family members who were symptomatic when visiting Unavoidable due to family non-compliance and non-believers of COVID-19	Patient isolated appropriately. Mother isolated with child inside room – meals provided to reduce transmission risk
Gladstone	29/3/2022	COVID-19	1 patient 3 staff	High prevalence of COVID-19 in the community Envornmental clutter	Storage solutions in place, ward re-fit Increase in cleanliness technican cover (10-4 shift)
Kenyon	25/03/2022	COVID-19	3 patients 3 staff	Lack of patient mask wearing when moving around ward Lack of social distancing	Additional break spaces made available for staff Encouraging patients to wear masks

4.2. Serious Incidents/ Periods of Increased Incidence

There were 2 serious incidents reported during Quarter 3 (Dec) 2021/22.

Gladstone Outbreak SI

In total 11 patients and 11 staff tested positive for COVID-19. All the patients affected contracted COVID-19 15 days (or later) following admission. The investigation found no single clear identified cause of the

outbreak, particularly given the level of prevalence in the community, but identified Trust factors which potentially contributed to the outbreak. Infection prevention and control contributory factors included:

- Cluttered patient areas (e.g., locker tops) meant that wiping down surfaces was compromised.
- Severely cluttered staff working areas with a large amount of paper records and storage meant that wiping down was a very large task which could not be completed
- Lack of awareness of the cleaning roles and responsibilities manual
- Sluice room needs upgrading and new macerator.
- Patient lockers needed upgrading.

Immediate identification and timely completion of estates work in relation to infection prevention included:

- Reflooring of corridors
- Redecoration of walls & woodwork within side rooms and bays where required.
- Replacement of handwash basins with HTM compliant IPS units.
- Replacement floors bays E, F & G
- Refurbishment of Storeroom including new floor and wall coverings and new cupboards.
- Refurbishment of Sluice Room including new flooring and hygienic cladding.

The IPC team responded to staff concerns around lack of understanding in relation to PPE, and a programme for donning and doffing refresher was completed that included students and staff from external care agencies.

The ward has invested in new patient lockers (that are located on the corridor) in order to create more space for patients' belongings and reduce the amount of items stored at the patient bedside. Patients are also being encouraged to keep their bed spaces tidy to facilitate cleaning and the prevention of infection.

The IPC team are working with the ward staff to develop a guide that will outline practical tips for outbreak management, and this will be shared across all wards once completed.

Sheldon outbreak SI

A total of 11 patients and 11 staff tested positive for COVID-19 and it has been determined that all eleven of the patients contracted COVID-19 whilst admitted under the care of RJAH.

Although there was no single clear identified cause of the outbreak, the resulting investigation found that there were several factors which could have contributed. These included increased community prevalence, Christmas period with prolonged holiday period and increased socialisation within the community, poor ventilation, reduced staffing numbers due to increased sickness, which included a heavy reliance on temporary staff and some evidence of estate in need of repair. There were reports of some staff not always taking the opportunity to perform hand hygiene on some occasions.

Full details of both serious incidents can be found in the respective SI report papers.

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

Training data not available at the time of this report.

The IPC team deliver numerous training sessions year round, these have included programme of mandatory sessions and corporate induction days. Additional training sessions provided by the IPCN include:

- Induction training for all clinical and non-clinical staff (separate sessions for junior hospital doctors).
- All new/rotational doctors receive a short induction session.
- All volunteers receive a short training presentation and hand hygiene education.
- The team is part of the work experience programme run by the Trust on a quarterly basis.
- Provided 'train the trainer' education for link practitioners.
- Engage in the work experience programme based at RJAH
- Engage in the Trust preceptorship programme
- Provided workshop training sessions at ward training days
- Face to face training for groups of staff such as:

- Catering
- Porters
- Domestics
- Estates Maintenance staff
- Volunteers

Going forward the Trust has invested in a IPC Support Worker to assist the IPC Team with training and surveillance.

4.2.2. Criterion 7: Provide or secure adequate isolation facilities

The Trust has always been able to accommodate patient isolation with minimal disruption to the running of the wards. A risk assessment tool is available to help staff in making these decisions and ensuring that practice is consistent.

The IPC team work closely with ward staff and Clinical Site Managers to ensure the most effective use of side rooms according to risk. Due to the increase of patients carrying antibiotic resistant organisms requiring siderooms for isolation, a door replacement programme was commenced to enable patients with the same carriage to be cohorted in a bay with the doors acting as a barrier as well as a reminder for staff to implement transmission based precautions.

To date doors have been installed to the following areas:

- Sheldon
- Wrekin
- Kenyon

There are three outstanding doors awaiting installation to bays on Gladstone Ward.

The Trust has 1 negative pressure sideroom to care for patients with multidrug resistant infections.

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

Laboratory services for RJAH are located at SaTH (Royal Shrewsbury Hospital & Princess Royal Hospital). The Microbiology Laboratory has full Clinical Pathology Accreditation (CPA).

The Infection Prevention Nurses work closely with the Consultant Microbiologist. The management of prosthetic joint infection is challenging, the microbiology ward round is held once a week with the consultant microbiologist, infection control nurse and the antimicrobial pharmacist. Each patient is reviewed and requires a tailored approach of antimicrobial prescribing due to the microorganisms grown on culture.

The microbiology laboratory send a daily list of all positive samples including sensitivities. This enables all patients to receive the appropriate treatment/antibiotic therapy and prompt isolation if required.

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

Infection Prevention and Control Policies and Standard Operation Procedures (SOP) are reviewed and agreed at the Infection Prevention & Control Committee.
IPC currently operates with 1 Infection Prevention & Control Policy, A framework of Infection Prevention & Control and specific IPC overarching operating procedures.

Policies Reviewed/Published in 2021- 22	
Coronavirus Policy	Viral Haemoraggic fever (VHF)
Streptoccocal Infections	Outbreak Management Policy

Vancomycin Reistant Enterococci (VRE)	Surgical Site Infection Policy

The IPC Team made good progress in reviewing the backlog of policies and procedures in 2021/22. The QMS includes a policy tracker and matrix and provides a robust system for the review and update of policies and procedures. The matrix serves as a working planner and provides dashboard data to the Infection Control & Cleanliness Committee for assurance. The Coronavirus policy is regulary monitored and updated to relect the changes in national guidance.

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

TP Health Occupational Health & Employee Well-Being

TP Health is committed to the protection of all Trust employees as an essential part of Infection Control policies and guidance.

In line with the Health and Social Care Act 2013 and Department of Health Guidelines, TP Health have arrangements in place for assessing the immunisation status of all Trust employees as well as regularly reviewing the immunisation status of existing healthcare workers and providing vaccinations as necessary and in accordance with the Green Book to reduce the risk and spread of vaccine-preventable disease.

There is a current backlog of Mantoux and BCG vaccinations due to previous vaccine shortage, Covid Pandemic and limited room availability at RJAH and SATH, which is where the second appointment is carried out.

Although we now have a department at SATH again, some of RJAH staff are unable or unwilling to travel.

Blood Borne Virus Exposure

Blood borne virus exposure incidents or injuries may represent a significant risk to staff working in healthcare environments.

Under Health and Safety Legislation, TP Health work collaboratively with the Trust to ensure their responsibility for the health and safety of staff in relation to preventing, reducing, and controlling the risks of healthcare associated infection and management of occupational exposure to blood borne viruses and post exposure prophylaxis.

TP Health are responsible for the assessment and follow up of all blood borne virus exposure incidents occurring during departmental opening hours and for the follow up of those exposure incidents occurring out of hours in emergency departments.

April 2021 to March 2022 exposure incidents reported to TP Health was a total of 14, which is the same number as the previous 12 months. 10 of the cases were due to a percutaneous injury.

Safer Sharp Regulations

The Health and Safety (Sharp Instruments in Healthcare) Regulations came into effect in May 2013 requiring employers to use safer sharps, which incorporate protection mechanisms to prevent or minimise the risk of accidental injury.

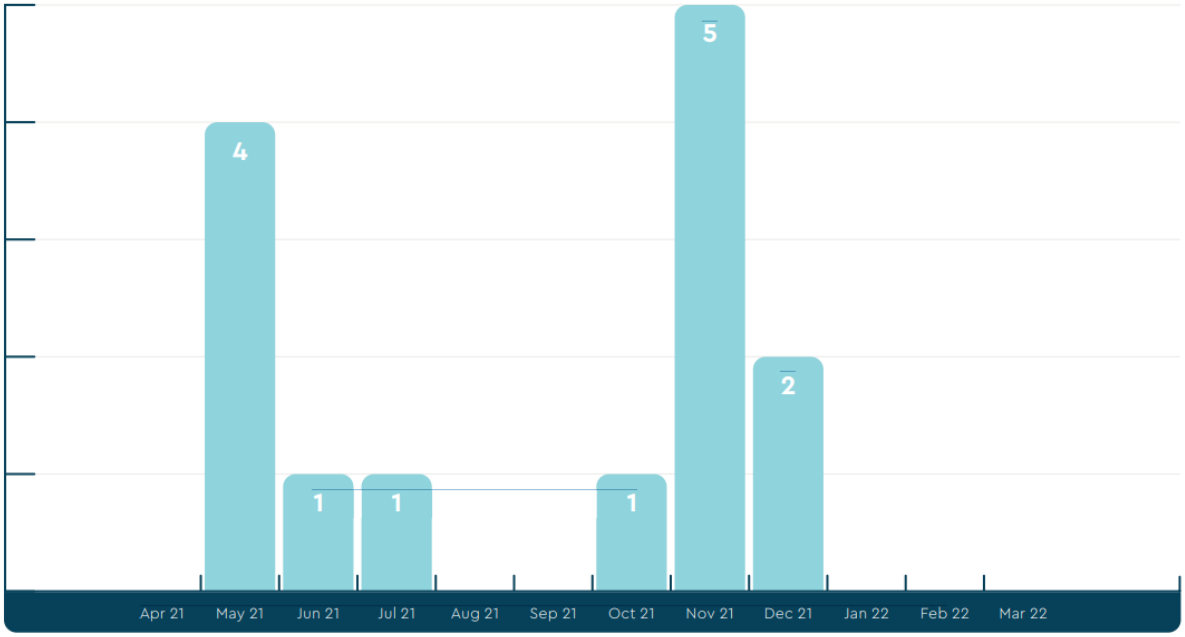
TP Health can see a reduction of blood borne virus incidents over the past 3 years since RJAH started using safety sharp.

There were 33 reported needlestick injuries in 2019/20 compared with 14 in 2021/22.

COVID-19

RJAH have been provided with numerous updated Covid Risk Assessments from TP Health to support in the management of staff within the trust. The most recent Covid Risk Assessment was sent to HR on 5th May 2022.

The graph below is a breakdown of reported Blood Borne Virus incidents in the last 12 months - April 2021 to March 2022



Conclusion

Overall, our success is measured by our compliance with the Health Act, which encompasses all aspects of infection prevention and control, including the QMS, environment, cleaning, training and policies to protect patients and staff.

The IPC team have reflected in what has been another challenging year as we responded to the global COVID-19 pandemic. The team have felt an overwhelming sense of responsibility to comprehend, disseminate and implement guidance that has changed frequently, yet have continued to remain focussed on providing support to patients and staff in order to aid in the prevention of transmission of infection.

Effective collaboration between IPC and Estates/Facilities team has resulted in significant improvements over the last year.

Progress for the BAF continues to be montored via the IPC Quality Management System and live dashboard data presents Trust position at Infection Control & Cleanliness Committee.

We have also completed 93% of our programme of work. Incomplete tasks will be carried forward into 2022-23 IPC Programme of works.

In response to the MRSA outbreak declared in July 21, NHSE/I and CCG visited the Trust on a number of occasions to seek assurance that concerns had been actioned and sustainable improvements made. In February 22 an inspection conducted by NHSE/I could not offer the assurance required and therefore discussions between the Trust and NHSE/I commenced regarding the level of oversite and input that support would be required from NHSE/I to ensure sustainable improvements for IPC are achieved.

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

Additonal support received from the Clinical Commisioning Group (CCG) and NHSE/Ihas proved invaluable during these difficult times.

Sara Ellis-Anderson: Director of Infection Prevention and Control (DIPC)

Hayley Gingell Infection Prevention and Control Team

Sue Sayles Infection Prevention & Control Lead Nurse

Anna Morris Infection Prevention & Control Nurse Specialist

June 2022

Key Areas of Focus for 22/23

Achieving UKHSA National & CCG Infection targets

PIRs for all Surgical Site Infections

New secure SSI database for data collection.

Embrace & utilise available digital platforms

Auditing of satelite clinics to be added to the QMS

Expand the administrative resource within the Team .

Appendix 1: Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship Committee
ANTT	Aseptic Non Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CCG	Clinical Commissioning Group
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
E.Coli	Escherichia coli
EPR	Electronic Patient Record
ESBL	Extended Spectrum Beta Lactamase
HCAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
IV	Intravenous
KPI's	Key Performance Indicators
MDT	Multi Disciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PALS	Patient Advice and Liason Service
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment

Appendix 1: Acronyms Continued:

RCA	Root Cause Analysis
RSH	Royal Shrewsbury Hospital
SATH	Shrewsbury and Telford Hospitals
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
TSSU	Theatre Sterile Services Unit
WTE	Whole Time Equivalent

Appendix 2: Glossary

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
C. difficile	or C. diff is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause

	diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.
E coli	is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.
HCAI	Health Care Associated Infection. An infection acquired as a result of receiving treatment in a health care setting.
MRSA	or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria,Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.
MSSA	or Methicillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

Infection Prevention & Control & Cleanliness Quarter 1 Report 2022/23

0.0 Reference Information

Author(s):	Infection Prevention & Control Team	Paper date:	21/07/2022
Executive Sponsor:	Sara Ellis-Anderson	Paper Category:	Governance and Quality
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Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1.0 Purpose of Paper

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

The Board is asked to note the progress report against the annual plan for Infection Prevention and Control and Cleanliness Report. The report has previously been presented to the Infection Control Committee and the Quality and Safety Committee in July 2022.

2.0 Executive Summary

2.1. Context

Through the monthly Board performance report, the Board are briefed on the mandatory HCAI surveillance and any key issues emerging from those results. Over and above the mandatory reporting, the Board receive a report at least four times per year from the Director of Infection Prevention and Control (DIPC) (Chief Nurse).

2.2. Summary

	MRSA Bacteraemia	MSSA Bacteraemia	E.coli/Pseudomonas/Klebsiella Bacteraemia	*C.difficile*
Month	**No. of Cases**	**No. of Cases**	**No. of Cases**	**No. of Cases**
Apr	0	0	1	0
May	0	0	0	0
June	0	0	0	1
Quarter total	**0**	**0**	**1**	**1**

- 1 Klebsiella reported in April 22. RJAH acquired
- 1 C.*difficile* infection reported in June 22, RJAH acquired
- 15 IPC quality assurance audits undertaken
- Improved compliance to national COVID-19 screening requirements.
- Hand Hygiene competencies uploaded to ESR and will be managed in line with mandatory training modules.

- New training report developed and presented by the Training Team to IPC&C Committee.
- Improved scores for hand hygiene and bare below the elbow audits.

There were IPC successes in Q1 to be celebrated:

- Appointment of a Surgical Site Infection Practitioner
- Appointment of an IPC Healthcare Support Worker
- An IPC fair was held which included interactive training sessions on hand hygiene/glove awareness, waste management, mattress cleaning/inspection, uniform policy, commode cleaning and Planet FM which was very well received with over 250 attendees.
- Glove awareness week coincided with world hand hygiene day and was promoted with competitions and prizes for staff
- Created new hand hygiene awareness posters – linked to handwashing video via QR code
- Relaunched the Bare Below the Elbow campaign to raise awareness around the Trust – created new posters
- The IPC team had away days to work on the new strategy and exciting summit preparation

2.3. Conclusion

The Board of Directors are asked to note the IPC quarterly report. The summary in the main report shows current performance in cleanliness and infection prevention and control against the work plan.

3.0 The Main Report

3.1.1. Introduction

This report provides an update on progress made within Quarter 1, 2022/23 to the Board of Directors, to ensure that the Board are briefed at a high-level on any trends or issues that identify best practice or any gaps in assurance from which further work or actions are required.

3.1.2. Infection Prevention & Control Committee (IPCC)

IPC Programme of Work (POW) has been developed with fresh objectives set for 2022-2023.
The IPC team continue to align all objectives to the 10 criterions set out in the Health & Social Care Act 2008.

Additional support provided by NHSE/I and CCG has had a positive impact on the progression of actions. Resulting in the 3-year plan being condensed to an annual plan. The Quality Management System (QMS) will continue to monitor progress with full programme reviewed at IPC&C Committee.

3.2. Cleanliness

Measured cleanliness has been maintained above the National calculated target (85.0%) and Trust target (94.0%) over the most recent quarter, achieving an overall average for the quarter of 98.83%, demonstrating a 2% increase from last quarter, in line with improvements reported through internal and external audits and reviews specific to infection prevention & control.

3.2.1. Cleanliness – Detail

Infection Prevention & Control & Cleanliness Quarter 1 Report 2022/23

3 functional areas failed to meet their cleanliness target by average across the quarter, all reporting average scores within 1% of their target score and therefore achieving a 4-star cleanliness rating. Any areas which fail to meet a 5-star rating for an individual audit are escalated through the Trust's Infection Prevention & Control Working Group, where any themes or potential contributing factors can also be shared with the multi-disciplinary team.

4 functional areas did not meet their National Specification for Cleanliness target audit for an individual month across the quarter – 3 in the FR1 category (this is, in part, due to the high score required to achieve a pass in this category, less than 1 in 50 elements failing) and 1 in the FR2 category.

All cleaning related fails are issues to Cleaning Technicians the morning following the audit, with a 24-hour deadline for completion; standard practice is for the Cleaning Technician to resolve all fails the day they are issued with the actions. Compliance is recorded via technician sign off and follow up spot checks by supervisors.

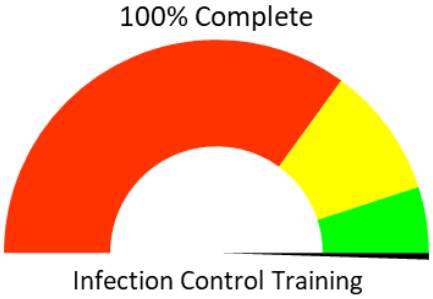
Actions identified through this process continue to be raised via action sheets to the relevant team, which includes meeting with ward/department managers to discuss potential strategies to avoid repeated fails.

Fail Theme	Action Response
Limescale build up on taps	• Phased roll out of IPS units with 'Marquick' taps (able to remove to complete robust descale) • Trial of gadget to support prolonged soaking of limescale remover on stubborn areas
Damaged/rusty waste receptacles	• Trust wide roll replacement of non-compliant waste bins
Wall & floor damage	• Formal escalation of fails through IPC working group to support funding and access to support risk-based approach to renovations

High/Low level dust areas difficult to access areas	Short Term Action • Utilised external contractor to undertake programme of deep cleaning across clinical departments • Support clinical areas to review unnecessary items/clutter and organisation of store cupboards and 'nonclinical' areas of wards & departments Long Term Action • Implement housekeepers in clinical areas will support effective cleaning by ensuring areas are made accessible for regular cleaning to take place

3.2.2. Cleanliness – Staff Competency

Training has a very high compliance for the rolling 12-month period, demonstrating our commitment to the highest level of staff competency. The rolling year position at end of June 2022 is shown.

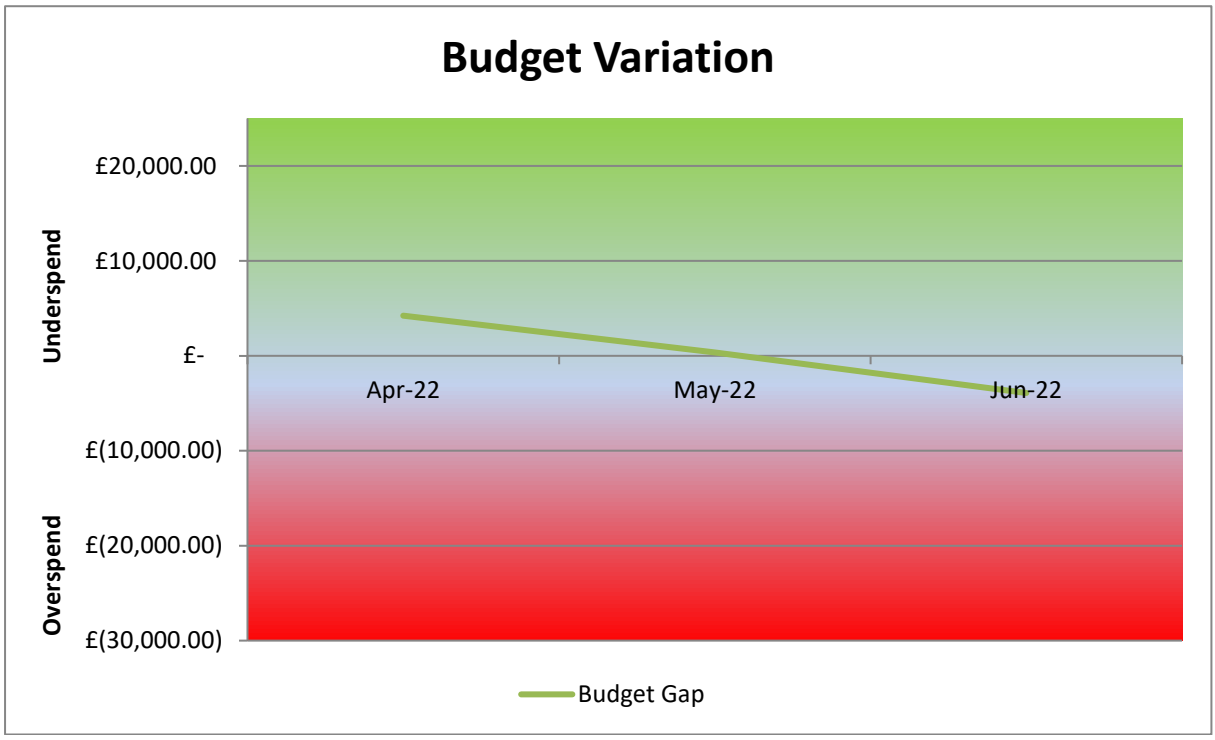


Staff across the Trust have also been required to complete NHS Midlands 'Cleaning for Confidence' programme, which reinforces the basic processes of cleaning and good cleanliness practice for staff in both clinical and non-clinical roles. Compliance at end of June 2022 is demonstrated below.

	Completed "in date" Cleaning for Confidence		
	Once Only		
Unit	**Number to complete**	**No's completed**	**% Complete**
Assurance & Standards Team	252	239	94.8%
Clinical Services Unit	302	287	95.0%
MSK Delivery Unit	424	400	94.3%
Office of the CEO	10	9	90.0%
Specialist Delivery Unit	298	284	95.3%
Support Services Unit	157	145	92.4%
Covid-19 Vaccination Centre	0	0	
TRUST WIDE TOTAL (Including Medical Staff)	**1443**	**1364**	**94.5%**
Bank Staff	173	146	84.4%
TRUST WIDE TOTAL (including Medical and Bank Staff)	**1616**	**1510**	**93.4%**

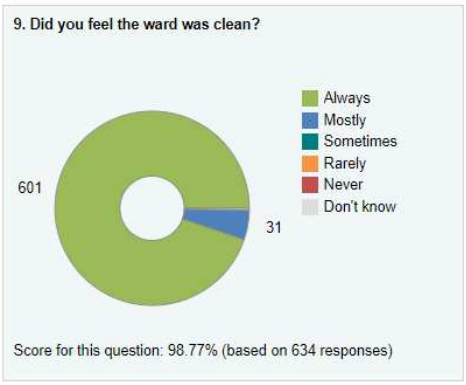
3.2.3. Cleanliness – Spend on Cleanliness

The below chart demonstrates the position at end of June 2022. Whilst staff spend is on track year to date, spend on non-pay items, specifically cleaning materials, is driving a small overspend.

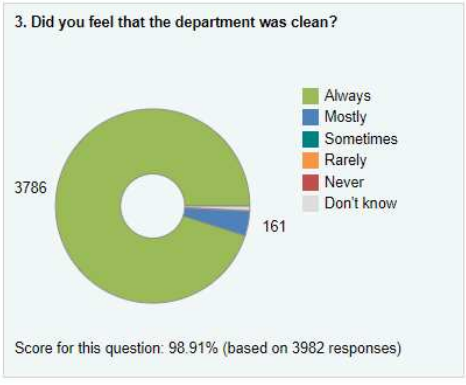


3.2.4. Cleanliness – Patient Satisfaction

As part of feedback questionnaires, patients are routinely asked if their ward or department felt clean. Comments are regularly fed back to operational teams.



Inpatient & Day Case



Outpatients

There were no comments, or detail relating to this specific question recorded, however feedback from the patient experience module included:

- I was very impressed with the efficiency of all the staff and cleanliness of the whole place *(Main Outpatients, April 2022)*
- Exceptionally clean, bright ward and room. I was on Ludlow and the hospital environment far exceeded my expectations *(Ludlow Ward, June 2022)*
- Spotlessly clean and safe covid protocol, lovely friendly staff. A credit to your organisation, very well-done thankyou *(MRI, May 2022)*

3.2.5. Specific Cleaning & Cleanliness Improvements

HPV Decontamination

The facilities team continues to provide HPV fogging decontamination in response to the Trusts needs via Dewpoint solutions. A summary of usage over the quarter is shown below. Following the update of the infection control isolation policy, room cleaning requirements are designated as:

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

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

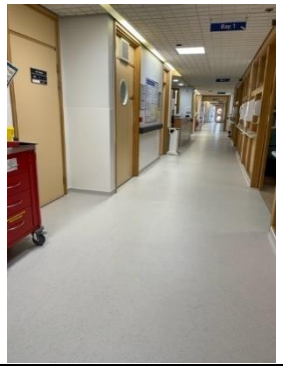
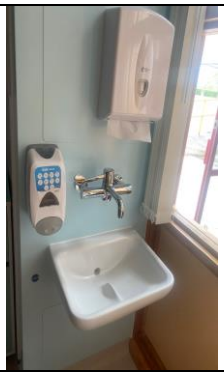
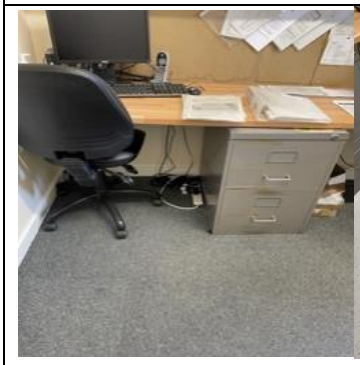
HPV fogging undertaken on site this quarter is summarised below:

Date	Ward/Department	Area	Rationale
16/05/2022	Gladstone Ward	Side Room	Red Clean
27/06/2022	Gladstone Ward	Side Room	Red Clean
28/06/2022	Wrekin Ward	Side Room	Red Clean

Collaborative Working

Through the IPC working group, the Estates & Facilities team continue to advocate a multi-disciplinary approach to environmental improvements across the Trust.

<table>
<tr><td colspan="2">Theatre Department Cleaning Cupboard & Lobby</td></tr>
<tr><td>   </td><td>• Updated sluice & handwash sink,
• Floor coverings,
• White rock fitted to walls,
• Shelving and racking replaced</td></tr>
<tr><td colspan="2">MCSI OPD</td></tr>
<tr><td>   </td><td>• Flooring
• Wall protection
• Door frame protection
• Creation of additional clinical room, combining x2 admin rooms to facilitate</td></tr>
<tr><td colspan="2">Clwyd Ward</td></tr>
</table>

 	• Bay refurbishment – flooring • IPS sinks • Radiators • Works remain ongoing
Speech & Language Therapy Office	
 	• Carpeted floor replaced with non-slip wipeable floor.

3.2.6. Compliance Update - Facilities

National Standards of Healthcare Cleanliness

The National Standards of Healthcare Cleanliness we published in May 2021. Developed in collaboration with an expert multi-disciplinary team including Infection Control, Health and Safety, Nursing, Clinical and Microbiology leads and healthcare cleaning professionals, the standards seek to drive improvement whilst allowing maximum flexibility to suit the needs of all healthcare organisations.

The standards are mandatory, with acute Trusts given implementation guidance and a deadline for completion of May 2022.

Implementation of the New Standards has been managed through the Infection Control Working Group. At each stage, relevant stakeholders (including the Senior Nursing Infection Control, Operational Cleaning and Ward/Department teams) are consulted. Facilities colleagues have benchmarked with system colleagues, to promote a consistent approach across all partners when implementing and communicating the standards.

Feedback, in particular for clinical colleagues following the launch of the standards at the Trust on April 1st has included:

- Star ratings are clear and easily understood by staff and service users. They provide a clear way of celebrating good practice.
- New responsibilities and frequencies have promoted ownership and focus on periodic cleaning.
- Efficacy audits have been welcomed by ward managers; the promote accountability and foster good relationships between wards & facilities colleagues with a focus on patient safety and good infection prevention practices.

As defined through the standards, formal escalation processes have been agreed through the infection prevention control working group and committee.

The final aspect of the standards to be rolled out will include arranging the external audit, where a subject specialist from our system partner will review results of both technical, and efficacy audits alongside an on-site review to provide assurance of the Trusts internal monitoring processes. This will be scheduled for Q3 2022/23.

Infection Prevention & Control & Cleanliness Quarter 1 Report 2022/23

Linen

Whilst under current restrictions, the Trust has been unable to complete its annual site audit of the linen contractor; assurance has been gained through monthly compliance reports – in line with their ISO accreditation and BS EN 14065 (Laundry Processed Textiles Biocontamination Control System) these include:

- Swatch testing (Machine Performance)
- Swab Testing (Personnel Hands)
- Swab Testing (Environment)
- Bioburden Testing (Final Products)
- Rinse Water

The linen contractor annual audit was completed in May 2022, attended by both facilities and IPC colleagues from across the consortium.

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

A formal audit report was issued on behalf of the consortium, and actions monitored through infection prevention & control working group. A re audit will be undertaken in late July / early August 2022 to gain assurance of action completion.

PLACE

The National PLACE assessment programme was paused throughout the pandemic, with the last national assessment completed in September 2019. Trusts have been encouraged to undertake internal assessments, using the PLACE lite tool. The tool and associated guidance have been updated, with additional questions in the mood data collection focusing on key recommendations of the National Food Review, and Buildings and Facilities data collection including reference to the National Standards for Cleanliness, Commitment to Cleanliness Charter and visible star ratings.

A programme of audits has been developed, covering all wards and departments usually assessed by the National model, with representation from Estates, Facilities and Clinical teams undertaking the assessments.

Ward/Dept Name	Audit Date	Cleanliness	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	Movement from Previous Audit
Oswald	07/04/22	100%	100%	100%	100%	100%	→
Ludlow	09/06/22	100%	76.92%	100%	45.45%	51.14%	↓ (19.5%)

Immediate feedback is shared with the ward/department team, accompanied by a copy of the full assessment report & associated comments.

Ludlow ward has seen a decline in score since the 2019 audit, despite significant improvements in the environment (as demonstrated by 100% scores in cleanliness & condition domains). The group recognised that whilst IPC concerns had been addressed throughout the ward, the installation of white floors, walls and protective cladding did not meet patient experience criteria defined by PLACE. The action plan was issued to the ward, who are working with estates teams and the Trusts charity to action. This includes purchase of large face clocks, a review of bathroom signage and installation of wipeable murals to add colour to walls.

Actions and themes identified through this audit programme will be monitored by the Infection Control Working Group. Where areas of good practice are found, the group will look to share this across the Trust, encouraging a consistent approach which will improve overall scores once the National programme is reinstated in September 2022.

COVID-19 Response

As previously reported, Estates & Facilities continues to support the wider Trusts COVID response, with the focus now on maintaining compliance with National guidance and safety measures whilst restoring services:

- Use of National Standard Operating Procedures for cleaning, including additional touch point cleaning and enhanced service, additional cleaning in staff only and office areas and documentation through additional sign off sheets has continued.
- Escalating any waste management issues to NHS England and maintaining links with professional stakeholder groups to ensure any limitations in terms of clinical waste disposal nationally are considered in a timely manner.
- PPE Management including stock control, top up delivery and liaison with regional partners and NHS England to ensure continued supply.
- Management of fit testing for FFP3 masks, with operational support for testing provided by NHS England, including this quarter a focus on ensuring staff are fitted to more than one model of mask.
- In order to support restoration, services are being brought back with consideration to all infection control guidance via the Estates Plan meeting – with representation from the Senior Leadership Team and Estates & Facilities. Challenges arising here are focused on keeping staff and patients safe.
- Ongoing support for the Trust vaccination hub including management of consumables and PPE for this service.
- Ongoing capital projects supporting the IPC agenda including further installation of wall cladding/protection, replacement of handwash basins, purchase of 'Air Scrubber' units.

3.2.7. Compliance Update – Estates

It is noted that chair reports will be produced and sent to IPC for assurance or escalation, replacing minutes previously circulated.

Decontamination and Ventilation Equipment Updates

Audit

Estates support the business continuity of the Trust sterile services by maintaining the on-site decontamination equipment on a scheduled periodic basis. These periodic tests challenge the processes carried out by the decontamination equipment in 'worst case scenarios' to validate the machines for safe use. All periodic testing due this quarter has been carried out; 133 weekly tests, 6 quarterly tests and 5 yearly tests. As is standard practice all out of parameter results are followed up and resolved (note that no decontamination equipment is returned to service until it passes its periodic test).

All periodic testing is audited by the Trust appointed Authorising Engineer (Decontamination).

Settle plate testing was resumed at the end of May 22 with no concerns raised.

Reverification of the Critical Air Plant across site is a requirement of HTM 03-01 and is completed annually for each piece of equipment. Where remedial works cannot be completed, this is escalated through Decontamination Group. All reverifications due in Q1 have been completed

Water Hygiene Updates
Audit

In line with HTM 04-01 and HSE Legionella Approved Code of Practice document, L8, the Trust conducts routine maintenance on the domestic water infrastructure across site on a planned and reactive basis. This quarter, the following water quality samples were taken:

Type	05/04/2022 → 30/06/2022
Legionella	51
Pseudomonas	69
Hydropool water quality	12
Z Bacteria	24

As is standard practice all out of parameter results are followed up and resolved.

3.3. Infection Prevention & Control

3.3.1. Training

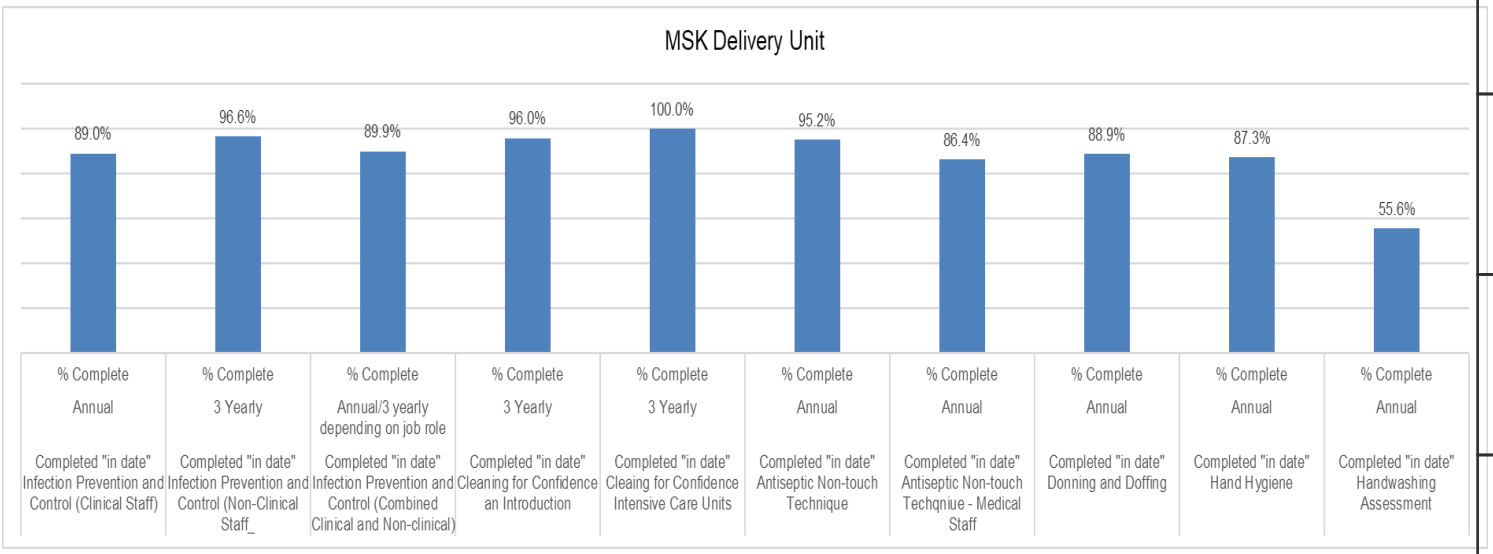
Training report is now presented by the Learning & Development Manager to the IPC&C Committe

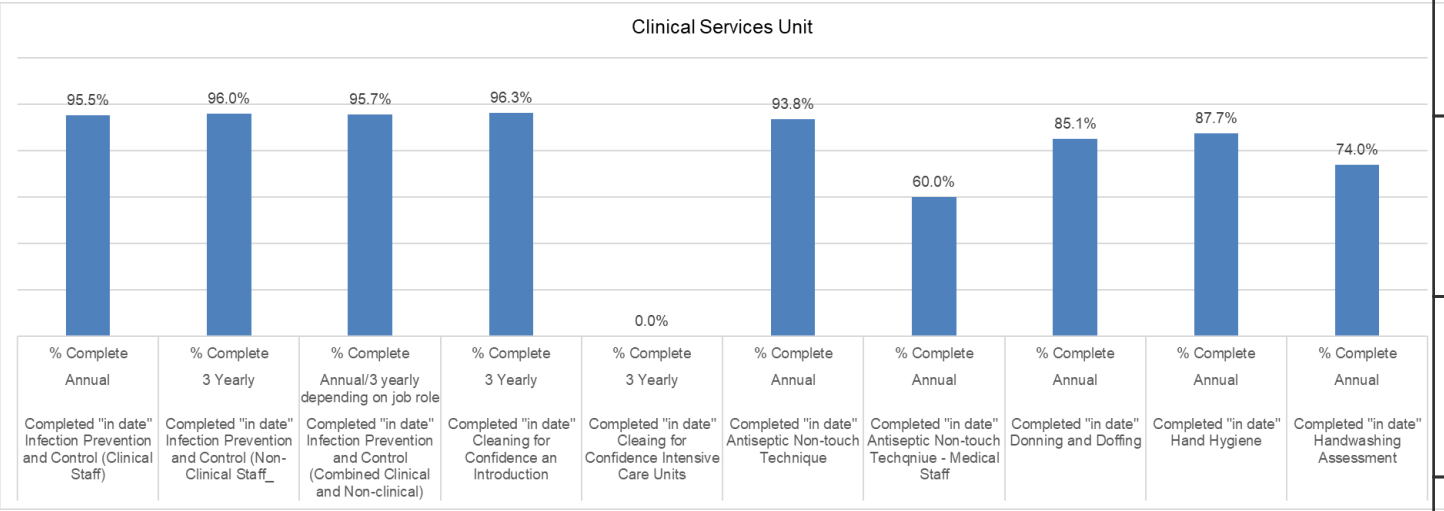
Hand Hygiene Competencies

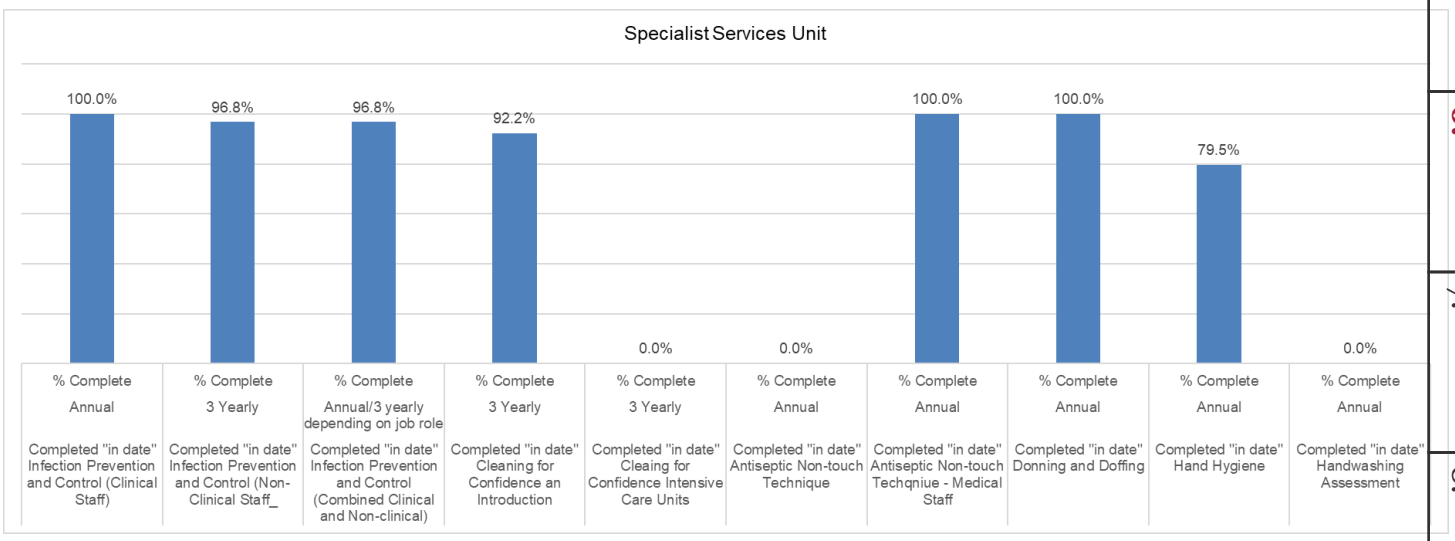
Hand Hygiene training is now a mandatory training module on ESR for all staff, clinical and non clinical.

Training comprises of a hand hygiene video that all staff are mandated to watch.
On completion of the video, this will electronically update staff compliance and singularly will satisfy compliace for non clinical staff. Clinical staff are required to complete an additonal practical element demonstrating correct technique to obtain full hand hygiene competency.

The Training team will continue to manage compliance to hand hygiene competencies on ESR inline with other mandatory training modules. Training report presented at IPC&C Committee will include compliance activity for all IPC training.







3.3.2. Infection Control Link Meetings

Link meetings are held on bi-monthly basis. IPC Link staff are required to disseminate infection prevention and control updates/information to their work colleagues, as set out in the Link Staff Roles & Responsibilities document.

Improved attendance was noted at the last IPC Link staff meeting in June. The IPC Team will utilise the IPC Bulletin, circulated Trust wide on a bi-weekly basis to promote and encourage Link Staff attendance.

Meetings will continue to be recorded to ensure all Link staff remain up to date with IPC related information.

June 22

- IPC Team Update
- Outbreaks
- Tendable - Audits & Action plan management
- IPC Bulletin
- Updates to national guidance - Monkey Pox, Coronavirus
- Surgical Site Surveillance - Surgical Site Infections, PIR process.

IPC Quality Assurance Audits

A total of 17 quality assurance audits were undertaken in Quarter 1 in the following areas:

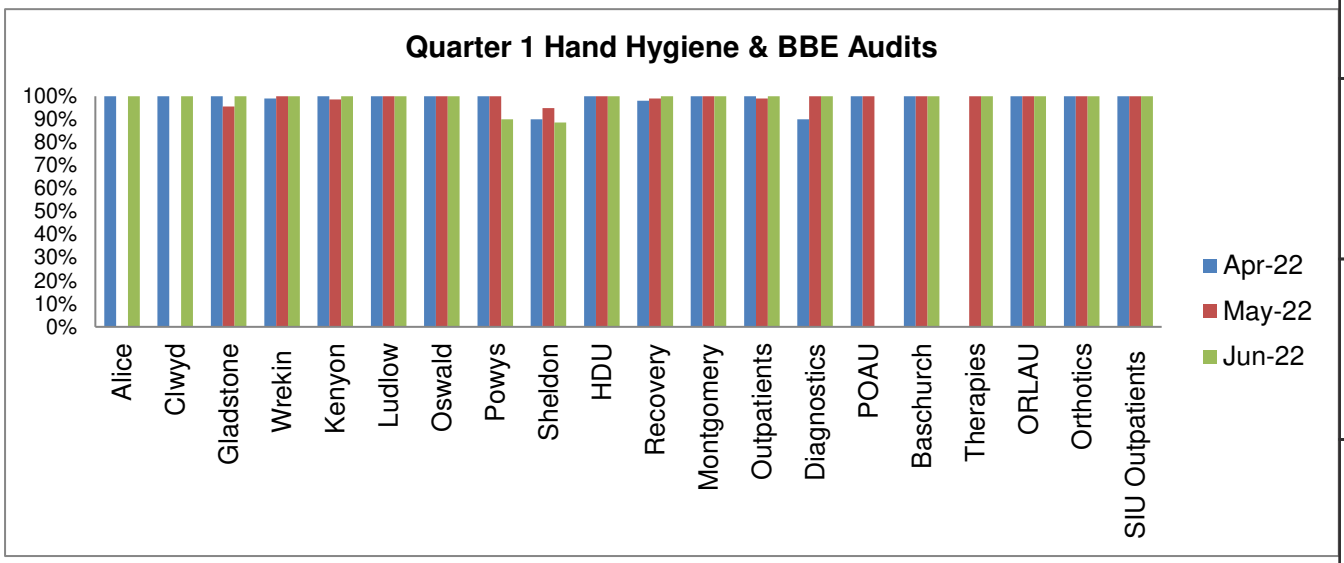
IPC Team reporting a 97% compliance to the completion of QA Walks with one walk due for Diagnsotics behind plan due to outbreak prioritisation. Audit will be undertaken by the IPC HCA with dates being arranged for July 22.

Ward/ Department	No. of Walks	General Observations
Gladstone	1	April 22: 93% Green = redaudit 6 months Multiple packets of lubricant in bathroom Shared box of lubricant gel in bathroom between bay F and G Macerator cleaning checklist completed but macerator unclean. Items found on the floor of the Sluice Clean rooms not clean and in poor state of repair with gloves dispenser to be removed from above sink. Inappropraite items in sharps bin with no temporary closing mechanism in place. Pumps ot labebelled and one unclean. Pull cords badly scaled
Oswald	1	April 22: 97.9% Green = reaudit in 6 months
Sheldon	1	June 22: 97% Green = reaudit in 6 months Some dust obeserved on Danicentres No wipes on Obs machines.
Recovery	1	April 22: 92.7% Green = reaudit in 6 months
Montgomery	1	April 22: 100% Green = reaudit in 6 months
Theatres	1	May 22: 93% Green = reaudit in 6 months
Outpatients	1	April 22: 94% Green = reaudit in 6 months
Diagnsotics	2	April 22: 83% Amber = reaudit Monthly Poor completion of cleaning checklists Detergent wipes not available on observation trolley Dust located under chairs. Dust located on curtain rails Holes located in walls May 22: 86% Amber = reaudit Monthly Detergent wipes not available on observation trolley

		Dust located under chairs. Dust located on curtain rails Holes located in walls Improved completion of cleaning checklists observed in reaudit with similar issues remaining from April. Further audit planned for June but not yet undertaken and behind plan.
Baschurch	1	April 22: 96.3% Green = reaudit 6 months
Physiotherapy	5	QA Walk undertaken in April 22 with an amber rated score of 81% Further audit undertaken in May 22 with areas failing to score above a red rating of 76% Escalation process engaged with reaudit planned within 7 days with Unit Lead and Therapies Manager in attendance. Unresolved issues saw a further deteriorated score of 70%. ACN led a thorough review with works undertaken to improve the following areas: • Identify adequate/suitable areas for storage. • Remedial works to physiotherapy equipment. • Organisation of kit • Replacement of pool side furniture. Further walk undertaken end of June with an improved score of 92%
Ludlow	1	May 22: 94% Green = Reaudit in 6 months
Powys	1	May 22: 90% Green = Reaudit in 6 months Poor completion of cleaning checklists Poor compliance to patient mask wearing observed Bed pan holders clean but not labelled.
Common themes identified		The following themes for non compliance have been identified: • Cleanliness of envrionment • Cleanliness of equipment • Cleaning checklists not completed • No BBE poster on entrances to the ward & depts Actions were generated where poor practice was observed. Data detailing all open actions will be extracted from Tendable on a monthly basis. The Infection Control & Cleanliness Working group will monitor progress and provide traction on actions. Trustwide review was undertaken for signage relating to hand hygiene and bare below the elbow by the IPC team. Details can be located in section 3.3.6.5

3.3.3 Ward and Departmental Audit

3.3.3.1. Hand Hygiene & Bare Below the Elbow



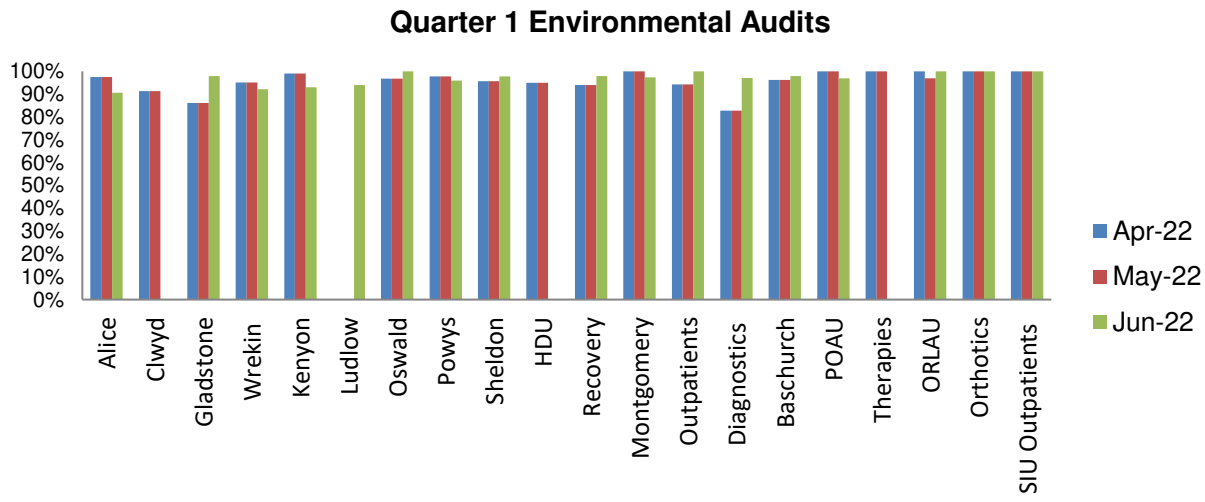
The above graphs demonstrate an average 99.4% compliance in Hand Hygiene and Bare Below the Elbow was achieved for this quarter.

A tailoring session was undertaken to review audit question set due hand hygiene competencies being managed via ESR. Questions relating to departmental compliance was therefore removed and as a result, scores improved for this quarter.

The portable SureWash Go device remains available for staff to assist in the practical element of the training.

The Trust continues to undertake ward & departmental IPC audits via the app-based audit system (Tenable) and audit questions are periodically reviewed to enrich data collection.

3.3.3.2. Environmental Audits



Scores for Environmental audits averaged at 97.2% for the quarter.

No audit was undertaken on Ludlow Ward for April and May 22 due to ward closure.

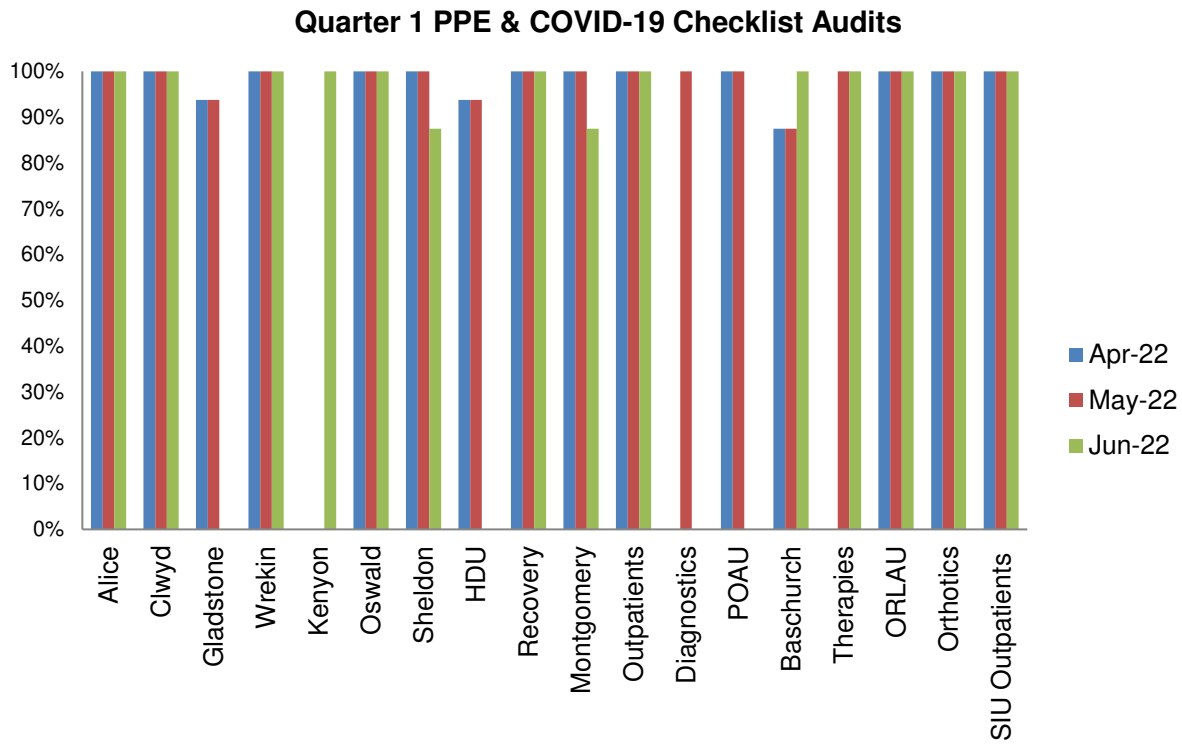
All failings have been summarised below with actions undertaken:

Location	Issue	Action Taken *(extracted from Actions on Tendable)*
Alice Ward & Theatres	Floors in poor state of repair with rubber lifting.	Works itemised on the Estates job plan.
Ludlow Ward	Hand cream dispenser missing	Dispenser removed during extensive refurbishment – replacement now installed.
Gladstone Ward	Bathrooms contain inappropriate items – Multiple packets of lubricant	Recent visit from NHSE/I a suggestion was made for bags/pouch to be located outside bathrooms to contain gloves, gel etc, to reduce the need to have gel etc in the bathroom

3.3.3.3 PPE & COVID-19 Personal Protective Equipment Checklist Observational Tool

PPE and COVID-19 checklist audits are amalgamated to align with the audit set up on Tenable.

Audits for the quarter demonstrate an overall compliance of 98.2%



The graphs above show no audits were undertaken in Diagnostics and HDU for June 22.

The following areas fell below the 95% target for this quarter due to some members of staff not being fit tested to FFP3 masks:

- Sheldon
- Baschurch
- Montgomery

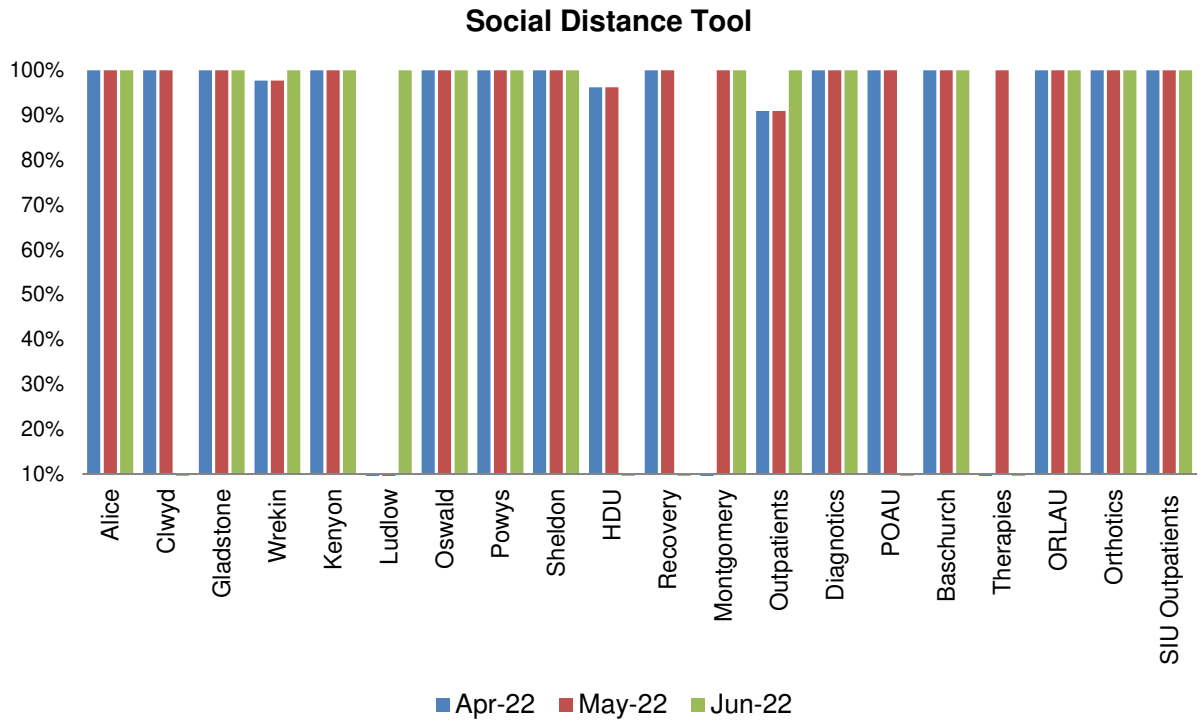
Department of Health Fit testers are still on site and there is a booking system in place for staff who require testing

Lack of audits undertaken for Kenyon ward in April was due to ward closure.

Failure to undertake audits is monitored by the Unit matron/lead via Perfect Ward/Tenable. All audits will continue to be reviewed to streamline frequencies.

3.3.3.4 Social Distance Checklist Observation Tool

The graph below shows an improvement to the volume of audits undertaken in this quarter. Results show an overall compliance 96.6% to social distancing requirements for this quarter.



Results show that all areas scored above the 95% target in Quarter 1.

Audits were not undertaken on Ludlow ward for April and May due to ward closure.

Improvements to clutter around nurses' stations has been noted within this quarter.

Clwyd ward have resolved an histroic issue relating to patients luggage being left at the central ward station. An alternative area has been identified for their safe store, away from the clinical area.

Therapies were assigned a QR code as part of the second phase role out of Tendable. Therapies Manager, IPC Assurance Lead and Tendable Quality Lead met in June to develop a comprehensive suite of questionsets for the department. Questions are currently being validated by the Tendable and will be uploaded to the system once complete to allow Therapies to undertake all audits electronically.

3.3.3.5 Correlating Themes

The IPC QMS has recently been expanded to sequentially analyse data generated from all IPC related audits. A quality accounts section has been developed to sub analyse the data and identify correlating themes.

There were 2 main themes captured within this quarter, summarised below:

Theme	Actions taken to improve compliance
Cleanliness of Environment	Open actions will be extracted from Tendable and will be reviewed by the Infection Control & Cleanliness working group monthly. The group will monitor upward trends and trouble shoot IPC related issues identified.
Cleanliness of equipment/labelling	

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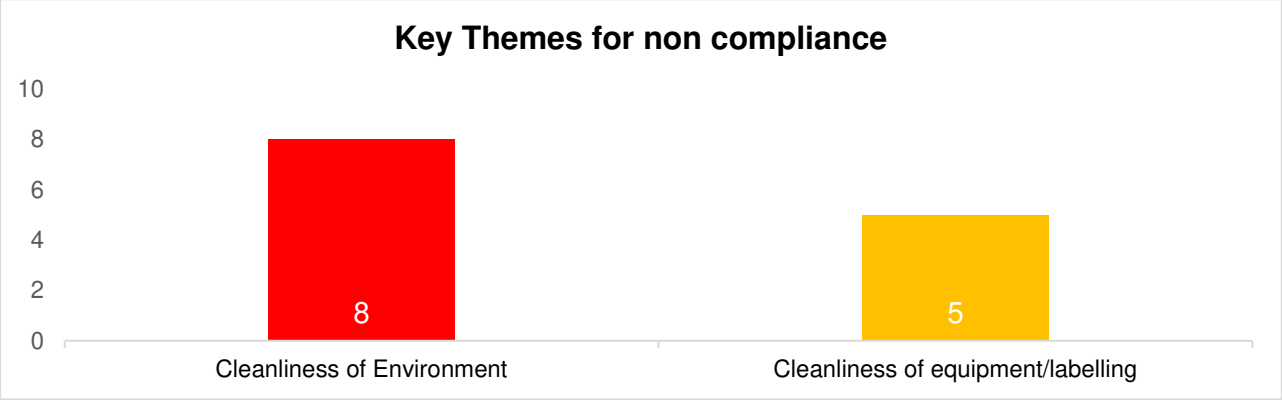
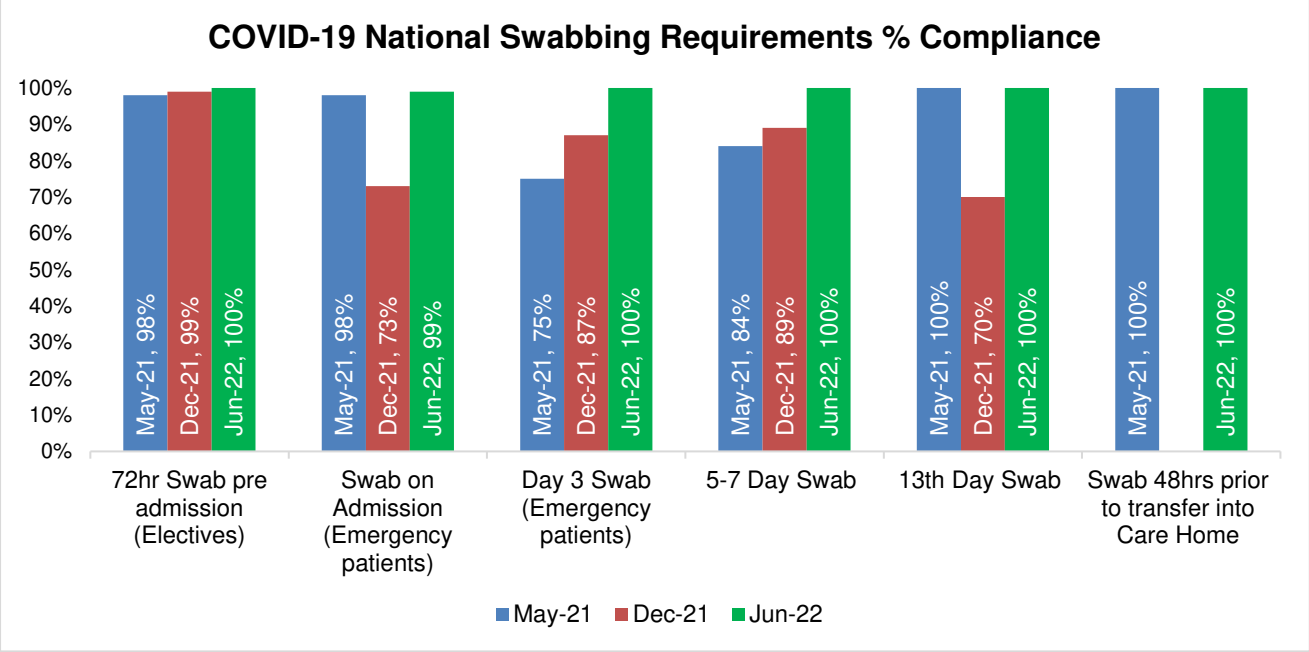


3.3.3.6 COVID-19 National Screening Requirements

Follow up audit was undertaken in June 22 to monitor Trust compliance to COVID-19 national screening requirements for all inpatients.



Findings showed significant improvements of compliance to day 3, 5-7 day and 13th day screening from that of the previous audit undertaken in December 21.

The IPC team will continue to monitor compliance to requirements in line with national guidance. Audits will be undertaken twice yearly tracked via the annual audit programme assigned to the IPC QMS. Further audit has been planned for December 22.

3.3.4 Surgical Site Surveillance

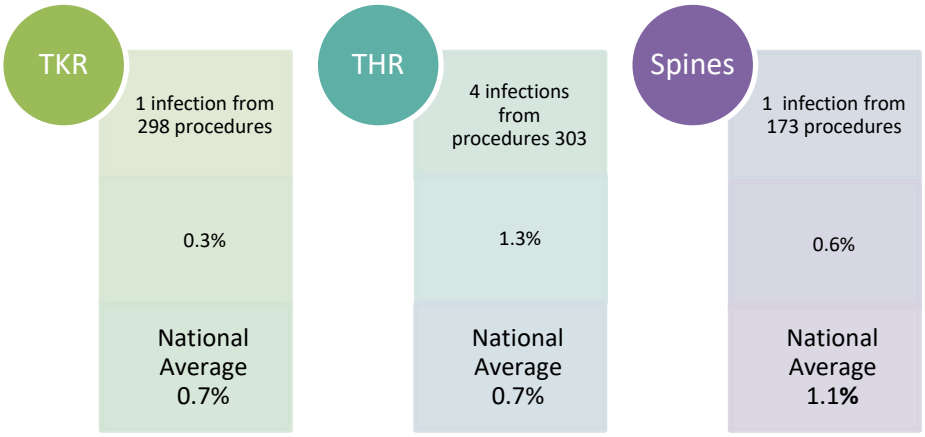
Providing data to the national SSI process enables the Trust to benchmark on a national basis with other Trusts. The process uses nationally agreed criteria from which the definition of a Surgical Site Infection is formed.

Understanding surgical site infection rates enables the Trust to estimate the risk of SSI in patients undergoing specific operations.

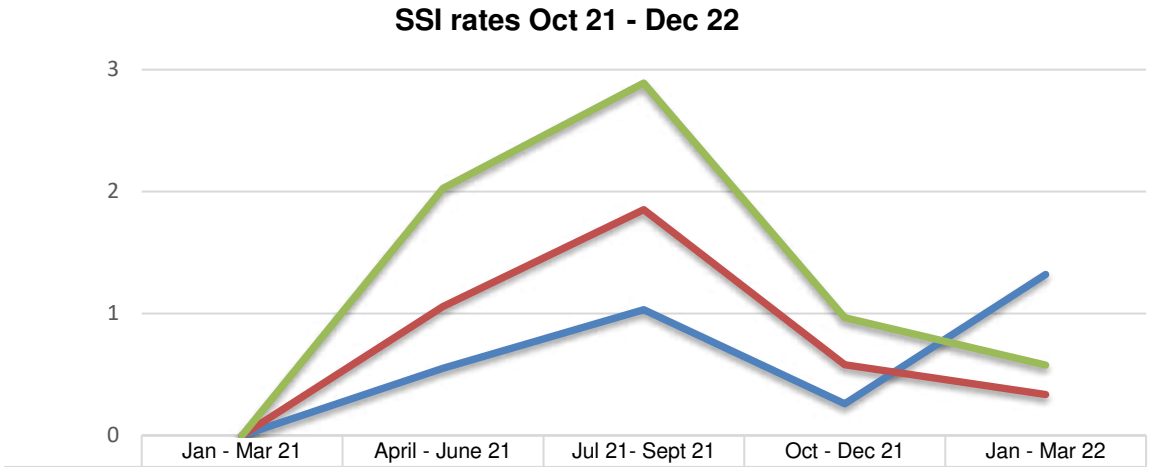
Year-round surveillance is performed for total hip, total knee and spinal surgeries which is above the national requirement for one quarter of surveillance in one category of surgery per year.

The Trust submits surgical site infection data to the SSISS database on a quarterly basis; reports are always one quarter behind to allow a window of time for any infections to present.

The data below shows the SSI rates for January- March 2022. The Trust has reported a total of 6 surgical site infections for this quarter.

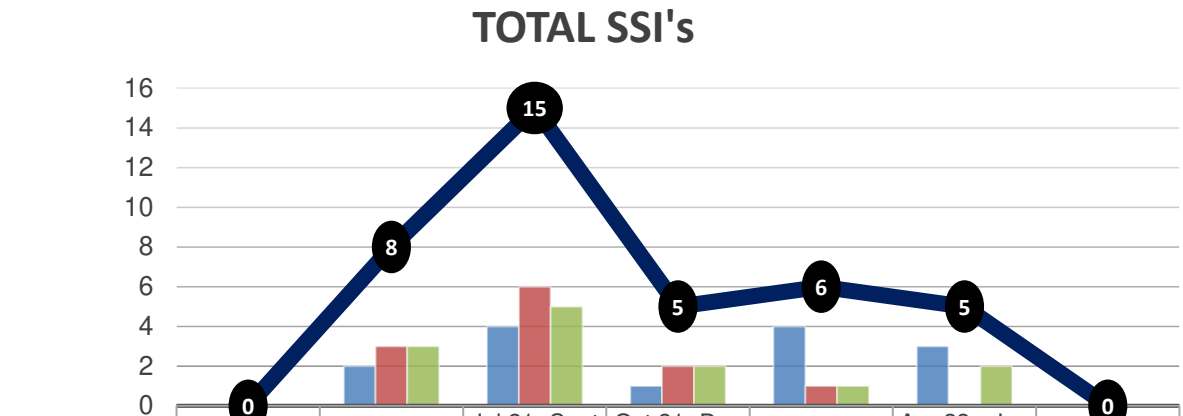


The Surgical Site Surveillance Nurse liaises with the consultants concerning wound infections. The data for Jan- March 2022 has been verified and the results have been submitted to UKHSA and published on their web site. All of these infections were discussed and confirmed at the Infection Multi-Disciplinary Team meeting (IMDT).



	Jan - Mar 21	April - June 21	Jul 21- Sept 21	Oct - Dec 21	Jan - Mar 22
Hips	0	0.6	1.0	0.3	1.3
Knees	0	1.1	1.9	0.6	0.3
Spines	0	2.0	2.9	1.0	0.6

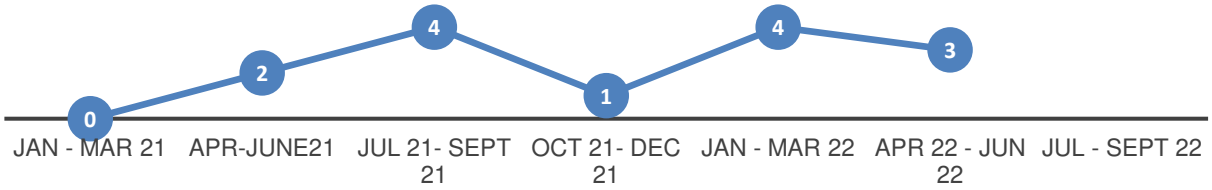
The graph above shows RJAH Infection rates for the last 12 months. Rates for Hip (THR), knee (TKR) and spinal surgery.



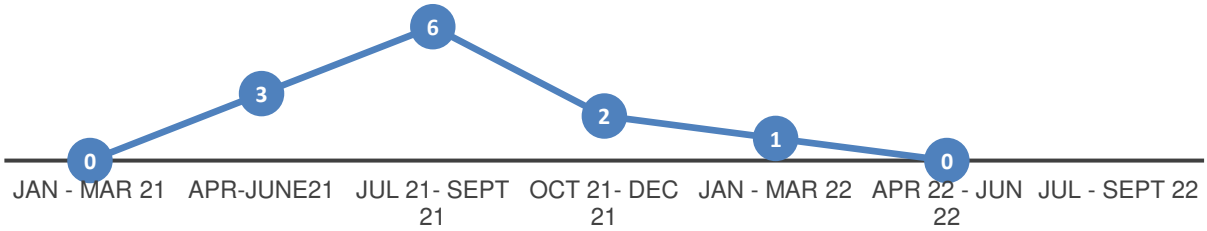
	Jan - Mar 21	Apr-June21	Jul 21- Sept 21	Oct 21- Dec 21	Jan - Mar 22	Apr 22 - Jun 22	Jul - Sept 22
Hips	0	2	4	1	4	3	
Knees	0	3	6	2	1	0	
Spines	0	3	5	2	1	2	
Total	0	8	15	5	6	5	0

The Trust reported a total of 6 SSI infections for January– March 22; the graphs below show the breakdown for each speciality:

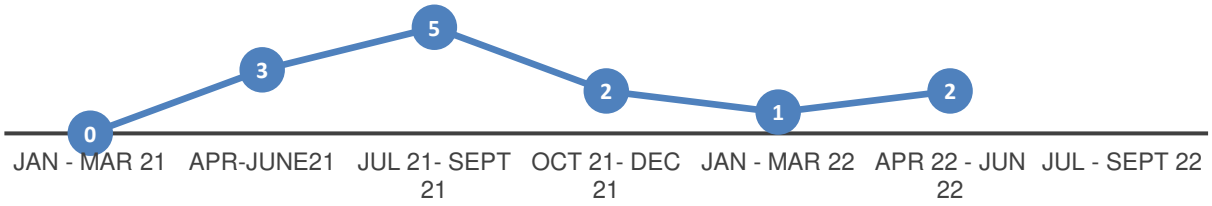
RJAH TOTAL HIP SSI (THR)



RJAH TOTAL KNEE SSI (TKR)



RJAH TOTAL SPINES SSI



SSI analysis tool has been expanded to include ongoing collection of key themes and contributary factors, identified following Post infection Review (PIR) meetings and the IPC Quality Management System (QMS) has been structured to track SSI rates against the national average for each speciality.

3.3.5 MRSA Swabbing and New Isolates

MRSA swabbing for all admissions (pre-operative assessment and emergency) continues and is monitored internally to ensure that the Trust remains compliant to the national requirements.

	April 22	May 22	June 22
Eligible patients	533	841	777
Screened for MRSA	531	841	773
% achieved	99.62%	100%	99.49%
Target	100%	100%	100%

MRSA and decolonisation

MRSA screening compliance remains high and above the target set by the commissioners. MRSA swabs that have not been undertaken are reported to the relevant line managers for investigation.

During quarter 1 a total of 3833 MRSA screening samples were received by the lab from RJAH. 2542 of these samples were collected from the Pre-Operative Assessment Unit (POAU) with no positive MRSA samples reported from a total of 2140 patients.

There have been no new inpatient MRSA acquisitions during this quarter.

The table below shows the breakdown of patients tested.

Location	Total Number of swabs	Number of patients	Number of positive MRSA (SAUR)
Pre-admission swabs	2542	2140	0
Other	1291	519	2
Totals	**3833**	**2659**	**2**

3.3.6 Alert Organisms

3.3.6.1 Clostridioides.*difficile*

There has been 1 reported case of C.*difficile* during Quarter 1. The patient had been on two courses of antibiotics for a chest infection. A post-infection review was undertaken which highlighted that the staff followed the policy and the case was managed well, however due to minimal attendance at this meeting is was agreed to complete a further review on 28th July 2022, as the patient has since had a relapse of C.*difficile* following appropriate treatment.

3.3.6.2 MSSA bacteraemia

There have been no MSSA bloodstream infections reported during Quarter 1.

There is not a set objective against MSSA blood stream infections.

3.3.6.3 E.coli/Klebsiella/Pseudomonas bacteraemia

There was one case of klebsiella bacteraemia for Q1 against a threshold of two. A post-infection review (PIR) was undertaken which defined this case as unavoidable. Lessons learned were identified in relation to the need to ensure that VIP scores needed to be improved – this was shared by the ward manager and displayed on a notice board as a reminder for staff. It was noted that going forward, the outreach team will be invited to future PIRs if they have been involved in patient care.

Post Infection Review meetings were undertaken for the above infections. Outcomes from PIRs are captured via the IPC QMS with a recurrent theme of poor completion of VIP scores identified.

3.3.6.4 COVID-19 Coronavirus

Outbreaks

During Quarter 1 the Trust continued to react and implement changes in response to COVID-19. The Trust reported 4 Covid outbreaks which are summarised below:

Dept	Date declared	Outbreak type	How many involved (staff and pts)	Themes identified/Contributory Factors	Actions Taken
Gladstone Ward	20/04/2022	Covid-19	2 patients 2 staff	Close contact of visitor. Covid contact would not isolate due to mental health reasons	Restricted visiting
Sheldon Ward	20/06/2022	COVID-19	2 patients 1 staff	Delay in identifying a patient as COVID-19	After action review completed and shared
Logistics	23/06/2022	COVID-19	4 staff	No root cause identified	After action review completed and shared
Electricians	24/06/2022	COVID-19	3 staff	No root cause identified	After action review completed and shared

Regular outbreak meetings were held which included representation from NHSE/I, UKHSA and ICS. The IPC team used an outbreak collection tool that has been shown to standardise the process for the collection of information in the event of an outbreak and to provide a consistent approach. This includes standard actions to be taken in the event of an outbreak, such as deep cleaning, IPC

assurance audits and training compliance data.

3.3.6.5 Board Assurance Framework, GAP analysis and Quality Improvement.

An updated version of the IPC Board Assurance Framework (BAF) was released on 24th December 2021 with 80 new key line of enquires (KLOEs) added and was presented to the Infection Control & Cleanliness Committee (IPC&C) in January 2022.

A documented evidence-based assessment was undertaken to determine Trust compliance. Approved position at the end of quarter 4 demonstrated robust compliance to 55 KLOEs with partial compliance to 25. Improvement plan was created to address gaps in assurance and strengthen compliance.

The improvement plan will be monitored via Infection Control & Cleanliness working group which continues to meet weekly following the NHSEI walk in February 22.

Works to introduce and refine key processes will continue to strengthen compliance to both frameworks with Trust wide position reported to IPC&C and Quality & Safety Committee.

IPC team continue to work collaboratively with wards and departments to deliver necessary improvements.

Issue	Action	Measurable Outcome
Poor Hand Hygiene compliance observed following IPC Assurance Walks	Trust wide Audit Hand Gel Dispenser	Audit undertaken to assess locational placement of hand gel dispensers in accordance with activity and footfall. Plan in place to re-site and replace dispensers
	Trust wide assessment undertaken of all hand hygiene signage on entrance to wards.	IPC Lead Nurse researching signage in other Trusts
	Relaunch of the bare below the elbow posters	New posters are now installed.
Outbreak Guide for staff.	Poster/one page guide to assist staff in the event of an outbreak.	Poster completed and circulated to all clinical areas.
Board oversite of Surgical Site Infections (SSI's)	Align SSI reporting with the monthly KPI reporting.	KPI's expanded to include a monthly breakdown for SSI's
		Data is now disseminated to ward level via the balanced score cards
		IPC QMS designed to capture live reporting.
Robust Post Infection Review Process for SSI's	Robust PIR process introduced and will be undertaken for all Surgical Site Infections agreed at Infection MDT meetings held on a weekly basis.	Live analysis helps to identify common themes and focus support.
		Surgical Site Improvement Working Group will drive further Improvement programmes where required. Learning opportunities disseminated Trust wide via SNAHP and Unit Governance Meetings

3.4 Serious Incidents

There were no SIs declared in Q1.

3.5 Conclusion

The Trust reports positive outcomes against national set targets for HCAI.

All orthopaedic surgery is being monitored closely and cases of suspected/confirmed infections are discussed at the Consultant led weekly Infection MDT meetings.

The Trust continues to follow national guidance to prevent and control the transmission of infections.

April – June remained particularly challenging times for the Infection Prevention and Control team due to a further rise in COVID-19 cases amongst patients and staff; resulting in outbreaks that placed increased demand for support in clinical areas.

Changes to national guidance continues to be a challenge in supporting the Trust to safely reopen capacity and flow whilst managing covid positive patients.

The IPC fair was a great success and demonstrated commitment from the Trust to ensure that infection prevention and control standards are embedded at the highest level possible, and that staff are equipped with the relevant knowledge and skills required to help keep our patients safe and prevent cross infection.

RJAH was escalated to Red on the NHSE/I IPC Matrix in August 2021. NHSE/I have continued to provide support to RJAH and the IPC team and alongside colleagues from partner organisations,

A full review was completed in June. Significant improvements have been made and the NHSE/I matrix has been reduced to amber.

IPC team

Sara Ellis Anderson

July 2022

Appendix 1: Acronyms

BAF	Board Assurance Framework
ANTT	Aseptic Non-Touch Indicator
C.*diff*	Clostridium *difficile*
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CQC	Care Quality Commission
E.coli	Escherichia. Coli
FFP3	Filtering Face Piece
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HPV	Hydrogen Peroxide Vapour
HSE	Health & Safety Executive
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPC(N)	Infection Prevention & Control (Nurse)
IPCC	Infection Prevention Control Committee
IPCCWG	Infection Prevention Control Cleanliness Working Group
KPI	Key Performance Indicator
MCSI	Midlands Centre for Spinal Injuries
MDT	Multidisciplinary Team
MRSA	Methicillin Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSSA	Methicillin Sensitive Staphylococcus Aureus
OPD	Outpatients Department
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessments of the Care Environment
PPE	Personal Protective Equipment
QMS	Quality Management System
QR	Quick Response
RAG	Red, Amber, Green
RCA	Root Cause Analysis

Appendix 1: Acronyms continued

RSH	Royal Shrewsbury Hospital
SaTH	Shrewsbury and Telford Hospitals
SNAHP	Senior Nurse and Allied Health Professional
SPC	Statistical Process Control
SSI	Surgical Site Infection
SSISS	Surgical site infection surveillance service GOV.UK
Tendable	In-house Auditing Software
THR	Total Hip Replacement
TKR	Total Knee Replacement
TSSU	Theatre Sterile Services Unit
UTI	Urinary Tract Infection

Glossary

Bacteraemia: The presence of bacteria in the blood without clinical signs or symptoms of infection

C.*Difficile*: or C.*Diff* is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.

E coli: is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.

HCAI: Health Care Associated Infection. An infection acquired because of receiving treatment in a health care setting.

MRSA: or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria, Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.

MSSA: or Meticillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community and are not associated with health care. However, some may arise because of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

0. Reference Information

Author:	Mary Bardsley	**Paper date:**	7 September 2022
Executive Sponsor:	Paul Kingston and Denise Harnin	**Paper written on:**	2 September 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the People Committee meeting held on 25 August 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of 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

- The meeting was quorate
- The Committee agreed for an extraordinary People Committee to be scheduled for consider the policies which were deferred within the meeting
- Concerns/areas to highlight to the Board relate to:
  - Nurse and AHP workforce - it was agreed that a progress report on the learning and development hub is to be presented on a quarterly basis.
  - Nursing Workforce Review – the Committee thanked Jacqueline Barnes for her support and welcomed the suggestion for the Operational Working Group to be established which will report to the People Committee on progress and actions being taken to improve nursing workforce.
  - Oversight Planning Framework - concerns were raised relating to the 3 areas (therapies, OPD capacity and consultant recruitment.) The agenda items will remain on the workplan with the next Consultant Recruitment update requested for September.
  - Freedom to Speak Up Action Plan - the Committee will receive a reviewed action log at the next meeting to support with oversight and to provide assurance.

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the People Committee which met on 25 August 2022. The meeting was quorate with 4 Non-Executive Director and 4 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Paul Kingston	Non-Executive Director (Chair)
Chris Beacock	Non-Executive Director
Sarfraz Nawaz	Non-Executive Director
Penny Venables	Non-Executive Director
Stacey Keegan	Chief Executive Officer
Denise Harnin	Chief People Officer
Ruth Longfellow	Chief Medical Officer (part meeting)
Sara Ellis Anderson	Chief Nurse and Patient Safety Officer
In Attendance:	
Sue Pryce	Head of People Services
Shelley Ramtuhul	Trust Secretary/Director of Governance
Amber Scott	Minute Secretary
Nia Jones	Head of Planning
Ian MacLennan	Assistant Chief Nurse for MSK Unit
Kirsty Foskett	Head of Governance and Quality
Sarah Thomas	Learning and Development Manager
Apologies:	
David Gilburt	

3.2 Actions from the Previous Meeting

The Committee noted all actions were noted 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. Declaration of Interest		
There were no declarations shared	N/A	
2. Nursing and AHP Workforce		

The following was highlighted to the Committee: ▪ HCA vacancies are not reducing in line with requirement. ▪ A recent attempt to recruit 11 HCA apprentices was only partial successful – with only 4 candidates appointed. ▪ Refresh of Learning & Development has moderate delays related to workforce priorities associated with the Covid-19 pandemic. ▪ Workshop outputs and initial working group thoughts were presented to SNAHP in October 2021 ▪ Amended strategy to be delivered Due to the concerning high levels of non-availability and vacancies the Trust have implemented a sub-group to the People Committee, Nursing, AHP and HCSW Subgroup, to have oversight of retention and recruitment and to make significant improvements to this area. A number of successful developments in terms of the Nursing and AHP workforce have been reported through TNA's and increased placement capacity with a positive impact from Q3/4 2023/24. Although, a number of challenges remain, particularly in relation to the availability of the nursing workforce driven by difficulties recruiting in a timely fashion, an increase in mandatory training requirements and some strategies that cause a temporary gap in workforce whilst staff are trained and onboarded.	Partial	To remain a focus area for the Committee – it was agreed that a progress reporting on the learning and development hub is to be presented on a quarterly basis.
3. Nursing Workforce Review		
The purpose of the review is to understand why nursing agency usage is increasing, and why the data currently presented in the performance report did not appear to reflect the reported experience of staff and whether any risks and learning needed to be considered. The recommendations from the review include: - A full establishment review for each ward - Consideration of recruitment above establishment to buffer the peaks of staffing gaps - A review of the implementation of the flexible workforce policy - Revised reporting of staffing and data to be triangulated with staff delivering active care and the impact on quality of care on a weekly basis. - The use of head count so that part time staff are reflected better in the data. - There is a need to review the Nursing bank provision. - Agency shifts to be reviewed to assess the impact of this way of working. - Options to block book nurses for continuity. - Focus on retention – Talent spotting, stretch assignments, new roles, career pathways using the wider system, links to affordable housing, align to operation activity and clinical strategy and ambition Following an in depth discussion, the Committee concluded that further planning is required to ensure that staffing levels and improved and maintained, alongside immediate actions being taken to support the increase in workforce. Ongoing projects for future and long-term improvements were noted and updates on these welcomed via future reporting.	Limited	The Committee supported the suggestion of the Operational Working Group to be established and to report to the People Committee on progress and actions being taken to improve nursing workforce.
4. Training Compliance Deep Dive		

The Trust highlighted a trend for continual improvement across the Trust. The 2 areas of concern to highlight were relating to Safeguarding and Resus training. The Trust informed the Committee that in relation to safeguarding, a System approach is being worked up to include Children, Adults, Prevent and LPS creating an electronic passport with an aim to improve the compliance rates going forward. To support the compliance records, the training has been discussed with the management to review the compliance and the requirements for each staff area. Following discussion, the Trust agreed to a full review of the mandatory training to be s undertaken, with the duration of the intervention against the subject matter and the review date of this training to relieve the current pressures being seen. Further to this, it was suggested that the compliance needed to be realistic and reviewed to ensure it is achievable.	Yes	
5. Performance Report		
The Trust highlighted the performance matrix which aligned to earlier discussions within the meeting. The Trust is currently reviewing the people baseline metrics which will support clarity on other key focus areas. Further to this, it was confirmed that the reporting is under review as a whole with a more refined report due to be presented incrementally in terms of how the data is presented, and more interrogated narrative to be included against the data for offer more assurance on the issues being discussed.	Yes	
6. Employment Checks and DBS Briefing		
The Committee were asked to consider the suggestion that the employment checks/DBS checks is reduced from 5 years to 3 years for staff working within Paediatrics. The Committee were in full agreement to this and requested employment checks remain at 3 yearly.	Yes	
7. Oversight Planning Framework including Consultant Recruitment		
The Committee received a Q1 stock take presentation in comparison to the plan. The following 2 areas were highlighted as a concern, therapies (behind plan with candidates due to be in post later in the year) and OPD capacity. Consultant recruitment relating to Anesthetists recruitment was also noted as a concern. With 5 vacancies currently and only one application being received. The following mitigations have been implemented to support the trajectory: ▪ Long-term - Associate Anesthetists going out to advert - Fellowships starting in August - International recruitment ▪ Short-term - Discussions with Retire and Return - Locum agency On a positive reflection, The Trust informed the Committee that 3 new starters are confirmed within Spinal due to start within the next month. Further to this, Arthroplasty and Upper Limb units have completed job plans and are due to go out to advert imminently.	Partial	Concerns relating to the 3 areas were noted. The agenda items will remain on the workplan with the next Consultant Recruitment update requested for September.
8. Freedom to Speak Up Annual Report and Action Log		
The change of reporting line was noted by the Committee as the portfolio has been aligned to the Clinical Governance Department to strengthen the patient safety aspects.	Partial	The Committee will receive a reviewed action log at the next

The Committee was informed that there is currently one Guardian within the Trust although, 4 individuals have applied to become Freedom to Speak Up Champions and are due to have training 15th September. 21 concerns were raised between January and March 2022, of which 18 were Bullying and Harassment relating to the same case. This was escalated and an external investigation has been completed with the final report due to be presented to the Trust in the next week. From March to date 7 further concerns have been raised, noting the reduction in concerns being raised as a positive trend with staff feeling confident to raise concerns directly with management. It was noted there have been progress on the actions since the action plan was submitted for presentation. The Committee asked for the action log to be presented at the next meeting for oversight and to offer assurance to the Board that actions are being implemented.		meeting to support with oversight and to provide assurance.
9. Guardian of Safe Working Hours Annual Report		
There were no concerns raised relating to the report. The Committee agreed for the information to be presented on a quarterly basis. The Committee approved the annual report for onward reporting to the Board.	Yes	
10. Pay Progression Policy		
Due to time constraints the Committee deferred the Policy	N/A	
11. Supporting Performance Improvement Policy		
Due to time constraints the Committee deferred the Policy	N/A	
12. Openness Policy		
Due to time constraints the Committee deferred the Policy	N/A	
13. Extreme Weather Policy		
Due to time constraints the Committee deferred the Policy	N/A	
14. Board Assurance Framework and Corporate Objectives		
The Trust confirmed that the framework will be presented at the next Board meeting for review and approval and will subsequently be presented to the Committee. It was noted that there have been significant changes to the document given the changes to the risks.	N/A	
15. Chair Report from Nursing, AHP and HCSW subgroup		
The Committee were informed that the frequency of this subgroup is due to be increased and that the Chief People Office will be the Chair. The improvement plan discussed at the beginning of the agenda will be the focus of the group going forward.	Yes	
16. Chair Report from Learning and Development Group		
The Committee noted the Chairs' report, and no issues were raised.	Yes	
17. Committee Workplan		
The Committee considered and approved the workplan.	N/A	
18. Committee Terms of Reference		
Following a review of the Terms of Reference, the membership is to be reviewed to reflect the changes within the Executive team.	N/A	

3.5 Policy Tracker

Due to time constraints within the meeting, the Committee agreed to defer the policies. The Trust agreed to schedule an Extraordinary People Committee to consider the policies prior to the next meeting.

3.6 Risks to be Escalated

In the course of its business the Committee agreed there were no risks to be escalated to Board however further assurance and actions were requested on the following:

- Nurse and AHP workforce - it was agreed that a progress report on the learning and development hub is to be presented on a quarterly basis.
- Nursing Workforce Review – the Committee thanked Jacqueline Barnes for her support and welcomed the suggestion for the Operational Working Group to be established which will report to the People Committee on progress and actions being taken to improve nursing workforce.
- Oversight Planning Framework - concerns were raised relating to the 3 areas (therapies, OPD capacity and consultant recruitment.) The agenda items will remain on the workplan with the next Consultant Recruitment update requested for September.
- Freedom to Speak Up Action Plan - the Committee will receive a reviewed action log at the next meeting to support with oversight and to provide assurance.

4. Conclusion

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

Guardian of Safe Working Hours: Doctors in Training Q1 2022 Report

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working Hours	Paper date:	7 September 2022
Executive Sponsor:	Chief Medical Officer	Paper Category:	Governance/Quality/Workforce
Paper Reviewed by:	Peoples Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors - Public	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the July 2022 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

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

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

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

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period Jul 2022

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

3.2.2 Exception reports (regarding working hours)

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

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

Currently there have been no exceptions reported to the Trust.

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

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

3.2.3 Work schedule reviews

None – please see above. Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. With no exception reports, no work schedule reviews should be expected.

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Please see Appendix 1

Trauma and Orthopaedics

Month	Number of Vacancies (28 posts)
Jul-21	0
Aug-21	1 (Spinal trust grade)
Sep-21	1 (Spinal trust grade)
Oct-21	0
Nov-21	0
Dec-21	0
Jan-22	0
Feb-22	0
Mar-22	1
Apr-22	0
May-22	0
Jun-22	0
Jul-22	Data not available
Aug-22	Data not available

Months	Number of Vacant Shift
Jul-21	13
Aug-21	4
Sep-21	2
Oct-21	1
Nov-21	4
Dec-21	10
Jan-22	17
Feb-22	0

Mar-22	3
Apr-22	0
May-22	4
Jun-22	2
Jul-22	Data not available
Aug-22	Data not available

Total cost - £35937 (July/August 22 cost not included)

Medicine - **Substantial amount of higher level data not made available**

Number of Vacancies (12 posts)

Jul - 0

Aug - 0

Sept - 0

Vacant shifts

Jul - 2

Aug - 7

Sept - 4

Total cost - £7020

Please not substantial data not available for report

MCSI

Month	Number of Vacancies (9 posts)
Jul-21	3
Aug-21	3
Sep-21	1
Oct-21	1
Nov-21	1
Dec-21	1
Jan-22	1
Feb-22	1

Mar-22	1
Apr-22	1
May-22	1

Month	Number of Vacant Shifts
Jul-21	17
Aug-21	15
Sep-21	6
Oct-21	8
Nov-21	50
Dec-21	7
Jan-22	8
Feb-22	6
Mar-22	7
Apr-22	5
May-22	5

Total cost - £ 25265.55

Long Term Vacant Shifts

MCSI is down to one vacancy

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction was attended in February 2022. During the pandemic Junior Doctor Forum was reinstated virtually and moved to a combined format recently. The last meeting was cancelled due to COVID infection.

Attendance was down from previous meetings. This has improved as face-to-face meetings have resumed. Poor attendance has, unfortunately persisted. This is an area I would like to

see increased engagement with and will liaise with the Comms department to try and achieve this.

Whilst the Juniors are happy with their working hours, concerns regarding training are significant.

GSWH conference occurred this year virtually and was attended.

3.3.2 Software System

Engagement with Allocate is still awaited. Significant issues with Allocate were discussed again at the GSWH conference. It appears to be far from fit for purpose.

3.3.3 Administrative support

There are currently no agreed standards regarding support of the GSWH, despite the role being embedded. Locally, difficulties obtaining the higher-level data to allow for a complete report have frequently occurred. Recent changes in staffing have added to this challenge.

3.4 Associated Risk

With the restart of elective activity, as previously discussed, appropriate focus on training needs to be ensured. Appreciation of the juniors working hours, with respect to evening or weekend work as it has resumed, needs also to considered.

COVID will have impacted on staffing and the requirements for short notice internal locums. The apparent spike in recent infections is likely to see this pattern recur.

3.5 Next Steps

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

3.6 Conclusion

The Trust continues to see no exception reports or fines.

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

Christopher Marquis

Guardian of Safe Working

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

RJAH Long Waiters - 2022/23

Trust Board

7th September 2022

Aspiring to deliver world class patient care

2022/23 July Performance

		Plan	Actual	Difference
July	English 104+ Weeks	61	60	-1
	Welsh 104+ Weeks	86	74	-12
	English 78+ Weeks	534	575	41
	Welsh 78+ Weeks	329	319	-10

The longest waits: - Spinal Disorders remains our challenged specialty:

ENGLISH 104+ Weeks - July Actual Performance = 60 patients

- 57 Complex (56 Spinal Disorders, 1 non-spines)
- 0 Capacity
- 3 Patient Choice (non-spines)

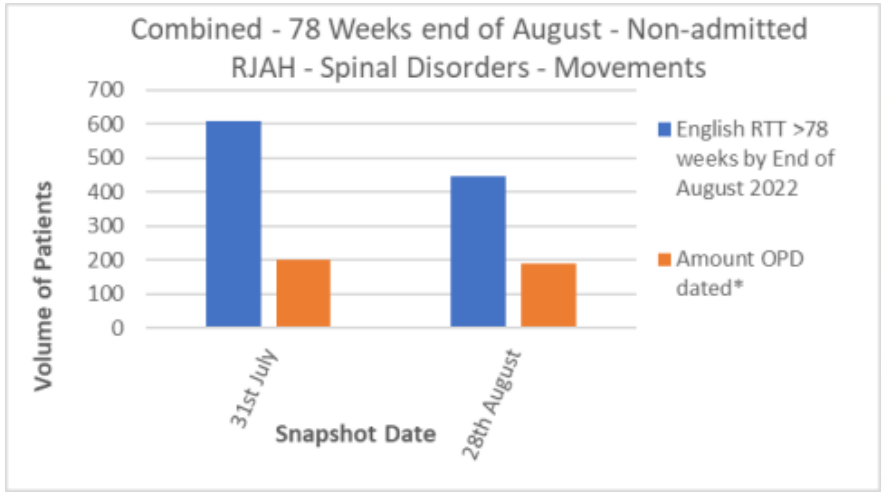
WELSH 104+ Weeks – July Actual Performance = 74 patients (74 Spines)

Milestone Visibility - Combined Waiting Lists > 78 weeks

	31.07.22		31.08.22* Unvalidated	
Combined	Patients	% of W/L	Patients	% of W/L
Milestone 1	419	47%	301	36%
Milestone 2	84	9%	177	21%
Milestone 3	391	44%	352	42%
Total	894		830	

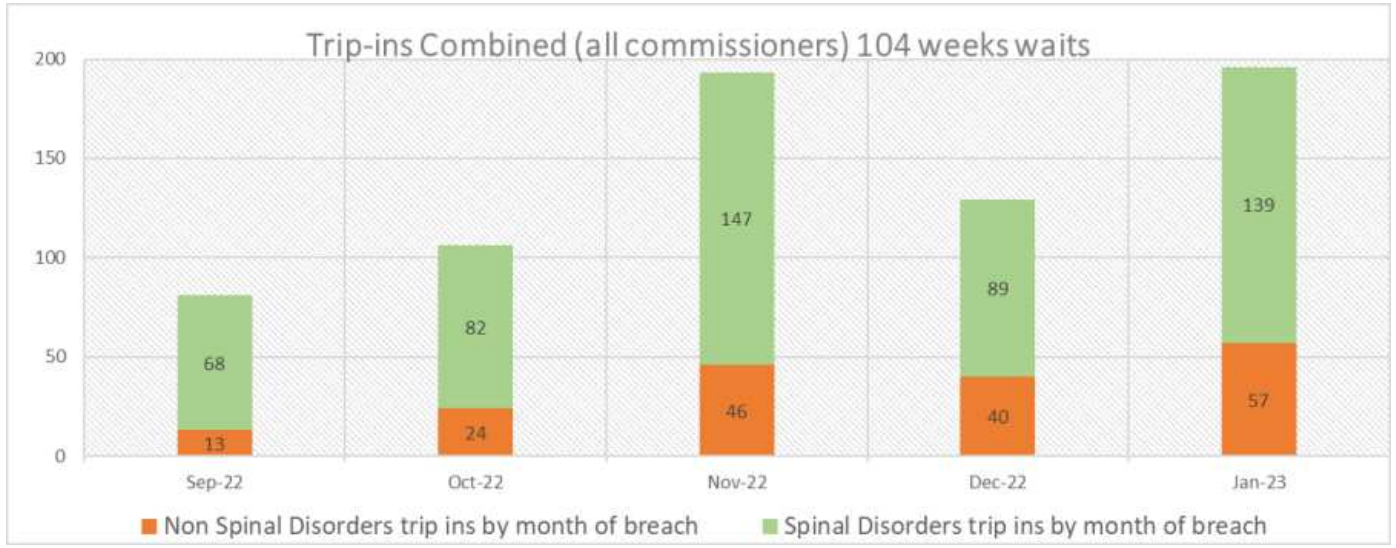
- Actions:
  - New consultants commenced in August 2022. Clinics being populated with long waiting patients.
  - Additional outpatient and inpatient capacity being explored.
  - Additional diagnostic capacity being scoped within the system.

Spinal Disorders Movement Example *(Sunday snapshots):*



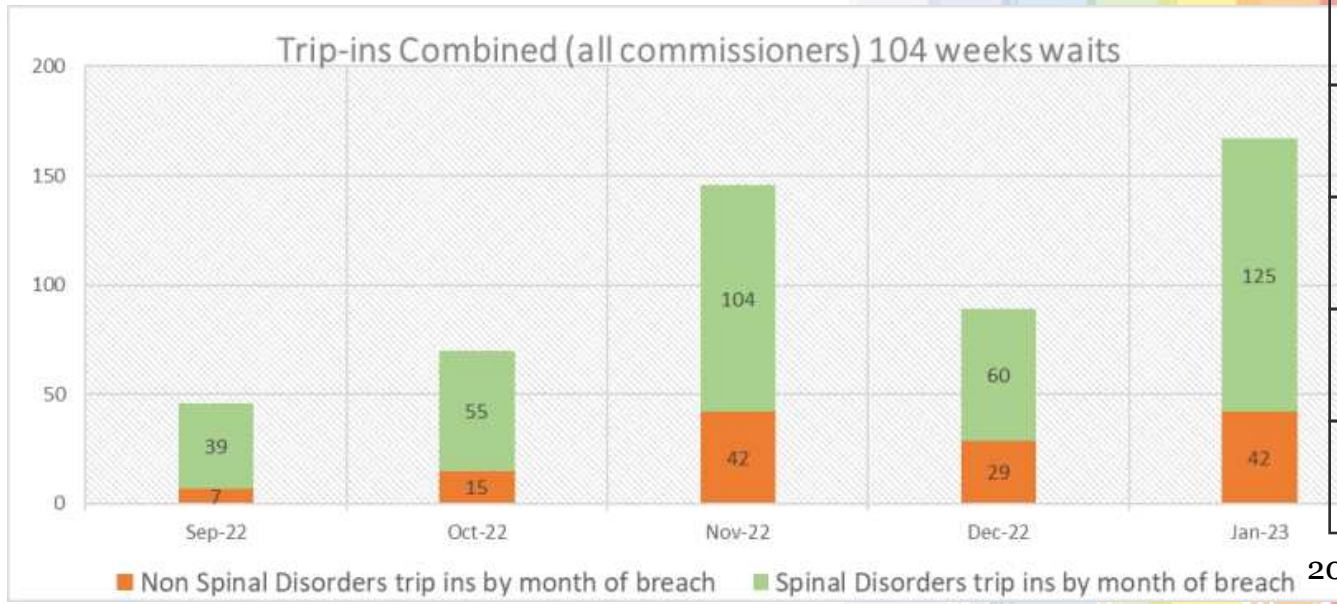
Managing The Trip-ins – 104 weeks - Combined

Snapshot: - 1st August 2022



During August trip-ins between September and January have reduced from 705 to 518.
Reduction of 27%

Snapshot: - 1st September 2022



Just Landed: - Next Steps - Further Awareness

– To be further understood and progressed. Letter received 19th August 2022. Further communication expected.

B1830: - Guidance on delivering the validation of non-admitted (outpatient) waiting lists to support the identification of patients suitable for mutual aid

The scope of patients to be included in this process and reviewed for suitability for mutual aid is set out below with delivery timescales:

- Patients on an RTT pathway who are currently waiting **over 78 weeks** and have not yet had a first appointment and do not have one booked within the next 4 weeks (from publication date of this letter) **by 16th September 2022**
- Patients on an RTT pathway who are waiting **over 52 weeks** and have not yet had a first appointment and do not have one booked within the next 4 weeks (from publication date of this letter) by **25th November 2022**
- **By 3rd February 2023**, patients still on a non-admitted pathway waiting **over 60 weeks** who have had a diagnostic (procedure/test) and awaiting a next activity (and could breach 78 weeks at 31st March 2023)

Letter states:
"Recording the outcome of the validation process will be included in the waiting list minimum data set (WLMDS) with effect from 1 September 2022"

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

Performance Against Plan £'000s

Category	Annual Plan	In Month Position			22/23 YTD Position			Forecast Position		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	112,919	9,430	9,277	(153)	33,961	33,819	(142)	112,919	112,284	(635)
Covid-19 Funding	1,411	118	118	0	470	470	0	1,411	1,414	3
Private Patient income	5,868	442	547	105	1,893	1,636	(258)	5,868	5,868	(0)
Other income	6,653	552	653	100	2,203	2,381	178	6,653	6,741	88
Pay	(76,490)	(6,404)	(6,480)	(76)	(25,285)	(25,283)	1	(76,490)	(76,552)	(62)
Non-pay	(43,804)	(3,619)	(3,597)	23	(13,158)	(13,191)	(33)	(43,804)	(43,449)	355
EBITDA	6,558	519	518	(1)	84	(168)	(253)	6,558	6,306	(252)
Finance Costs	(7,962)	(662)	(652)	10	(2,587)	(2,516)	70	(7,962)	(7,710)	252
Capital Donations	3,300	484	324	(160)	1,987	1,220	(767)	3,300	3,300	0
Operational Surplus	1,896	341	190	(151)	(516)	(1,465)	(949)	1,896	1,896	0
Remove Capital Donations	(3,300)	(484)	(324)	160	(1,987)	(1,220)	767	(3,300)	(3,300)	0
Add Back Donated Dep'n	632	52	50	(2)	202	201	(1)	632	632	0
Control Total	(772)	(91)	(84)	7	(2,301)	(2,484)	(184)	(772)	(772)	0
EBITDA margin	5.2%	4.9%	4.9%	0.0%	0.2%	-0.4%	-0.7%	5.2%	5.0%	-0.2%

Statement of Financial Position £'000s

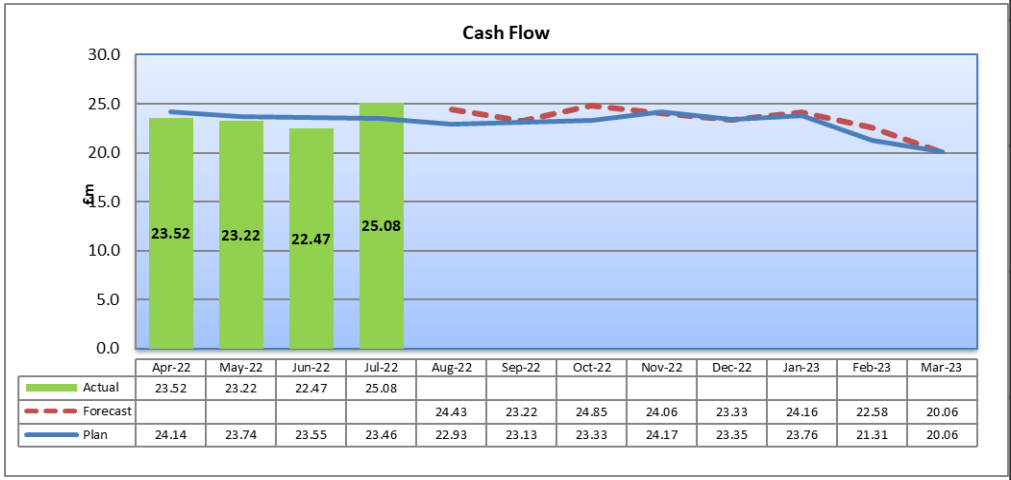
Category	Jun 22	Jul 22	Movement	Drivers
Fixed Assets	90,092	90,031	(61)	
Non current receivables	1,363	1,188	(175)	Higher than normal RTA/CRU withdrawals.
Total Non Current Assets	91,455	91,219	(236)	
Inventories (Stocks)	1,273	1,289	16	
Receivables (Debtors)	6,678	6,694	16	
Cash at Bank and in hand	22,470	25,081	2,611	Phasing of plan driving increase in cash in addition to: lump sum cash received from HEE (deferred income), cash received on account from Headley Court donation.
Total Current Assets	30,421	33,064	2,643	
Payables (Creditors)	(18,776)	(21,009)	(2,233)	Increases in HEE deferred income, cash received on account from Headley Court and accrued payables.
Borrowings	(2,017)	(2,021)	(4)	
Current Provisions	(336)	(336)	0	
Total Current Liabilities (< 1 year)	(21,129)	(23,366)	(2,237)	
Total Assets less Current Liabilities	100,747	100,917	170	
Non Current Borrowings	(4,740)	(4,734)	6	
Non Current Provisions	(1,046)	(1,032)	14	
Non Current Liabilities (> 1 year)	(5,786)	(5,766)	20	
Total Assets Employed	94,961	95,151	190	
Public Dividend Capital	(36,354)	(36,354)	0	
Retained Earnings	(30,598)	(30,598)	0	
Revenue Position	1,655	1,465	(190)	Current period deficit
Revaluation Reserve	(29,664)	(29,664)	0	
Total Taxpayers Equity	(94,961)	(95,151)	(190)	

Finance Metrics (NHS Oversight Framework)

Financial efficiency - variance from efficiency plan	
Financial stability - variance from break-even *	
Agency spending	

* Subject to system position through IFP arrangements

	YTD
Debtor Days	20
Creditor Days	60

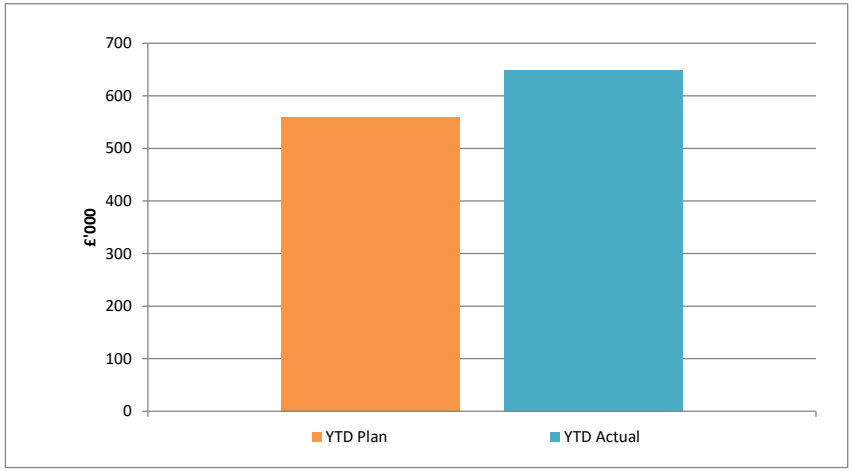


	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	23.52	23.22	22.47	25.08								
Forecast					24.43	23.22	24.85	24.06	23.33	24.16	22.58	20.06
Plan	24.14	23.74	23.55	23.46	22.93	23.13	23.33	24.17	23.35	23.76	21.31	20.06

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

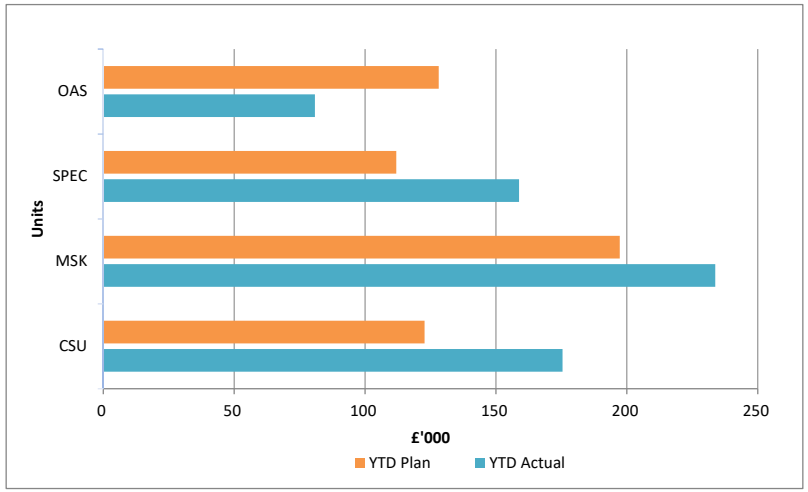
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's



Capital

Position as at	2223-04	Capital Programme 2022-23						
Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn £000s
Backlog maintenance	350	20	0	20	45	63	-18	350
I/T investment & replacement	300	10	0	10	20	0	20	300
Capital project management	130	11	10	1	42	42	0	130
Equipment replacement	750	50	14	36	100	14	86	750
Diagnostic equipment replacement	920	0	-3	3	390	246	144	920
IPC & safety compliance	360	80	95	-15	210	158	52	600
EPR planning & implementation	4,500	1,000	3	997	1,000	3	997	4,500
Invest to save	200	0	0	0	50	0	50	200
Enhanced staff facilities	500	0	0	0	0	0	0	500
Additional theatres x 4 (replace barns)	3,000	0	0	0	0	0	0	3,000
Leases (IFRS16)	149	0	0	0	0	0	0	149
Veterans' facility	3,200	484	324	160	1,962	1,220	742	3,200
Veterans' facility (HEE)	0	0	0	0	0	2	-2	58
Donated medical equipment	100	0	0	0	25	0	25	100
Contingency	500	0	0	0	0	11	-11	202
Total Capital Funding	14,959	1,655	443	1,212	3,844	1,760	2,084	14,959
Veterans' facility	-3,200	-484	-324	-160	-1,962	-1,220	-742	-3,200
Donated medical equipment	-100	0	0	0	-25	0	-25	-100
Capital Funding (NHS only)	11,659	1,171	119	1,052	1,857	540	1,317	11,659

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Chair's Assurance Report

Finance, Planning & Digital Committee
26 July 2022

0. Reference Information

Author:	Mary Bardsley	**Paper date:**	7 September 2022
Executive Sponsor:	Sarfraz Nawaz and Craig Macbeth	**Paper written on:**	2 September 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Finance, Planning & Digital Committee meeting held on 26 July 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of 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 Committee requested an Extra-ordinary meeting in August to gain further assurance on 104+ Week, Theatre Activity and Restoration Improvement Plan for Outpatients.

- Performance and Restoration Validation - a validation report is to be presented to offer an overview of percentages of waiting lists validated at each milestone, along with an action plan for improvements and accountability.
- Theatre Activity – going forward, a robust and credible plan is to be presented, to ensure lessons are learnt and greater focus is given to allow improvements to be made in year.
- Financial Performance - the estimated impact of £700k relating to the risk of not reaching the recovery plan target is a concern.
- Outpatient Deep Dive - given the significant gaps in restoration the Committee requested regular oversight of progress.

2.3. Conclusion

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Chair's Assurance Report
Finance, Planning & Digital Committee
26 July 2022

Main Report
3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Finance, Planning & Digital Committee which met on 26 July 2022. The meeting was quorate with 2 Non-Executives and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Craig Macbeth	Chief Finance & Planning Officer
Mike Carr	Chief Operating Officer
Stacey-Lea Keegan	Chief Executive Officer
In Attendance:	
John Pepper	Associate Non-Executive Director
David Gilburt	Associate Non-Executive Director
Mark Salisbury	Operational Director of Finance
Shelley Ramtuhul	Trust Secretary/Director of Governance (Part)
Dawn Forrest	Managing Director of Specialist Unit (part)
Jo Banks	Managing Director of MSK Unit (Part)
Laura Peill	Managing Director of Clinical Services Unit (Part)
Nia Jones	Head of Planning
Steph Wilson	Performance Insight & Improvement Manager (Part)
Amber Scott	Executive Assistant – Minute Secretary
Apologies:	
Simon Adams	

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
Declaration of Interest		
There were no declarations shared	N/A	
Board Assurance Framework and Corporate Objectives		
The Board agreed the objectives in June and following this the risks associated with delivery have been compiled. The Trust is currently working to reduce the volume of risks which is	Partial	

related to gaps within the corporate risk register and therefore rationalising between the two documents is required. The Committee noted the updated, recognising the current gaps, with a request to review the completed BAF at September Committee.		
Performance and Restoration Update		
The Trust continue to book patients in line with guidance regarding clinical priority as a primary rather than date order, with an additional focus on eliminating 104-week waiters. The Committee discussed the details of the performance and concerns were highlighted relating to the following: ▪ Overdue follow up of patients - Consultants are continuing to review follow-up waiting lists and priorities in clinical urgency, along with a focus on Patient Initiated Follow-Up (PIFU), as way of validating waiting lists. For further oversight of the concerns of the volume of overdue patients, the Committee requested inclusion of trajectories of where the Trust expect to be for December 2022, along with sighting Quality and Safety Committee to ensure overarching good governance. ▪ Validation – a update on the progress of the validation team was requested due to the increase in recruitment to the area. The recruitment was for the technical element of validation, looking at clock-stops and pathways, where the team are completing 5k to 7k patient validations per month, adding that c7.5% patients has been removed following validation, although further work is required to complete all waiting lists. ▪ Requested a report including the percentages of patients validated at each milestone to offer context and clarity, suggesting this is revisited and brought back to the next meeting supported by an action plan with clear accountability to who will take this forward, linking to the IPR for further assurance.	No	The Committee requested a validation report to be presented to the Committee to offer overview of percentages of waiting lists validated at each milestone, along with an action plan for improvements and accountability.
Forecast Theatre Activity (July and August)		
The Trust explained that the forecasting tool is reviewed on a weekly basis, offering a week-by-week position of coming months. The Trust gave context on the issues impacting on activity with the biggest concern from an operational perspective around workforce. Following a discussion on the detail of the report, the Committee were concerned on the slippage of 20% against plan. The teams will continue to increase activity for July and August and an investigation into the constraints will be completed to drive the improvement of restoration. Going forward a clear narrative is to be included within the report including the triangulation of plans and the percentages against each variable as these are multifactorial and will therefore bridge the gaps. Further to this the Committee requested a further review of OJP behind plan to be presented to Quality and Safety and	Limited	The Committee took limited assurance from the report, requesting that a more robust and credible plan is presented going forward, ensuring lessons are learnt and greater focus is given to allow improvements to be made in year. OJP deep dive to be completed and presented to People Committee and Quality and Safety Committee in relation to

People Committee to offer understanding and mitigate any issues arising relating to staff wellbeing and patient safety.		staff wellbeing and patient safety concerns.
National and Regional Elective Recovery Programme		
The Committee noted the amendments made following request from the Trust due to the previous exclusion of Welsh patients. The Committee noted the assurance can be sought from the context of the Trust in relation to other Organisations.	Yes	
Productivity Dashboard		
The Committee requested for the dashboard to be revised to include the target dates of achieving each aspect along with a definition of a 'late start' and 'late finish' for clarity. The Trust confirmed that support is being offered by clinical leads to investigate a number of factors before setting target dates to ensure balanced assurance or factors are considered. The aim to this is to highlight how the Trust are performing and where the opportunities can be sought.	Yes	A request to update the dashboard to incorporate the target times and late start/finish times for further clarity was noted. An update is to be presented to the Committee.
104+ week waiters		
It was noted that the differing ministerial guidance indicating potential changes to trajectories was required. Health Boards are currently undertaking alignment exercise between ministerial priorities and Welsh Government targets. Further to this, due to contracts not being signed and delay over interpretation of Welsh Government expectations, internally to Health Boards, there is still a lack of clarity on what the performance expectation will be for orthopaedics overall. There is an ongoing firm focus on equity of access for Welsh patients in English providers which is relative to English waiting lists. The actions in place to continue improvement the position include: ▪ Additional outpatient clinics to progress patients through milestones 1 and 2 ▪ Mutual aid and ISP activity has been negligible despite significant efforts to progress this. ▪ Staffing availability has reduced the opportunity for further additional activity from our own workforce. ▪ Daily scrutiny and validation of the PTL over 104 weeks. Going forward, a weekly table noting the Trust position will be circulated to the Executive team for oversight and assurance. The Committee requested that the trajectory up to December was presented to enable a stretch target of eliminating 104-week waiters for the Trust and to offer contingency. The Committee agreed for the information to be presented as a live data dashboard at the meeting to ensure current data is presented.	No	The Committee requested further assurance is provided at the Extra ordinary Committee in August.
Financial Performance		
The Trust are £35k adverse to plan, due to the income/ performance with private patient activity being down by 9 cases. Although, some adverse clinical income impact is reported from the shortfall in the theatre activity. There is the assumption that the full elective recovery funding will come into position year to date, adding this is in line with System Colleagues, flagging this as a risk to the Committee,	Partial	Following discussions throughout the meeting (relating to the risk that the recovery plan targets with not be met) the estimated impact of £700k was noted as a concern.

at this stage, with an assumption of relocating funding at this position. Regarding expenditure the Trust are favorable overall, flagging some of the underlying factors that are being reported further on in the year due to adverse expenditure to run OJP activity. The core agency costs are significantly adverse at £80k. Further scrutiny will be sought from the regulator over the next few months, therefore the Trust are working closely with System Colleagues to understand the cap and the plan envelope to operate within, as there will be consequences from the regulator to breaching this. A £190k adverse to plan year to date was noted with efficiency delivery adverse to plan by £23k, although no risks need raising as the forecast is still showing that the Trust can achieve the plan. Capital spend was reported at £149k below planning month due to slippage on billing of the Veterans Centre. The slippage of the Veteran build with a reprofile of the cash forecast, commenting this will be back on plan later in the year with confirmation due from the contractors on the exact times. Cash balances are strong at £22.5m this is adverse to plan due to the re-phasing of the Elective Recovery Funding (ERF) cash to the second half of the year.		
Unit Efficiency Delivery Update – Specialist Services		
The Committee agreed to defer the paper until the next meeting due to time constraints.	N/A	
Outpatient Restoration Deep Dive		
The national target for virtual outpatients is 25%, with the Trust at 14.65% in June, actions are in place to improve this by encouraging the use of Attend Anywhere with the Rep due to visit Clinicians and Operational Managers supporting Teams to fully utilise the System. The outpatient follow-up target nationally is to reduce by 25%, although the Trust are not committing to do this due to the overdue follow-up backlog, activity backlog and patient-initiated follow-ups (PIFU) target of 5% by March '23. The Trust are currently standing at 3.03% in June against target trajectory of 2% and that equates to 370 patients who have been moved onto a PIFU pathway across a number of specialties. Further improvements to be made to increase restoration and the key drivers for under-performance include: ▪ Therapies vacancies and closure of hydrotherapy pool due to an estates issue ▪ New: FUP ratio within spinal disorders – 104-week cohort ▪ Under-utilisation of physiotherapist clinics within main outpatients ▪ Consultant job plan changes and unplanned retirement ▪ Annual leave fluctuations ▪ OJP session allocation lower than plan ▪ Transformation schemes not currently achieving required activity levels	Partial	Given the significant gaps in restoration the Committee requested regular oversight of progress.

For further assurance around the governance of Outpatients, it was confirmed an Outpatient Improvement Board is in place with the terms of reference under review, noting this will feed into the Trust Performance Operational Improvement Board that feeds up into FPD for ongoing assurances and any further deep dives requested and required.		
Planning Risks Review for Finance and Operational		
The Committee noted the financial risks as below: ▪ Estimated £700K impact from forecast July/August activity shortfalls ▪ ERF in position YTD but technically not earned as restoration threshold not achieved The Committee requested that mitigating actions are included on the risk register to ensure oversight by the Board. The Committee were reminded that the workforce risks within the operational plan are presented to the People Committee for oversight and assurance however the Committee would like to raise the concerns to the Board.	Partial	
EPR Programme Board Update		
The verbal updated was accepted by the Committee and assurance noted.	Yes	
Chair Reports		
Trust Performance Operational Improvement Board The Committee noted the Chair report. **ICS Sustainability Committee** The Committee noted the Chair report. **Veterans Project Group** A6-week slippage was noted due to a supply chain issue, with fire doors and plaster although ongoing progress is being made to accelerate the completion date of the Centre. **MSK Transformation Board** The report was unavailable due to timing issues although, CM noted the board remained focused on the 1st of October go-live date and a further update but there was still much to be done. **Procurement Steering Group** The cost difference of implants between the Trust and other organisation was highlighted, questioning if this will alter due to the ICS. The Trust confirmed that costs are based on quantity of usage, although there are reviews on-going by procurement, aiming to achieve an equal pay rate for implants. **Digital Transformation Program Board** The Committee noted the Chair report and the assurances received.	Yes Yes Yes Yes Yes Yes	
Review of the Work Plan		
The work plan was considered and noted by the Committee.	N/A	
Attendance Matrix		
The attendance matrix is shared with the Committee for information only.	N/A	
Any Other Business		

The Committee requested an Extra-ordinary meeting in August to gain further assurance on 104+ Week, Theatre Activity and Restoration Improvement Plan for Outpatients.	N/A	

3.5 Committee Cross Cover

The Committee suggested a deep dive is presented to the People and Quality and Safety Committee regarding the OJP levels in relation to staff wellbeing and patient safety concerns.

3.6 Risks to be Escalated

During its business the Committee identified the following concerns are to be escalated:

- Performance and Restoration Validation - a validation report is to be presented to offer an overview of percentages of waiting lists validated at each milestone, along with an action plan for improvements and accountability.
- Theatre Activity – going forward, a robust and credible plan is to be presented, to ensure lessons are learnt and greater focus is given to allow improvements to be made in year.
- Financial Performance - the estimated impact of £700k relating to the risk of not reaching the recovery plan target is a concern.
- Outpatient Deep Dive - given the significant gaps in restoration the Committee requested regular oversight of progress.

3. Conclusion

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

Chair's Assurance Report

Extraordinary Finance, Planning & Digital Cc

0. Reference Information

Author:	Mary Bardsley	**Paper date:**	7 September 2022
Executive Sponsor:	Sarfraz Nawaz and Craig Macbeth	**Paper written on:**	2 September 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Extraordinary Finance, Planning & Digital Committee meeting held on 23 August 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of 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 following areas to highlight to the Board included:

- The Trust is at risk of not reaching the agreed plan for 2022/23.
- The Committee will continue to focus on the delivery of the plan and the impact of the finances
- Support requested from the People Committee to focus on the workforce risks which are aligned to the delivery of the plan

2.3. Conclusion

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

Chair's Assurance Report

Extraordinary Finance, Planning & Digital Cc

Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Extraordinary Finance, Planning & Digital Committee which met on 23 August 2022. The meeting was quorate with 2 Non-Executives and 3 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Craig Macbeth	Chief Finance & Planning Officer
Mike Carr	Chief Operating Officer
Stacey-Lea Keegan	Chief Executive Officer
In Attendance:	
John Pepper	Associate Non-Executive Director
David Gilburt	Associate Non-Executive Director
Mark Salisbury	Operational Director of Finance
Dawn Forrest	Managing Director - Specialist Delivery Unit
Laura Peill	Assistant CEO
Nia Jones	Managing Director – Planning and Strategy
Amber Scott	Executive Assistant – Minute Secretary
Apologies:	
None to note	

3.2 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
Declaration of Interest		
There were no declarations shared	N/A	
Presentation: 104 Weeks Waiters / Theatre Activity / Outpatient Restoration		
104+ Week Waiters – July. • English Patients – 8 patients over plan • Welsh Patients – 12 patients over plan 78+ Week Waiters – July • English Patients – 41 behind plan • Welsh Patients – 10 patients over plan For August – Welsh patients continue to be better than plan, whilst English patients are appearing to be slightly behind plan. The reason for this is due to accepting 5 patients from a partner organisation. 'Trip in' patients are also being monitored month by month with further positive reduction in long waiting patients with a 15% reduction to English Patients and a 14% reduction to Welsh patients, this was due to a combination of validation of	No	Concerns raised with not reaching the agreed plan noting the continued steps the Trust has taken to mitigate the risk. The three areas will continue to be a key focus area for the Committee and asked for support from the People Committee to monitor the workforce risks which are aligned to the delivery of the plan.

patients, increased outpatients' appointments or treatment of the patient. Scoliosis Patient cohort - there are currently 78 patients waiting to be treated by the end of March. The Committee discussed the potential constraints to achieving the trajectory being capacity within the spinal team and the ability to put on extra activity is the main constraint. Concerns were raised over the potential lack of a plan being worked up to support the long waiting spinal patients. The Trust disagreed with the comment, noting that this is the highest risk cohort of patients, but there is a plan in place and the team are working to ensure all patients are being seen at the appropriate time. Mitigations in place to support this include scheduling additional sessions and having a robust understanding of how many of these patients require treatment. The plan is not resilient due to the lack of opportunity for mutual aid and the spinal team being smaller consultant cohort. ROH have supported by accepting some spinal patients and ongoing monitoring is in place to mitigate any issues. There is a positive impact in agreeing mutual aid for many different services although it was noted that due to the speciality nature the Trusts opportunity is reduced. A call is being held with NHSE imminently where this point will be raised further to gain the best understanding of this. The risk to the plan was recognised with the fragility of the reliance noted to be relating to staffing/workforce. The Trust remain on trajectory with this, which has been noted as challenging, therefore offered some reassurance and confidence for the continuation of the plan. The importance of ensuring the stakeholders are fully sighted on the roots the Trust have explored such as mutual aid was highlighted. Adding that the data presented is good and this now needs building on in terms of resilience suggesting a planning assumption is produced to ensure a long-term strategy is in sight for continuity. It was suggested that the People Committee investigate this further in terms of increasing the team due to the current small number of consultants and build on a succession plan. **Outpatient Restoration** The presentation offered a line by line of where Outpatients are not hitting planned activity. Live updates were available and are currently standing 86% to plan. Drivers for this were noted as. ▪ Annual Leave – phased planning not integrated into the planning ▪ Covid related Absence ▪ Outpatient Appointment Ratio with an increase in new appointments are required than follow-up appointments creating timing issues, meaning less patients are being booked per clinic ▪ DNA Rates – 7% DNA Rate with planned 5% ▪ Therapy Services, there are concerns regarding, Vacancies, IPC Constraints and OJP.		

An outpatient improvement plan has been developed to tackle the issues as above by ensuring the governance is in place for clinic templates and moving towards virtual appointments and patient-initiated follow-ups. There is an ongoing review of the recording of data within outpatients, with an issue found to be the lack of recording of inpatients attending outpatient appointments, the Trust confirmed this has now been rectified with coding also in place to ensure all patients are captured in activity data. Further work is ongoing via a task and finish group to improve DNA rates. **Theatre Activity** The Trust is currently 200 cases away from plan in August, with the availability of anesthetist's accounting for half of the lost activity due to. All organisations were asked not to include Covid impact within planning, therefore mitigations have not been in place, with a current average of 10-15 cases being lost each week due to Covid related issues. The Trust explained that the planned 2 cases per session have not been achieved with c1.7 and 1.8 cases per session. MC confirmed this was due to several justifiable factors including Outsourced lower complexity work, Increase in complex work And Prioritisation of Spinal Patients. To drive improvement the following has been implemented: ▪ two Anaesthetic Fellows are in place to provide additional capacity with less complex cases, ▪ Associate Anaesthetists with a plan to start before the end of the financial year There is a significant risk to plan currently with the majority accounting to underactivity, although offered assurance that there is continued oversight of the issues and regular monitoring to ensure improvements are being made. With this being the current main risk, it was suggested that forward planning to ensure the risk is reduced and learning is taken from this for H2 to ensure all is in place to achieve to which the Committee agreed.		
Finance Update		
The Trust noted that there is risk associated with the financial impact following the activity shortfalls, however, due to the new financial framework the Trust will be partially protected from the full impact. Although there was still a loss of £420k worth of income from the NHS activity shortfalls, the Trust explained that formal confirmation has been received that there will be no clawback of ERF allocation for H1 of 2022/23. Further to this there has been an increase in Private Patient recovery in month which is forecasted to continue for August. The following highlights were presented: ▪ In month £84k deficit, £7k favourable to plan. ▪ Income adverse by £112k with pass through elements excluded. ▪ Clinical income adverse due to activity shortfalls £420k, offset by private patient recovery £105k, ERF rule change £121k and coding review £91k.		

▪ Expenditure £119k favourable with pass through costs excluded. ▪ Underutilisation of the Independent sector funded by ERF £250k favourable, partially offset by continued high agency usage above cap, for 4th consecutive month. ▪ Year To Date £2,484k deficit, £184k adverse to plan. ▪ Predominantly driven by YTD shortfalls in private patient income. Full year forecast to achieve plan of £0.8m deficit. Assumptions: ▪ Clinical income – full delivery of activity plan from September onwards. No clawback of ERF mitigating activity shortfalls in H1. ▪ Private patients – recovery of Year-to-Date shortfalls by year end. ▪ Other income – continuation of run rate excluding pass through funding. ▪ Pay – based on detailed agency forecast including step up in anaesthetic consultant requirement for H2. Assumes recruitment to remaining consultant and nursing posts aligned to plans. ▪ Non-Pay – activity driven Year to Date, remaining forecast assumes achievement of activity plans with benefit from private sector underspend in H1 funded by ERF. Commissioner Position: ▪ STW - block adjustment position Year to Date includes M1 mutual aid support c£1m. ▪ NHSE ERF – accrued to plan in M4 aligned to rule changes (no clawback assumed for H1). Efficiency performance has improved in month following a deep dive of schemes and start dates. The Trust highlighted that the plan value includes internal carry forward target from 2021/22 and planned slippage of 20%. Cash is currently £1.6m favourable to plan mainly due to: ▪ Slippage on capital schemes ▪ Receipt of Headley Court Charitable funds on account ▪ High cash balances supporting interest payments c£250k benefit in forecast. Further rate hikes likely to increase this further. Month 4 agency expenditure £200k, which is £68k adverse to cap in month. Off framework agency levels are high c42% of spend – regulator have no tolerance for off framework usage. Highest hourly rates significantly exceeding price cap – again key focus for regulator and driven by off framework agencies. The full year forecast is averse to agency cap c£650k, which is driven by step change in agency costs for consultant anaesthetists required to deliver the activity plan with a current assumption of 4 posts from October 2022. The Year-to-Date position also includes £136k mental health agency support for MCSI.		
Any Other Business		
There were no further items of business discussed.		

3.5 Risks to be Escalated

During its business, the Committee identified that Trust is at risk of not reaching the agreed optional and financial plan for 2022/23.

3. Conclusion

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

Chair's Assurance Report

Audit and Risk Committee 12 July 2022

0. Reference Information

Author:	Mary Bardsley	**Paper date:**	7 September 2022
Executive Sponsor:	Martin Newsholme	**Paper written on:**	12 July 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Trust Board	**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 a summary of the Audit and Risk Committee meeting held on 12 July 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control and risk assurance to the Audit and Risk Committee. This Committee is responsible for seeking assurance that the Trust has adequate and effective controls in place. It 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 quorate
- Approved the Standards of Business Conduct for Board Members Policy

Areas to highlight to the Board include:

- Medication Incidents - assurance gained from the increase of reporting across the Trust with staff having the confidence to raise issues and concerns however, a medication incident deep dive to be presented to the Quality and Safety Committee.
- Policy Tracker - assured that a process is in place to oversee the overdue policies however further assurance was requested for clarity. The table presented within the paper is to be reviewed to present policies only.
- Internal Audit Reporting - to strengthen risk oversight, each internal audit is to be aligned to the BAF. Going forward, internal audit terms of reference require the sign off of each Committee Chair.

2.3. Conclusion

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

Chair's Assurance Report
Audit and Risk Committee 12 July 2022

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Audit and Risk Committee which met on 12 July 2022. The meeting was quorate with 4 Non Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Martin Newsholme	Non-Executive Director (Chair)
Sarfraz Nawaz	Non-Executive Director
Chris Beacock	Non-Executive Director
Paul Kingston	Non-Executive Director
In Attendance:	
Craig Macbeth	Chief Finance & Planning Officer
Simon Adams	Director of Digital (Part)
Mike Carr	Chief Operating Officer
Mark Salisbury	Operational Director of Finance (Part)
Ian Maclennan	Assistant Chief Nurse
Linda Elliott	MIAA Senior Audit Manager
Claire Smallman	MIAA Senior Anti-Fraud Manager
Mo Ramzan	External Audit Representative (Part)
Kirsty Foskett	Head of Clinical Governance, Quality & Patient Safety Specialist (Part)
Lisa Newton	Assistant Chief Nurse (Part)
Mary Bardsley	Assistant Trust Secretary
Amber Scott	Executive Assistant – Minute Secretary
Apologies:	
Stacey-Lea Keegan, Diana Owen, Shelley Ramtuhul, Sara-Ellis Anderson, Anne-Marie Harrop	

3.2 Actions from the Previous Meeting

The Committee noted that all the actions from the previous meeting were completed.

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	Assurance Sought
Declaration of Interest		
MC informed the Committee; declarations of interest have been submitted which included noting his parent is a member of the MPFT Board.	Yes	
Finance Governance Pack		
The following was highlighted: • Fixed assets increased by £2m, mainly due to leased assets now being on the SOFP as a result of the IFRS16 lease accounting standard implementation. • Receivables increased by £1.7m, mainly due to an increase in accrued receivables (£1m) and prepayments (£1.3m).	Yes	

• Cash decreased by £1.8m, due to the I&E deficit. • Payables increased by £1.2m due to an increase in accrued payables (£1.4m) and deferred income (£0.4m) less the Headley Court payment on account being used (£0.6m). • Borrowings increased by £2m due to lease liabilities as a result of the implementation of IFRS16. • A £1.3m deficit was made in the period. • Total invoiced receivables have increased by £0.3m since March 2022, mainly due to a large invoice raised for Health Education England towards the end of May. • The value of receivables aged greater than 90 days at the end of May 2022 was £78k which relate to 6 individual invoices greater than £5k in value. The gap between actual and plan I&E was noted and the Committee questioned what the trajectory of the year is. The Trust reminded the Committee this is overseen by the Finance, Planning and Digital Committee. The Committee queried whether there were any concerns being raised at a System level given the prevalence of Covid before suggesting exploration of the expected pressures of the increase in covid. The Trust have noted and increased a focus on the 7 current themes which are discussed both locally and within the System to ensure improvements are made or mitigations are in place in preparation for any potential changes.		
Register of Interest and Hospitality Register		
There are a total of 14 declarations outstanding which the office will continue to chase. Following the meeting the report will be shared with the procurement team as a way of an update. The Committee queried the reason for outstanding forms and the Trust confirmed that individuals are chased on a regular basis and compliance is reliant on staff members replying to the request. Internal Audit suggested a section of the policy is shared as part of the communication to staff to which the Trust agreed to revise. There have been 7 entries recorded onto the hospitality register since April 2022.	Yes	
Reference Cost Update		
The Trust presented the document for good governance and oversight of National costing, confirming the Trust have a strong process in place. The submission is planned for the end of July and there are currently no risks to escalate. A post submission paper will be presented to the Committee to show relative performance against other organisations. The Trust agreed to consider the following ahead of the submission: ▪ The impact relation to conversion of orthopaedic wards to general wards during Covid and whether this could impact submission. ▪ The effect to the cost of re-deployment of staff to SaTH as part of mutual aid. It was noted this for review during the system to ensure RJAH costs are allocated appropriately.	Yes	

It was noted that the last audit was completed in 2016/17, to which the Trust confirmed was correct as the audit is subject to a national schedule which has been disrupted during Covid.		
Counter Fraud		
The following was highlighted: ▪ The Counter Fraud Functional Standard Return (CFFSR) was submitted on the 07/06/22 with the Trust receiving 10 green ratings and 3 ambers against all 13 components comprising the CFFSR. ▪ Three anti-fraud awareness short animation videos have been issued to the Trust for circulation. ▪ 'Introduction to the new AFS' article has been requested to be upload onto the fraud intranet page via Comms. ▪ Eleven local MIAA fraud prevention checks (FPCs) were issued to the Trust for appropriate action to be taken. ▪ There were no new referrals received in the reporting period and none brought forward from 2021/22. The timescale on progress of the amber rated actions of appendix A was queried. It was noted that some aspects will be completed by the next Audit/Risk Committee due to urgency, and others will be completed by the next return date of May 2023. Discussion were held relating to the ratings within the report with confusion from the Committee to the rationale behind the Amber rating of receiving no referrals. It was confirmed that this is set by the Counter Fraud Authority noting that there are no repercussions to the Trust of having Amber ratings on their return. Further to this the comparison to other organisations was requested, and whether assurance is sought from a complete green rated submission.	Yes	
Internal Audit		
A full handover has been received from BDO with a checklist to ensure a seamless transition and for continued assurance of progress. After discussion and consideration, the Committee asked for the following: ▪ each review has explicit reflection to the risks within the risk register. A further column is to be added to the report to note the link to the Board Assurance Framework and risks to allow a clear trail for assurances. ▪ the terms of reference for each Audit to be noted for information to each the Committee linked to the Audit for good governance and oversight Further clarification was requested in relation to the quality spot check audits, and whether this related to clinical quality or quality of process. Internal Audit confirmed that the spot checks are clinical and the quality on the wards with scoping discussions commenced for this program of works to include a range of activities. The process is currently under review for this to ensure it is the best for the Trust and to confirm where assurances are required.	Yes	To strengthen risk oversight, each internal audit is to be aligned to the BAF. The Committee agreed that go forward, internal audit terms of reference require the sign off of each Committee chair and are to be noted for information within the Committee agenda.
External Audit		

The progress update was presented to the Committee, confirming all actions have been completed to achieve the submission deadline. The three areas for noting were: ▪ the arrangements for the value for money versus financial sustainability, ▪ the more challenging environment from a system perspective and delivering efficiencies. ▪ the peak in tender waivers reported, due to the quick response to IPC issues and actions taken to make improvements. Concerns were raised relating to the wording within the report relating the to the IPC issues, following lengthy discussions the Committee agreed that acknowledgment of the issues is required, along with the inclusion of the improvements made and actions taken to ensure misinterpretation is not made when the report is in the public domain. External Audit agreed to review this and meet with Committee leads outside of the meeting for formal approval.	Yes	The Executive Lead and Chair of the Committee liaised with Deloitte to refine and agree the wording of statutory reports to ensure they are up to date with our IPC/Governance actions and are accurate.
Standards of Business Conduct for Board Members		
The reviewed policy was presented to the Committee for consideration and approval. It was noted that there have been no material changes to the policy. Amendments to the policy include job titles and reference to policies. The Committee considered and approved the policy.	Yes	
Policy Tracker		
The Committee received the paper which outlines the documents that are currently overdue a review and the process that is taken to ensure documents are reviewed timely. As of the end of June there were currently 19 overdue policies – 10 of which have been scheduled for an upcoming meeting. Further assurance was requested on the following: ▪ The number of policies overdue as the papers also reported other overdue documents including procedures ▪ A validation of the policies was requested to ensure that any of the overdue policies have not been combined with in date policies and are therefore defunct. ▪ The full policy register was asked to be presented at the next meeting to offer oversight of alignment of policies to committees.	Limited	The Committee noted limited assurance as there was significant concern raised about the apparent number of overdue policies that were presented.
Risk Management		
As of 01 July 2022 the trust position is as follows: • 34 incidents overdue for review, investigation, or approval • 11 risks are overdue, 7 of which are 'Treat' risks. • 52 risks were closed in Quarter 1. • 69 new risks were registered in Quarter 1. • 0 Serious Incidents or Never Events were reported via the 'Strategic Executive Information System' (STEIS) in Quarter 1. • 3 top themes include Patient Delay Incidents, Patient Transfers and Medication Incidents • 741 live risks were on the risk register of which 11 were overdue	Partial	The Committee took assurance from the increase of reporting across the Trust with staff having the confidence to raise issues and concerns and for improvements to be made however, a medication incident deep dive to be presented to the Quality and Safety Committee.

Concerns were raised regarding the consistent volume of medication incidents, questioning where the Trust are with the electronic prescribing and to what extent that would obviate some of these problems that continue to occur. The Trust confirmed that the EPMA system is part of the new EPR process. The Trust confirmed that deep dives are presented to the Patient Harms Group on trends and themes before upward reporting the Patient Safety Committee. The Committee took assurance from the increase of reporting across the Trust with staff having the confidence to raise issues and concerns and for improvements to be made.		
Specialist Unit Deep Dives		
The report presented to the Committee offering context to the changes within the report with an ongoing review and update of the register to reduce the 'tolerate' risks and to manage and treat risks. There were 125 risks noted on the register and monthly are scheduled to review. There are 17 high risks on the register, although assurance has been sought that the register is live, with regular updates from management.	Yes	
MSK Unit Deep Dive		
The paper presented to the Committee noting 89 risks have been approved on the register, of which 6 are high risks. Further to this, 20 new risks were opened, 14 risks were closed, and 4 risks increased their risk rating and 3 risks have reduced their rating. There were no overdue risks reported at time of writing the report. The Trust confirmed the risks are being taken through the correct forums following a querying relating to the reporting line of investment risks.	Yes	
Information Governance Committee		
The Trust confirmed that the Data Protection Toolkit submission was completed. The training element was submitted with 97% compliance rate. Partial assurance was noted in relation to the reporting of incidents and the lessons learned, with an updated version of the report requested going forward to present lessons being fully learned and inclusion of the team involved in the incident for better understanding. The Committee queried the lessons learnt from the last-minute chasing for training to be completed. The Trust confirmed that the whole process is being reviewed and monitored to ensure there is no slippage going into the next year, by encouraging staff to complete their training earlier than required to mitigate the backlog. It was also noted for further assurances that the training has been aligned to the Board Training workplan to ensure all Board members have completed. Following a query, the Trust confirmed that the EPR project meeting will be reporting to the Finance Planning and Digital Committee for oversight as well as receiving an assurance chairs report. The Chairs report will also be noted at the Quality and Safety Committee to ensure assurances are received from a clinical perspective.	Yes	
Any Other Business		

The Chair of the Committee invited internal and external audit to a private discussion following the meeting to which they agreed.	N/A	
Review of the work plan		
The NHSE new guidance is to be added to the work plan.	N/A	
Attendance Matrix		
The attendance matrix is shared with the Committee for information only.	N/A	

3.4 Approvals

Approval Sought	Outcome
Standards of Business Conduct for Board Member	Approved

3.5 Risks to be Escalated

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

- Medication Incidents - assurance gained from the increase of reporting across the Trust with staff having the confidence to raise issues and concerns however, a medication incident deep dive to be presented to the Quality and Safety Committee.
- Policy Tracker - assured that a process is in place to oversee the overdue policies however further assurance was requested for clarity. The table presented within the paper is to be reviewed to present policies only.
- Internal Audit Reporting - to strengthen risk oversight, each internal audit is to be aligned to the BAF. Going forward, internal audit terms of reference require the sign off of each Committee Chair.

4. Conclusion

It is to be noted that the Chair of the Committee also met with the following members of the Committee:

- Internal auditors (MIAA) to discuss their work plan and methodology
- External auditors (Deloitte) as noted within the report
- Head of Clinical governance and Quality to discuss the Trusts' risk management processes and to refine our reporting.

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