The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Chair's Assurance Report
People Committee 23 June 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	6 July 2022
Executive Sponsor:	Paul Kingston, Chair of People Committee	Paper written on:	1 July 2022
Paper Reviewed by:	N/A	Paper Category:	Governance and Assurance
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents a summary of the People Committee meeting held on 23 June 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 approved 5 policies
- Concerns to highlight relate to:
  - STW People Plan - concerns raised with ownership of risks and understanding the baseline metrics of the people plan.
  - 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.

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
People Committee 23 June 2022

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 12 May 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:	
Chris Beacock	Non-Executive Director (Chair)
Penny Venables	Non-Executive Director
Sarfraz Nawaz	Non-Executive Director
David Gilburt	Associate Non-Executive Director
Stacey Keegan	Interim Chief Executive Officer
Sarah Sheppard	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
Kirsty Foskett	Head of Clinical Governance and Quality
Jo Banks	Managing Director for MSK Unit
Allen Edwards	Learning and Development Officer (part)
Amber Scott	Minute Secretary
Apologies:	
Craig Macbeth, Shelley Ramtuhul, Kerry Robinson	

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. STW People Plan		
The presentation was shared with the Committee to express the context ahead of moving into the System. The presentation highlighted the detailed plan for the next 12months the key drivers the ICS is responsible for. The Trust is currently recruiting a full time Chief People Officer who will support the collaborative working with partners and suggested one of the examples of working together would be shared policies.	Partial	Further information to be shared with the Committee to be fully assured. Concerns raised with ownership of risks and understanding the

The Committee raised concerns relating to the lack of ownership and the delivery of this if there is uncertainty about the temporary nature of central teams whilst the ICS is forming. It was noted that conversation have been held between CEOs to ensure that individuals complete on agreements and how this is moved forward and to ensure assurances are offered. The Committee welcomed a presentation on the baseline metrics relating to the people plan. This is to be presented to the Committee in September.		baseline metrics of the people plan.
3. Health Care Support Worker Academy		
This initiative has been implemented across the system to make a difference for recruitment of healthcare support workers. The Trust is to focus on the following to ensure effective implementation: • Commitment to doing things as a system • Commitment to tailor and shape to meet the needs of the Trust The Trust highlighted the opportunity to retain staff and to ensure a robust induction and training schedule is in place and to ensure the wrap around support by working collaboratively with the System to offer professional development nurses to provide the training. It was noted that the potential financial (compared to agency) has been incorporated into wider plans within workforce. Going forward, the Trust will provide an update via the Nursing Workforce update.	Yes	
4. Operational Plan Risks		
The main risks relate to Covid-19 and mutual aid. The Committee queried the impact on delivery and long waiters. The Trust confirmed there is a risk on the corporate risk register relating to 104-week waiters. The Trust highlighted the risks associated with People Committee and Finance, Planning and Digital Committee. Adding that there are more in-depth risks around the 104-week waiters from both a Quality and Safety perspective as well as from a Harms perspective, and this is the reasoning for them all not being presented to the People Committee to which the Committee thanked the Trust for the assurance and confirmation. To present further assurance to the Committee, the Trust agreed to review the paper to include triangulation against the other operational risk.	Partial	To review the paper to include triangulate against the other operational risk to increase assurance.
5. Just Culture		
The Committee received a briefing on the Just Culture to enhance understanding. This included the next steps which was to offer assurance that the core principles of Just Culture are being embedded into the Trust, adding that progress of this will be presented to the Committee regularly for oversight.	Yes	
6. Performance Report		
Performance Report A deep dive has been instigated into the Voluntary Staff Turnover, to review if this is of a healthy nature, adding the findings will be brought to the Committee once completed. Staff Appraisal and Mandatory Training also require attention to improve completion.	Yes	

The Trust suggested the E-Rostering plan and actions are presented to the Committee regularly for review and assurances.		
7. Consultant Recruitment Plan		
Actions that have been implemented to support the recruitment include: • Enhanced reporting to the People Committee • Project group meetings have increased to fortnightly to enhance oversight and escalation of risks • Widening of the project meetings membership • Report submitted to the Senior Leaders Group The Committee suggested a risk to be recorded on the register if targets are continuing to fair and requested clear detail of the impact if targets are not met. Following discussions, the Committee requested the Consultant Recruitment Plan becomes a specific risk rather than a general. The Trust agreed to present the risks and articulate the implications to the Finance, Planning and Digital Committee in July.	Partial	Although steps are in place to monitor, the Committee asked for further detail on the impact on the operational plan if the recruitment plan does not meet the required targets.
8. Freedom to Speak Up Update		
The following actions have been implemented: • Review and strengthening line reporting – An Executive Lead and nominated Non-Executive Director are now in place • Quarterly report submitted to the NGO with further discussion on how this is presented to People Committee for review • Development sessions are in place with Board • Increased capacity for guardians • Implementation of F2SU Champions- recruitment has commenced • Triangulating with Patient Safety Committee. • National Guardian Office implemented a Gap Tool available to be utilized by the Trust for further support.	Yes	
9. Staff Survey		
The ICS Staff Survey has been included to offer context to the Committee on how the Trust fit into the System. The information presented today was to offer updates on progress and to also note themes that link into the People Plan. There are staff survey engagement and the lines of enquiry with Engagement and Listening Exercises planned over the next few weeks to get further information from staff about what specific things they do want to see which will then lead into the OD piece of work that is being commissioned. A further update is to be presented to the Committee in October aligning with the new staff survey campaign to which the Committee agreed.	Yes	
10. Uniform Policy		
The Committee suggested the following amendments: • wording around mobile phones is amended due to being in a digital world, and the increase in using phones for tasks such as audits • The Committee agreed that personal calls are not allowed, although staff may have their device on their person	N/A	

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The Committee approved the policy pending the minor amendments as discussed and confirmed once amendments are complete to the policy is to be implemented.		
11. Corporate Local Induction Policy		
The Committee considered and approved the Policy.	N/A	
12. Recruitment and Selection Policy		
The Committee considered and approved the Policy.	N/A	
13. Terms and Conditions of Employment for Locally Employed Doctors Policy		
The Committee considered and approved the Policy.	N/A	
14. Employment Checks Policy		
The Trust has a robust approach to DBS checks at the point of recruitment which is set out in the employment checks policy document which includes internal recruitment. All staff are required to notify their managers of any conviction or caution however no regular checks are carried out by the Trust once an individual is in employment unless they move to another role which requires a higher-level check. The Trust has had this policy in place since the DBS system was introduced and whilst a very small number of dismissals have taken place due to declaration of a conviction/caution, there have been no reported incidents due to this policy. Concerns were raised regarding the 5-year DBS checks, especially within Paediatrics, where organisations outside of the NHS undergo checks 3 yearly. The Trust agreed to present a briefing paper is presented to the Committee to highlight how the policy has been written, and the reasoning for decisions made. The final view of the Committee was to approve the policy based on a further review in 3 months' time, with a request to examine other Trusts policies and review the 3- and 5-year checks in line with concerns with Paediatrics. The Trust confirmed the policy will be enacted immediately to ensure checks are completed for longer standing Staff.	Partial	The policy was approved by the Committee for 3 months only. A briefing paper is to be presented to the Committee following a review of other organisation as there were concerns relating to the timeframe of DBS being undertaken, especially with paediatric patients.
15. Board Assurance Framework and Corporate Objectives		
The framework was shared with the Committee for information only.		
16. Committee Work plan		
The Committee approved the workplan.		
17. Committee Terms of Reference		
The Terms of Referenced are shared with the Committee at each meeting for information only.		
18. Any Other Business		
There were no further items of business discussed.		

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:

- STW People Plan - concerns raised with ownership of risks and understanding the baseline metrics of the people plan.
- 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.

Chair's Assurance Report
People Committee 23 June 2022

4. Approvals

The Committee approved the following:

- Uniform Policy
- Corporate and Local Induction Policy
- Recruitment and Selection Policy
- Terms and Conditions of Employment for Locally Employed Doctors Policy
- Employment Checks Policy

5. Conclusion

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

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NHS Foundation Trust

FTSU Guardian – National Survey 21/22

0. Reference Information

Author:	Kirsty Foskett, Head of Clinical Governance & Quality. Liz Hammond, FTSU Guardian	Paper date:	6th June 2022
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Patient Safety Committee	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:		Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Patient Safety Committee and what input is required?

This paper is provided as an update on the outcome of the national FTSU Guardian Survey 2021, associated recommendations, and what actions are required of the Trust.

2. Executive Summary

2.1. Context

The FTSU Guardian Survey 21/22 was undertaken to gain insight into the implementation of the Freedom to Speak Up Guardian role and how it could be improved

2.2. Summary

Based on the findings of the survey several recommendations have been made and as a Trust, the following actions should be considered:

1. Review and strengthen the line reporting for the FTSU guardian.
2. FTSU quarterly NGO data and patient safety data, included detriment should be triangulated on a quarterly basis, reporting to Patient Safety Committee and Quality and/or Safety Committee
3. Senior Leaders should complete the 'Speak Up, Listen Up, Follow Up' training available through HEE and consider whether this needs to be shared wider
4. Review capacity of the FTSU Guardian, using the tool kit provided by NHS England and NHS Improvement.
   Report template - NHSI website (england.nhs.uk)
5. Implementation of FTSU Champions within the Organisation

2.3. Conclusion

The Committee is asked to note the content of the report and agree the actions as described above.

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

3. The Main Report

3.1. Introduction

The FTSU Guardian Survey 21/22 was undertaken to gain insight into the implementation of the Freedom to Speak Up Guardian role and how it could be improved.

Feedback from respondents helps the NGO to assess developments since the launch of the Freedom to Speak Up Guardian role and identify and prioritise improvements that may need to be made to support the Freedom to Speak Up network.

This is the fifth survey of its kind. 745 Freedom to Speak Up Guardians to participate in the survey, which was open from 13 September to 31 October 2021. In total, there were 333 responses - a response rate of 44.7%.

3.2. The Survey

The survey looked to ask a number of questions, include those around health and wellbeing, FTSU networks and the NGO, to gain insight into the following areas:

- Speaking Up Culture
- Appointment to and carrying out the role of the FTSU Guardian#
- Ring fenced time
- Training for workers
- Demographics

2021-FTSUGuardian-Survey-Report.pdf

3.2.1. Recommendations

Based on the responses, the following recommendations were summarised:

- Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.

- To improve their ability to act as effective role-models for speaking up we encourage all senior leaders to complete the NGO / HEE ‘speak up, listen up, follow up’ training.

- Senior leaders should discuss the findings of this survey with their Freedom to Speak Up Guardian and assess with them the amount of ring-fenced time and the balance of time available for reactive and proactive support for speaking up.

- There should be visible action on detriment for speaking up wherever this is reported.

- The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.

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- Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.

3.3. Next Steps

In terms of next steps for the Trust, the following actions are asked to be considered.

6. Review and strengthen the line reporting for the FTSU guardian.

7. FTSU quarterly NGO data and patient safety data, included detriment should be triangulated on a quarterly basis, reporting to Patient Safety Committee and Quality and/or Safety Committee

8. Senior Leaders should complete the 'Speak Up, Listen Up, Follow Up' training available through HEE and consider whether this needs to be shared wider

9. Review capacity of the FTSU Guardian, using the tool kit provided by NHS England and NHS Improvement.
Report template - NHSI website (england.nhs.uk)

10. Implementation of FTSU Champions within the Organisation

3.4. Conclusion

The Committee is asked to note the content of the report and agree the actions as described above.

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

Appendix 1: Acronyms

FTSU	Freedom to Speak Up
NGO	National Guardian Office
HEE	Health Education England

FTSU Self-Assessment 2022

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Kirsty Foskett, Head of Clinical Governance & Quality	Paper date:	9th June 2022
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Patient Safety Committee	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:		Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Patient Safety Committee and what input is required?

This paper is provided as an update on the Trust position on the recently completed FTSU (Freedom to Speak Up) self-assessment and next steps required.

2. Executive Summary

2.1. Context

The FTSU self-assessment tool was devised by NHS England and NHS Improvement as guide to help Trusts reflect on its current position and the improvement needed to meet expectations. It is recommended that the Trust repeats a self-assessment review every 2 years, the last review was completed in 2018.

2.2. Summary

Overall, the Trust has partial assurance that there are effective processes in place to support FTSU.
Themes for improvement on completion of the self-assessment are as follows:

- Strengthening of reporting processes from Ward to Board Level
- Board and Executive development around FTSU
- Implementation of FTSU champions
- Review of the capacity for the FTSU Guardian
- Completion of the NGO gap analysis for FTSU services
- Regular FTSU meetings to be established between the FTSU Guardian, Executive and Non-Executive Lead.

The next steps will be for the recommendations to be tabled into an action plan and to be shared and progressed through the FTSU task and finish group

2.3. Conclusion

The Committee is asked to note the content of the report and agree the recommendations as described above.

3. The Main Report

3.1. Introduction

Effective speaking up arrangements help to protect patients and improve the experience of workers. We know the main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change.

Meeting the expectations set out in this self-assessment tool will help the Trust create a culture responsive to feedback from workers and focused on learning and improving the quality of patient care and the experience of workers.

Undertaking regular and in-depth reviews of leadership and governance arrangements in relation to Freedom to Speak Up (FTSU) will help boards to identify areas for further development.

3.2. Self-Assessment Compliance

The self-assessment is split across 7 domains which align to the CQC's KLOE for Well-led. Each of the domains have been broken down into further elements to assess the evidence available and the level of assurance that can be gained.

The review has been completed by the Director Governance / Trust Secretary, Head of Clinical Governance & Quality and the Trusts FTSU Guardian.

Domain	Compliance Rating		
	Fully	Partial	Not
Behave in a way that encourages workers to speak up	0	5	0
Demonstrate commitment to FTSU	3	3	1
Have a strategy to improve your FTSU culture	2	2	1
Support your FTSU Guardian	5	2	0
Be assured your FTSU culture is healthy and effective	2	6	1
Be open and transparent	2	4	0
Individual Responsibilities	0	0	1

Overall, the Trust has partial assurance that there are effective processes in place to support FTSU.

Areas of lacking in assurance are:

- the trust regularly evaluates how effective its FTSU Guardian and champion model is
- the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.
- board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.
- The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.

3.3. Recommendations

Themes for improvement on completion of the self-assessment are as follows:

- Strengthening of reporting processes from Ward to Board Level
- Board and Executive development around FTSU
- Implementation of FTSU champions
- Review of the capacity for the FTSU Guardian
- Completion of the NGO gap analysis for FTSU services
- Regular FTSU meetings to be established between the FTSU Guardian, Executive and Non-Executive Lead.

3.4. Next steps

Recommendations to be tabled into an action plan and to be shared and progressed through the FTSU task and finish group

3.5. Conclusion

The Committee is asked to note the content of the report and agree the recommendations as described above.

Summary of the expectation	How fully do we meet this now?		Evidence to support a 'full' rating
	Insert review date	Insert review date	
Behave in a way that encourages workers to speak up			
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should de			
understand the impact their behaviour can have on a trust's culture	06/06/2022		
know what behaviours encourage and inhibit workers from speaking up	06/06/2022		
test their beliefs about their behaviours using a wide range of feedback	06/06/2022		
reflect on the feedback and make changes as necessary	06/06/2022		
constructively and compassionately challenge each other when appropriate behaviour is not displayed	06/06/2022		
Demonstrate commitment to FTSU			
The board can evidence their commitment to creating an open and honest culture by demonstrating:			
there are a named executive and non-executive leads responsible for speaking up	06/06/2022		Chief Nurse and Patient Safety Officer and Paul Kingston Non-Executive are responsible for FTSU.
Speaking up and other cultural issues are included in the board development programme	06/06/2022		Board training programme agreed and included in development programme
they welcome workers to speak about their experiences in person at board meetings	06/06/2022		
the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility	06/06/2022		

there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made	06/06/2022		The FTSU Gaurdian as part of the feedback loop to individuals who use the service, discusses whether detriment has been suffered. The data for this is also captured as part of the data submitted to the NGO on a quarterly basis.
the trust continually invests in leadership development	06/06/2022		The Trust offers multiple avenues for Leadership development, internal and external to the Trust
the trust regularly evaluates how effective its FTSU Guardian and champion model is	06/06/2022		
Have a strategy to improve your FTSU culture			
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate:			
as a minimum – the draft strategy was shared with key stakeholders	06/06/2022		FTSU Strategy completed and shared at People Committee
the strategy has been discussed and agreed by the board	06/06/2022		People Committee upward reports to the board
the strategy is linked to or embedded within other relevant strategies	06/06/2022		
the board is regularly updated by the executive lead on the progress against the strategy as a whole	06/06/2022		
the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	06/06/2022		
Support your FTSU Guardian			
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate:			
they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively	06/06/2022		
the Guardian has been given time and resource to complete training and development	06/06/2022		Training completed and attends regional and national guardianship meetings

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there is support available to enable the Guardian to reflect on the emotional aspects of their role	06/06/2022		The FTSU Gaurdian seeks supervision from the NGO
there are regular meetings between the Guardian and key executives as well as the non executive lead.	06/06/2022		
individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner	06/06/2022		There is a clear process in place for the FTSU Guardian to escalate patient safety matters and ensure FTSU cases are progressed in a timely manner
they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes	06/06/2022		Data avaialable to FTSU Gaurdian. The FTSU service has also moved to sit under Clinical Goverance, to support triangulation of patient safety data.
the Guardian is enabled to develop external relationships and attend National Guardian related events	06/06/2022		The FTSU Gausrdian attends regional and national guardianship meetings
Be assured your FTSU culture is healthy and effective			
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate:			
that the policy is up to date and has been reviewed at least every two years	06/06/2022		FTSU Policy availabe on the Trust intranet page
reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Gaurdian	06/06/2022		
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate:			
assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience.	06/06/2022		Data avaialable to FTSU Gaurdian. The FTSU service has also moved to sit under Clinical Goverance, to support triangulation of patient safety data.
you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances	06/06/2022		
you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inpsection	06/06/2022		

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you evaluate gaps in assurance and manage any risks identified, adding them to the trust’s risk register where appropriate.	06/06/2022		
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	06/06/2022		
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	06/06/2022		Recruitment process and associated JD as per NGO guidance
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	06/06/2022		
Be open and transparent			
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate:			
discussion with relevant oversight organisation	06/06/2022		
discussion within relevant peer networks	06/06/2022		
content in the trust’s annual report	06/06/2022		Overview of the Trusts FTSU is provided in the Trusts annual Quality Account
content on the trust’s website	06/06/2022		Content on Trust's website. A web page has been set up on Percy Intranet which publishes the Guardians contact details and details about FTSU service.
discussion at the public board	06/06/2022		
welcoming engagement with the National Guardian and her staff	06/06/2022		
Individual Responsibilities			

The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	06/06/2022		

Principal actions needed in relation to a 'not' or 'partial' rating
monstrate that they:
Training to be completed by the Board - commenced 8/6/2022
Training to be completed by the Board - commenced 8/6/2022
Survey to be issued
Board session to be scheduled to coincide with survey results
360 appraisal to be completed
The FTSU gaurdian is invited to update the board on an annual basis. To strengthen this process, the FTSU Guardian should report to People Committee on a quarterly basis, inviting those who have used FTSU to share their experiences.
The Trust is in the process of triangulating information from the staff survery, patient complaints and FTSU data to understand the improvements that are required for this area. The Trust has implemented Civility Matters training.

Key	
Not	
Partially	
Fully	

The FTSU Gaurdian has ring fenced time to support the service. However an evaluation based on service demand needs to be undetrtaken to ensure the alloacated capacity is sufficient.
Review needs to be undertaken to look at links with other strategies
Added to the work plan on 9/6/22 so updates will be received going forward
FTSU Group to be established with reporting against strategy included in the work plan
The FTSU Gaurdian has ring fenced time to support the service. However an evaluation based on service demand needs to be undetrtaken to ensure the alloacated capacity is sufficient. FTSU champions need to be appointed into the Trust.

Regular meetings need to be scheduled with the executive leads of FTSU
Gap analysis exercise set by the NGO to be undertaken
FTSU reporting needs to be strengthened in terms of line reporting and frequency. Recommendation for FTSU to report to People Committee on a quartely basis to improve assurance and highlight any gaps/risks.
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FTSU reporting needs to be strengthened in terms of line reporting and frequency. Recommendation for FTSU to report to People Committee on a quartely basis to improve assurance and highlight any gaps/risks.

These have been adhoc so FTSU updates added to the work plan on 9/6/2022 to ensure the Board receives updates going forward starting with the July meeting

Gap analysis exercise set by the NGO to be undertaken

A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn. The Board should routinely discusse challenges and opportunites presented by matters raised through speaking up.

This requires the Trust to share the learning from FTSU concerns raised, which at times can be difficult as it is important to always maintain confidentiality. There needs to be more of a focus on the changes in processes as a result of the FTSU concern raised.

Added to the work plan on 9/6/22 so updates will be received going forward and discsussed in public

The Board receive an annual update from the FTSU, recommendation that this should increase to a 6 monthly basis.

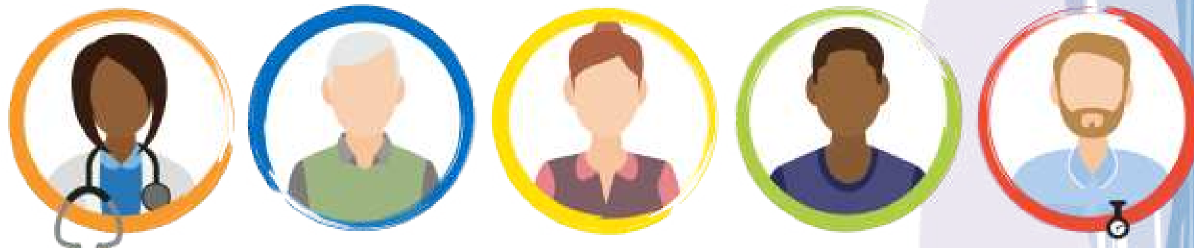
Specific template to be devised to compliment discussion on FTSU for appraisal of all baord members

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

104+ Week Waits and 78+ Week Waits 2022/23 Plans – Deep Dive

FPD

28th June 2022



Aspiring to deliver world class patient care

National Priorities and RJAH Trajectories

- NHS England National Planning Guidance 2022/23
  - 0 x 104+ Weeks by 30th June 2022
  - 0 x 78+ Weeks by 31st March 2023

RJAH is submitting plans that are non-compliant with NHSE priorities.

English Trajectory - 104 week waits
13th June 2022

	All Milestones - 104 week waits											
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust Total	106	99	93	61	53	45	39	33	27	20	9	0

78 weeks waits												
English RTT Waits	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust total	600	650	580	534	532	490	387	345	361	327	264	247

- 104 weeks reduction in trajectory of 32 between June and July is a combination of a reduction in trips in during July and an increase in capacity during July
- Two years ago – complete lockdown has had an impact on numbers

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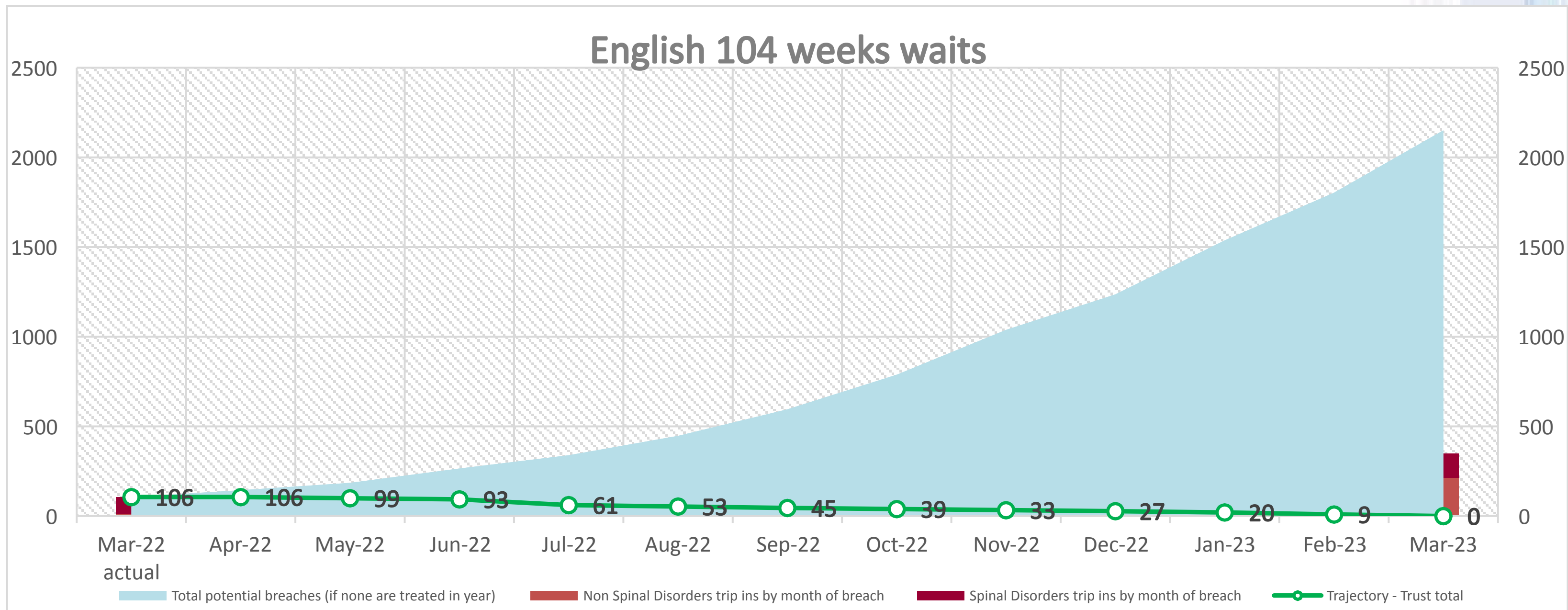
Managing The Trip-ins – 104 weeks

NHS



- We will achieve the trajectory for June!
- 2151 patients would breach 104 weeks if no action taken.
- Graphs shows the scales of trip in breaches by month split between spines and non spines.
- Risk to achievement patient choice, complexities, winter pressures and covid waves.
- Regularly reviewing pathways at weekly performance meeting, focus on prioritising milestone 1 (new appointments), identifying early in the pathway diagnostic capacity and scheduling patients in strict chronological order.
- Additional operating capacity (ISP, mutual aid and internal sessions) identified.

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Managing The Trip-ins – 78 weeks

English 78 weeks waits

	Mar-22 actual	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trajectory - Trust total	526	600	650	580	534	532	490	387	345	361	327	264	247

Legend: Total potential breaches (if none are treated in year); Non Spinal Disorders trip ins by month of breach; Spinal Disorders trip ins by month of breach; Trajectory - Trust total

- 5077 patients would breach 78 weeks if no action taken.
- Graphs shows the scales of trip in breaches by month split between spines and non spines.
- Risk to achievement patient choice, complexities, winter pressures and covid waves.
- Regularly reviewing pathways at weekly performance meeting, focus on prioritising milestone 1 (new appointments), identifying early in the pathway diagnostic capacity and scheduling patients in strict chronological order.
- Additional operating capacity (ISP, mutual aid and internal sessions) identified.
- Capacity and Complexity is the reason we cannot achieve zero – it is nationally recognised that Spinal Complexity is a factor in this.

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Key Actions

- 1.5 WTE new consultants starting in August – increasing IJP capacity
- Clinical validation by specialist nurse and physician's associate
- Improving efficiencies in clinic templates
- Prioritising long waits pathways
- Patient validation – patients being contacted to identify if they still require treatment (non-clinical discussion)
- Contacting patients in advance to confirm their availability
- Mutual aid and additional internal capacity
- Close working with consultants to prioritise long waits and be in accordance with RTT and trust policies.

NHS

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Welsh Planning Guidance

The Trust is externally being monitored against NHS England planning priorities for English patients.

The Welsh Government elective recovery guidance was released on the 26th April 2022. This differs from NHSE and stipulates that Trusts:

- Should eliminate the number of people waiting longer than two years in most specialties **by March 2023**.
- Have no one waiting longer than a year for their first outpatient appointment **by the end of 2022**.

78 Week Welsh Trajectory

Trust Total	317	343	329	331	337	336	345	413	444	463	539
Non Spinal Disorders	55	65	70	73	55	46	36	44	34	28	29
Spinal Disorders	262	278	259	258	282	290	309	369	410	435	510

104 Week Trajectory

Trust Total	85	85	86	84	93	97	93	83	83	84	118
Non Spinal Disorders	0	0	0	0	0	0	0	0	0	0	0
Spinal Disorders	85	85	86	84	93	97	93	83	83	84	118

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Welsh Planning Guidance

Welsh 52 week breaches - Spinal Disorders - Milestone 1 (new appointments)

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Trip ins in month	67	60	65	79	59	73	58

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Chair's Assurance Report
Finance, Planning and Digital Committee – 28th June 2022

0. Reference Information

Author:	Amber Scott, Executive Assistant	**Paper date:**	6th July 2022
Executive Sponsor:	Sarfraz Nawaz, Non-Executive Director	Paper written on:	28th June 2022
Paper Reviewed by:	N/A	Paper Category:	Governance and Assurance
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

Purpose of Paper
Why is this paper going to the Trust Board and what input is required?
This paper presents a summary of the Finance, Planning and Digital Committee meeting held on 28th June 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

Executive Summary
2.1 Context
The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance Planning and Digital Committee. This Committee is responsible for seeking assurance that the Trust is operating within its financial constraints and that the delivery of its services represents value for money. Further it is responsible for seeking assurance that any investments again represent value for money and delivery the expected benefits. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary
- The meeting was well attended
- All actions were completed from the previous meeting
- The Committee received the deep dive into 104 week waiting patients
- Risks of the Financial Plan and Operational Plan were received and discussed
- BAF and Corporate Objectives were reviewed and approved

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

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Chair's Assurance Report
Finance, Planning and Digital Committee – 28th June 2022

Main Report
3.1 Introduction
This report has been prepared to provide assurance to the Board of Directors from the Finance, Planning and Digital Committee which met on 28th June 2022. The meeting was quorate with 2 Non-Executive Directors, and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
Present:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Martin Newsholme	Non-Executive Director
Mark Salisbury	Operational Director of Finance
Stacey-Lea Keegan	Chief Executive Officer
Simon Adams	Director of Digital
Shelley Ramtuhul	Trust Secretary
In Attendance:	
Dawn Forrest	Managing Director of SpSU (part)
Jo Banks	Managing Director of MSK (Part)
Nia Jones	Head of Planning
Steph Wilson	Performance Insight & Improvement Manager
Victoria Brownrigg	Head of Financial Management and Planning (Part)
Amber Scott	Executive Assistant
Apologies:	
Apologies were received from David Gilburt, Craig Macbeth and Paul Kingston.	

3.2 Actions from the Previous Meeting
The Committee noted that all actions were complete.

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
Performance & Restoration Update		
In terms of the overdue follow ups, priority one patients have come down by about a third in the last year. With priority two patients flatlining. Trust are on plan for the number of sessions offered and the key focus at the moment being around cases per session where case mix for month 2 was relatively complex. Weekly demand and capacity of the Trust was requested and whether this is enough to reduce the backlog. Confirmation was offered that a scheduled increase to 134 sessions a week is within both the operational and finance plan outlining the actions in place for this. • Currently 108 sessions per week • July increase to 116 sessions per week • September increase to 134 sessions per week	Partial	Further assurances requested to be presented on Overdue Follow Ups and the Demand and Capacity model.

Risks were noted to be in place are around workforce and consultant recruitment. An update on overdue follow ups and the planned increase to the validation team and the impact was requested for further assurances on improvements. It was also noted that the Trust have a commitment to SaTH to continue supporting with Mutual Aid, although, SaTH are starting back elective surgery, therefore a reduction in this is likely. Assurance was offered to the Committee that the sessions are only being offered where the Trust do not require them.		
National & Regional Elective Recovery Programmes		
It was to note that NHSE have recognised an error in this report due to Welsh and English activity adjustments required. The VWA and activity assessments are currently recognised as being artificially low for the system and the Trust. The Trust is expecting further updates to resolve this issue which will increase system and Trust reported performance.	Partial	Partial assurance was received by the Committee due to the position not being reflective of the Trust, with an accurate reported aimed to be received next month.
104 Week Deep Dive		
• Trust will achieve the trajectory for June • Risk to achievement: - patient choice - complexities - winter pressures - covid waves • Regularly reviewing pathways at weekly performance meeting, focus on prioritising milestone 1 (new appointments), identifying early in the pathway diagnostic capacity and scheduling patients in strict chronological order • Additional operating capacity (ISP, mutual aid and internal sessions) identified Mutual aid has been received from Stanmore London. • Cohort 1: - 120 patients contacted – 4 accepted • Cohort 2: - 53 patients contacted – 8 accepted 72 week waiting patients: • Regularly reviewing pathways at weekly performance meeting, focus on prioritising milestone 1 (new appointments), identifying early in the pathway diagnostic capacity and scheduling patients in strict chronological order. • Additional operating capacity (ISP, mutual aid and internal sessions) identified. • Capacity and Complexity is the reason we cannot achieve zero – it is nationally recognised that Spinal Complexity is a factor in this.	Yes	The Committee requested continued oversight of the 104 week waits.

The Committee were informed that Nationally, going forward, there will be 3 domains under review. • Complexity of cases • Capacity • Patient Choice with suggestion that this will enable further understanding of the positioning of the Trust, as well as a national overview. Key actions: • Consultant recruitment, increasing IJP capacity • Clinical validation by specialist nurse and physician's associate • Improving efficiencies in clinic templates • Contacting patients in advance to confirm their availability • Mutual aid Consultant engagement and communication has improved significantly and has enabled longer working days and the addition of Emergency sessions to complete P2 patients, enabling IJP sessions to complete long waiting patients. Welsh Government elective recovery guidance was released on the 26th of April 2022 which differs from NHSE and stipulates that Trusts: - Should eliminate the number of people waiting longer than two years in most specialties by March 2023. - Have no one waiting longer than a year for their first outpatient appointment by the end of 2022.		
Financial Performance Report		
Overall £161k adverse to plan in month and £156k adverse YTD. Income £224k adverse in month due to: - Pass through costs (high-cost drugs and Health Education England) adverse. - Clinical income favourable due to Welsh over performance partially offset by adverse Elective Recovery Funding (ERF). - Non-clinical income adverse performance on private patients, research, car parking and TSSU Expenditure £64k favourable in month due to: - High vacancy levels offset by out of job plan (OJP) costs and underlying pressures on agency exacerbated by Mental Health agency costs for 1:1 support on MCSI wards. This is driving adverse performance against the core agency cap set by the regulator. - Pass through costs (high-cost drugs and Health Education England expenditure) favourable.	Yes	

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- Private sector outsourcing favourable offset by ERF income. To note the core agency is above cap which is exacerbated by the mental health agency 1:1 and system winter pressures support. Actions have been put in place to target improvement.		
Revised Planning Submission		
The Committee were cited on further detail added to the plan following the last meeting, drawing out on the Outpatient activity, in particular built-in improvements to the plan that take the Trust up to 96% in terms of full year restoration, with a planned 100% restoration from Q3.Additionally, system updates have been included to reference back to in terms of putting the improvement target in terms of the delivery plan. Further to this, the System discussed the elective spells recovery with an expectation as to whether or not this could improve from the 102% restoration to 104%. As a provider this will be maintained at 102% which leaves the Trust with a shortfall of 229 elective spells to reach 104%.	Yes	Approval was given for submission of the revised plan.
Board Assurance Framework & Corporate Objectives		
The Committee discussed and agreed that the deep dives within the work plan are to be added to the BAF to capture the control and monitoring of the risks. With MN commenting that MSK and Veterans should be included within the work plan to cover the risks within the objectives.	Yes	
Chair Assurance Reports		
Trust Performance Operational Improvement Board The Chair report was noted by the Committee. **ICS Sustainability Committee** The Chair report was noted by the Committee. **Veterans Project Group** The Chair report was noted by the Committee. **Procurement & Steering Group** The report was noted by the Committee.	Yes	
Any Other Business		
Concern was raised on the investment in cleaning still being blocked by the system finance pressures suggesting the risk should be escalated to the Board. It was noted that an ICS Sustainability meeting was held last week, where a persuasive and forceful case for the Trust to be able to release the funds for this investment was made. A further call was scheduled following this with a fairly hopeful view that the funding will be released. Adding to this it was recognised that the Trust cannot deteriorate its or the systems financial position but if sufficient efficiency can be identified through stretch delivery to offset the investment this would be an opportunity to take the case forward. This approach would need to be agreed with the ICS for full transparency but as the case is the highest rated risk	Yes	

on the ICS investment panel register it is likely to be looked upon favorably.		

3.4 Approvals

Approval Sought	Outcome
Work Plan	The work plan was approved pending amendments requested throughout the meeting.
Attendance Matrix	The attendance matrix was noted by the Committee. The Committee noted a change in terms of reference will be presented to Board next week, suggesting 2 Non-Executive Directors and 2 Executives are to attend the Committee. Should this be approved the amended terms of reference will be presented for approval at committee and the change will be noted in the attendance matrix to ensure a true reflection of the changes with the year.

3.5 Risks to be Escalated

Risk to IPC should investment funding not be received.

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

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

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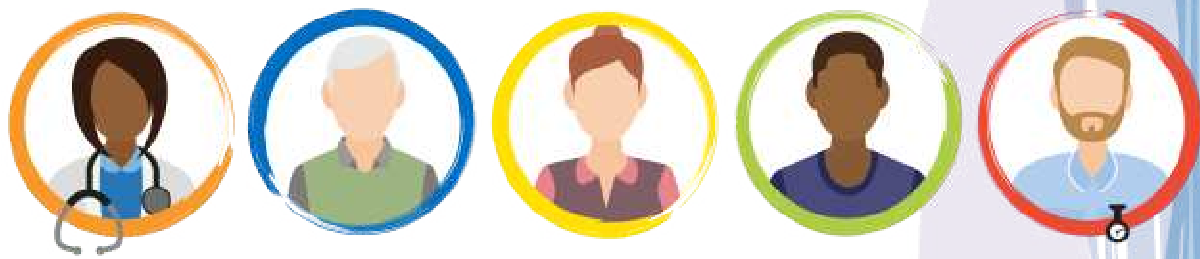
Operational Plan 2022/23 Resubmission – 20th June 2022



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Planning resubmission update - Headlines

NHS

- **Resubmitted plans required to achieve activity at 104% of 19/20 baseline value at system level**
  - Challenging to achieve given April COVID impact
  - Delays to elective hub approvals mean no additional capacity will be available to system in year
- **Inpatients - Restoration of 102% (no change)**
  - 104% achieved but for April COVID impact (2% full year impact)
  - Independent sector activity reduced by 267
  - Offset by increased activity delivered ytd and improved theatre utilisation (emergency spinal lists to be used for elective spinal)
  - **Stretch from 102%-104% requires further 229 spells for RJAH (added by ICS as additional Independent Sector activity stretch with clear narrative on risk as part of submission)**
- **Outpatients – Restoration of 96% (previous submission was 91%)**
  - Further stretch added following internal sub specialty review (work in progress)
  - 100% restoration from Q3.
  - Further work required to deliver above plan to 104%
- **Diagnostic activity** – No change following IPC review
  - MRI restoration of 101%, Ultrasound 108%, CT 110%

Waiting times

NHS

- **104 week waiters – 93 remaining by end of June (target zero)**
  - Improvement of 3 on previous submission
  - All 104 week waits to be eliminated by March 2023
  - Mutual Aid yield is low due to complexity/patient choice
  - Internal capacity maximised to ensure priority access

- **78 week waiters – 247 remaining at end of March 2023 (target zero)**
  - No change to previously submitted trajectory
  - System under tier 2 level escalation
  - Keep under review as confirmed ICS capacity is realised.

Delivery trajectory (Theatre activity - cases)

NHS

Cases		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Total	IJP	582	647	578	556	501	665	647	746	519	655	653	715	7,464
	IJP Flex	102	-	-	-	-	-	-	-	-	-	-	-	102
	OJP	-	257	217	209	190	250	242	279	195	245	244	267	2,595
	OJP Flex	-	110	11	160	280	39	131	26	122	133	61	127	958
	Plan	480	794	784	925	971	954	1,020	1,051	836	1,033	958	1,109	10,915
	Baseline	755	903	830	801	923	1,042	921	1,033	789	924	889	925	10,735
	% restoration	64%	88%	94%	115%	105%	92%	111%	102%	106%	112%	108%	120%	102%
	OJP %	0%	19%	26%	40%	48%	30%	37%	29%	38%	37%	32%	36%	33%

19/20 Adjusted Baseline	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
NHS	755	903	830	801	923	1,042	921	1,033	789	924	889	925	10,735
PP	61	61	67	50	42	56	66	83	40	65	51	55	697
% of Activity	8%	7%	8%	6%	5%	5%	7%	8%	5%	7%	6%	6%	6%

22/23 Draft Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
NHS	480	794	784	925	971	954	1,020	1,051	836	1,033	958	1,109	10,915
PP	35	61	67	50	42	56	66	83	40	65	51	55	671
% of Activity	7%	8%	9%	5%	4%	6%	6%	8%	5%	6%	5%	5%	6%

- Plan is to deliver 10,915 NHS cases as compared to 10,735 in 2019/20
- Increased in job plan capacity linked to recruitment plans (from September)
- OJP averages at 33% (peak of 48% in August)
- PP remains proportionate to baseline

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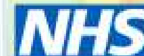
Delivery Trajectory – Outpatients



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
19/20 Baseline working day adj	14,417	15,164	14,342	14,489	14,980	16,434	15,248	16,275	13,149	16,230	14,880	17,023	182,631
Physio Pool and Classes	-247	-262	-251	-258	-280	-237	-242	-238	-139	-214	-199	-135	-2,702
Revised technical Baseline	14,170	14,902	14,091	14,231	14,700	16,197	15,006	16,037	13,010	16,016	14,681	16,888	179,929
Plan	11,657	12,683	12,232	12,992	13,196	14,647	13,806	15,154	12,054	14,698	13,898	15,512	162,528
% Restoration	82%	85%	87%	91%	90%	90%	92%	94%	93%	92%	95%	92%	90%
Transformation - Locum						38	36	38	35	36	35	40	258
Transformation - STIG	10	10	20	20	20								80
Transformation - ORLAU							20	20	20	10	20	20	110
Transformation - Physio Gym Class			-	436	485	394	653	636	340	787	730	457	4,917
Recruitment								85	85	85	85	85	425
Underutilisation LLP Clinics				50	50	50	50	50	50	50	50	50	450
Cancellation pre 48 hours	88	103	91	88	71	100	97	110	79	100	93	106	1,126
Lost PA's MSK Recruitment							174	183	166	174	166	191	1,054
Additional Out of Job Plan Activity	241	258	192	395	372	454	287	379	394	377	323	360	4,032
DNA reduction 1.9% improvement	34	43	36	37	27	39	39	44	32	41	35	41	448
Orthotics demand			90	87	89	87	87	102	79	90	86	87	884
IPC Covid Swabbing				-251	-263	-263	-251	-263	-239	-251	-239	-275	-2,297
Actual Update	-297	852											555
System update				581	606	606				875	831	958	4,457
Plan inc transformation	11,710	13,974	12,661	13,854	14,047	15,546	14,998	16,537	13,095	16,197	15,282	16,674	174,573
% Restoration	83%	94%	90%	97%	96%	96%	100%	103%	101%	101%	104%	99%	97%

- COVID swabbing removed (loss of 2297)
- Additional therapy and Orthotics attendances added (increase of 5801)
- Stretch of 4457 to achieve 100% by Q3 - awaiting delivery plan from Units

Delivery trajectory - Diagnostics

NHS

CT	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Baseline	362	379	431	382	380	408	407	389	370	397	379	484	4,768
Plan	398	417	474	420	418	449	448	428	407	437	417	532	5,245
Restoration Target	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%

MRI	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Baseline	922	1,049	1,109	985	1,092	1,086	1,044	1,185	1,010	1,073	1,090	1,367	13,012
Plan	876	997	1,054	936	1,037	1,032	1,134	1,263	1,092	1,156	1,159	1,440	13,175
Restoration Target	95%	95%	95%	95%	95%	95%	109%	107%	108%	108%	106%	105%	101%

US	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Baseline	650	732	766	749	704	773	864	757	646	775	743	906	9,065
Plan	702	791	827	809	760	835	933	818	698	837	802	978	9,790
Restoration Target	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%

- Step change in MRI capacity from October (additional weekend working)

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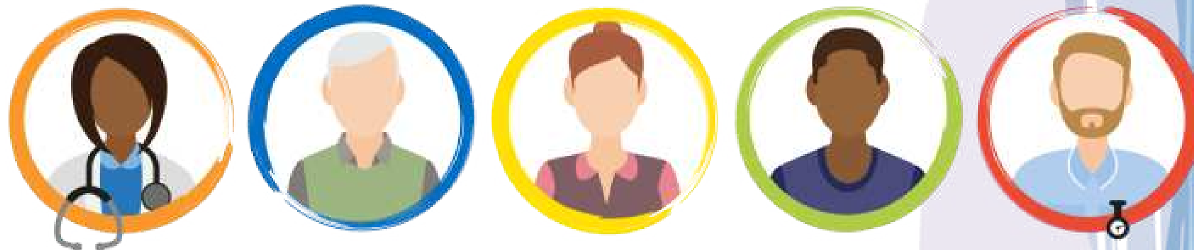
Financial Plan

Resubmission 20th June 2022



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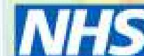
Financial Plan Resubmission Headlines

- The regulator has requested a further update to financial plans following national funding of inflationary pressures and updates to IPC guidance.

- RJAH deficit of £1.6m improved to £0.8m :
  - £0.7m inflation pressures funded through tariff inflation
  - £0.1m share of NHSI/E direct non recurrent funding

- ICS deficit of £38.1m improved to £19m deficit against breakeven requirement :
  - £7.9m net improvement from inflationary funding
  - £2.8m NHSI/E direct non recurrent funding
  - £1.1m slippage in expenditure
  - £7.3m additional efficiency (at risk) on top of £5m from previous submission
  - Uncommitted investments remain excluded, c£20m

Financial Plan Phasing



Category	22/23 Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income	£ 126,852	£ 8,454	£ 9,713	£ 9,847	£ 10,542	£ 10,700	£ 11,089	£ 11,201	£ 11,735	£ 9,670	£ 11,278	£ 10,508	£ 12,116
Pay	-£ 76,207	-£ 6,284	-£ 6,296	-£ 6,300	-£ 6,368	-£ 6,347	-£ 6,326	-£ 6,386	-£ 6,376	-£ 6,353	-£ 6,389	-£ 6,378	-£ 6,404
Non Pay	-£ 44,087	-£ 2,805	-£ 3,363	-£ 3,383	-£ 3,656	-£ 3,724	-£ 3,695	-£ 3,950	-£ 4,013	-£ 3,630	-£ 4,025	-£ 3,782	-£ 4,060
EBITDA	£ 6,558	-£ 635	£ 54	£ 164	£ 518	£ 630	£ 1,069	£ 864	£ 1,346	-£ 313	£ 864	£ 347	£ 1,652
Finance Costs	-£ 7,962	-£ 644	-£ 644	-£ 636	-£ 662	-£ 660	-£ 661	-£ 663	-£ 662	-£ 663	-£ 688	-£ 687	-£ 688
Capital Donations	£ 3,300	£ 493	£ 493	£ 517	£ 484	£ 479	£ 784	£ -	£ -	£ 25	£ -	£ -	£ 25
Operational Surplus / (Deficit)	£ 1,896	-£ 786	-£ 97	£ 45	£ 339	£ 448	£ 1,191	£ 201	£ 683	-£ 952	£ 175	-£ 340	£ 939
Remove Capital Donations	-£ 3,300	-£ 493	-£ 493	-£ 517	-£ 484	-£ 479	-£ 784	£ -	£ -	-£ 25	£ -	£ -	-£ 25
Add Back Donated Dep'n	£ 632	£ 50	£ 50	£ 50	£ 51	£ 52	£ 52	£ 52	£ 53	£ 53	£ 56	£ 56	£ 56
Adjusted Surplus / (Deficit)	-£ 772	-£ 1,229	-£ 540	-£ 422	-£ 94	£ 21	£ 459	£ 253	£ 736	-£ 924	£ 231	-£ 284	£ 1,020

Note:
- M1 includes impact of mutual aid to SaTH c£0.4m adverse to bottom line
- £3.2m ERF costs offset by income – needs to be delivered through ERF regime
- M3 includes 'catch up' of inflation funding through tariff for M1&2
- M6 onwards includes step up in activity linked to delivery of 134 theatre sessions (linked to recruitment)

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NHS Foundation Trust

DRAFT

Title:	Research Strategy 2020 – 31st March 2025		
Unique Identifier:		**Document Type:**	Strategy
Version Number:	1.3	**Status:**	*For approval*
Responsible Executive:	Ruth Longfellow, Medical Director		
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To be Read in Conjunction with the Following Documents: (list related policies)			
Keywords:	Research, Innovation, Ethics, Local Clinical Research Network, Keele University		
Executive Summary	The Research Strategy has been designed to ensure a robust programme of research to support improved patient outcomes at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and in the wider community. It will ensure appropriate Clinical Governance arrangements are in place to safeguard patients, staff and the Trust itself.		
Considered By Executive Owner:	Stephen White, Medical Director	**Date Considered:**	
Endorsed By:	Research Committee	**Date Endorsed:**	*27* April 2022
Approved By:	Quality & Safety Committee	**Date Approved:**	23 May 2022
Issue Date:		**Review Date:**	31 March 2025
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

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Purpose

The Research Strategy has been formulated to support the Trust's research as an important core clinical activity **to support World-Class patient care**

Research Strategic Objectives

Caring for Patients

- Ensuring that where possible, patients are offered the opportunity to participate in clinical research.
- Improving treatment for musculoskeletal conditions through innovation and rapid implementation of evidence based practice.
- Continuously improving the quality of care for patients.
- Involve patients in the planning and management of our research
- Ensure robust research governance and support for high quality research

Caring for Staff

- Developing and supporting a culture of enquiry within the workforce
- Enhancing the skills of the workforce
- Attracting and retaining a high quality workforce.

Caring for Finances

- Engage with industry to make the Trust the musculoskeletal partner of choice

Specialist Services

- Supporting the development and promotion of the Trust's specialist services

Integrated MSK Care

- Supporting vertically integrated musculoskeletal care through research

To realise these objectives, the Trust will:

- Use research to support the Trust's;
  - Quest to continuously improve patient treatment and care
  - Education, training, performance management and capital strategies
- Value strong academic partnerships
- Capitalise on value added through research and innovation partnerships, including those with The Orthopaedic Institute Ltd, National Institute for Health Research (NIHR), Research Councils, medical charities, other academic institutions, Academic Health Science Network (AHSN) and industry
- Ensure that new staff understand their role in research

These objectives can be divided into 4 enabling programmes, under which sit key initiatives:

Developing our workforce
Working with the Trust's 5 Year People Plan: Make the Difference and through development of the Innovation Hub, we will develop the workforce of the Trust to enhance the research culture and environment to grow the research and innovation business by fostering an improved understanding of the value of research and innovation. We intend to embed a philosophy of continuous enquiry and improvement in all staff groups. We will work with other System Partners in the development of our workforce.

Building on our world class infrastructure and facilities
To work with the estates and facilities dept. as well as the clinical areas to ensure that each patient is given the opportunity to be involved in a research project and that their patient journey is a positive experience.
To further develop the regenerative medicine facility to capitalise on cell therapy and manufacturing opportunities that may arise.

Strengthen our existing and develop new partnerships
By building on current and developing new relationships, we have the opportunity to grow our research which has benefits to the patient, the staff, the finances of the Trust and the wider medical community through successful grant applications and publications in medical or scientific journals.

Developing our systems
Through the continuation of the work already started, including the lessons learnt during the COVID-9 pandemic, we will ensure that the Trust has a robust governance process leading to the delivery of high quality research.

Key Research Strategy Performance Indicators

These will be achieved via the 5 yr. Delivery Plan (appendix 1) and Annual Delivery Action Plan.

- Increase the number of participants involved in sustainable research by 5% each yr.
- Increase the number of patients participating in research as a percentage of total patient episodes by 0.1% each yr.
- Increase the number of patients being offered participation in research as a percentage of total patient episodes by 0.1% each yr.
- Increase the number of studies developed to full grant application in the Trust by 5% each yr.
- Increase the number of collaborative grant applications in the Trust by 5% each yr.
- Increase the number of peer reviewed publications by 5% each yr.
- Increase the number of non-medical Principle Investigators in the Trust by 1 each yr.
- All Job Descriptions from 2021 to have the opportunity for and importance of research described within it.
- Increase the number of staff including non-medical with a Higher Degree (MSc, PhD) by 1 over the 5 yrs. through development support and recruitment.
- Adherence with National Institute of Health Research West Midlands Clinical Research Network metrics (alter on an annual basis).

Delivery

Delivery of the research strategy will be implemented through the Research Strategy 5 yr. Delivery Plan (Appendix 1) which will be supported by a detailed Annual Delivery Action Plan including ownership and SMART (Specific, Measurable, Achievable, Realistic, Time bound) objectives. The Annual Delivery Action Plan will be reviewed and approved on an annual basis by the Research Committee.

Monitoring

Research performance will be documented on an annual basis in the Annual Research Report.

The Research Committee reports to the Trust Quality and Safety Committee on a monthly basis ensuring overview with respect to performance and safety by means of a Chair's Report.

The Research Office also reports on performance at monthly Clinical Services Unit Meetings.

Appendix 1 Research 5 yr. Delivery Plan 2020-2025

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Research Strategy

5 Year Delivery Plan 2020 to 31st March 2025

(Approved by the Research Committee 28th October 2020)

Delivering the Research Strategy

The Research Strategy is a key element in the delivery of the Trust's aspiration to **deliver world class patient care**.

In line with the Research Strategic Objectives and the four Enabling Programmes described, the Research Strategy will be delivered through a set of initiatives under each programme. Each initiative has a target date and will be supported by a detailed Annual Delivery Action Plan with SMART objectives and clear ownership.

The Initiatives are described below:

The initiatives:

Developing our workforce	Target date
Re-structure the research dept. into a delivery and a development arms to ensure delivery of the studies to time and to target as well as creating capacity to grow RJAH Sponsored studies.	31-Mar-22
To develop a culture of enquiry and receptiveness to evidence and strengthen the impact of research in every day clinical practice.	31-Mar-23
Work with the Trust's Senior Leadership Group, Unit Triumvirates and departmental management teams to embed research in the day to day activities in line with the NHS Constitution.	31-Mar-23
Develop a programme of opportunities to develop research skills in staff.	31-Mar-24
Work with the People Services Business Partner and the Director of People Services to inform the People Plan to ensure research is a key element in job descriptions.	31-Mar-24
Encourage nurses and Allied Health Professionals (AHPs) into the role of non-medic Principle Investigator (PI).	31-Mar-25
Work with the Training dept. to embed Good Clinical Practice and other research training opportunities into the Trust training hub, facilitated through the Electronic Staff Record (ESR) system. This will include the training offered free of charge by the National Institute of Health Research (NIHR) both electronically and in a face to face setting.	31-Mar-25

Build infrastructure and facilities	Target date
Collaborating with the outpatient dept. to further develop areas to accommodate the research specific tasks such as gaining informed consent, completion of questionnaires, taking into consideration the privacy and dignity element of the pt. journey.	31 March 2022
Work with the senior management to develop capacity and capability within pharmacy and imaging depts. to support and lead research studies.	31 March 2023
Collaborating with Keele University Clinical Trial Unit and Research Design Service to build the number of RJAH sponsored studies and national grant awards as well as exploring the option of a hub and spoke model.	31 March 2023
Work with the new academic clinicians in regenerative medicine and population orthopaedics to capitalise on the facilities and opportunities as well as growing own possibilities.	31 March 2025
Work with our academic partners and medical schools to offer work placements for students to build research capacity and capability and instil a research culture in the future clinical leaders.	31 March 2025

Strengthen existing and develop new relationships	Target date

Improve the visibility of research within the Trust through various communication methods including social media to staff and patients.	31-Mar-22
Ensure that the Orthopaedic Institute Ltd is fully aligned with the Research strategy.	31-Mar-22
Build on relationships with the Education Hub using research to enhance education and learning so driving evidenced based practice and change.	31-Mar-23
Working with the Medical Director, Director of Nursing, plus the Managing Directors and Clinical Chairs of the new organisation units, to embed the value of research.	31-Mar-23
Build on the relationships with external organisations with a view to collaborative working.	31-Mar-24
Working with West Midlands Clinical Research Network (WM CRN), develop the Research Champion role and expand the role of the Research Patient Panel to enhance public engagement in the planning and management of research.	31-Mar-24
Enhance our relationships with industry and academia, ensuring studies are developed and delivered to a high quality and to time and target wherever possible, thus making RJAH the site of choice.	31-Mar-25
Continue to develop relationships with clinical teams and encourage their participation in research.	31-Mar-25
Continue to work with WM CRN, to increase our participation in studies thus meeting National Institute for Health Research (NIHR) Performance Standards, for example recruitment, number of commercial and non-commercial studies opened and delivered to time and target.	31-Mar-25
Develop relationships with Clinical Commissioning Groups (CCG) and the local sustainability and transformation plans (STP) to ensure our research meets the needs of the local population and that evidence drives change.	31-Mar-25
Engage with Academic Health Science Network (AHSN) to facilitate enhanced collaboration for innovation and adoption of evidence based best practice.	31-Mar-25

Develop systems	Target date
Develop a policy to ensure that Post Market Surveillance studies are conducted in a robust manner via the research office.	31-Mar-21
Strengthening the Quality Management System (QMS) to ensure sponsor oversight leading to high quality and robust research studies.	31-Mar-22
Increasing study monitoring capabilities.	31-Mar-22
Continue to work with the finance department to develop appropriate forecasting tools, ensuring risks to the Trust budget are highlighted early and managed appropriately.	31-Mar-22
Monitor Key Performance Indicators (KPIs) through the Research Committee and Clinical Services Unit with risks escalated to the Quality and Safety Committee.	31-Mar-22
Continue to review and update our governance structure to reflect the expansion of research activity in the Trust ensuring that risk to the Trust is limited.	31-Mar-22
Ensure all clinical research is registered on the clinical trials registry to encourage honest and open reporting of clinical trial results, ensuring access to the high quality journals governed by the International Committee of Medical Journal Editors.	31-Mar-22
Developing transparent and inclusive processes for decision making around research activity.	31-Mar-22
Have a robust process for accurate feasibility assessment in place.	31-Mar-22
Ensure that the Research Committee has appropriate representation from the wider Trust to ensure transparent and inclusive decision making.	31-Mar-22
Develop systems (continued)	**Target date**
Working with the IM&T, Outcome and Audit depts. develop or obtain the best data collection	31-Mar-25

software to ensure data quality and accuracy.	
Ensure that Intellectual Property is effectively managed in collaborative projects.	31-Mar-25

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NHS Foundation Trust

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	6 July 2022
Senior Leader Sponsor:	Stacey Keegan, Chief Executive Officer	Paper written on:	8 June 2022
Paper Reviewed by:	Strategy Board	Paper Type:	Governance
Forum submitted to:	Public Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents the Board Governance Framework for the Board of Directors to note.

Following a discussion at the Strategy Board in June, the amendments have been incorporated into the framework.

The framework will also be table for discussion at the next Council of Governors Meeting for information.

2. Executive Summary

2.1. Context

Governance in the NHS can be defined as the systems and processes by which board-led health bodies including NHS FTs lead, direct and control their functions, in order to achieve organisational objectives, meet the necessary standards of accountability and probity, and by which they relate to their partners and the wider community.

A governance framework is an important tool for effective board oversight which supports authority and accountability while enabling effective decision-making in an organisation.

2.2. Summary

- The framework has been reviewed
- All appendices have been approved by the relevant committee meeting
- The following amendments have been incorporated following consideration at the Strategy Board in June:
  - Open invitation for the Chairman to attend the assurance committees (except Audit and Risk)
  - EPRR to be aligned to Chief Operating Officer
  - Director of Nursing to be replaced with Chief Nurse and Patient Safety Officer
  - SIRO to be noted as the Director of Digital
  - Director of Digital to be 'in attendance' at the Finance, Planning and Digital Committee
  - Finance, Planning and Digital Committee quorum to be updated to 2 Non-Executive Directors and 2 Executive Directors

2.3. Conclusion

The Board of Directors is asked to note the amendments incorporated into the framework following the discussions held at the Strategy Board session in June and approve the document for wider circulation.

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

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BOARD GOVERNANCE FOR THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

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1. THE BOARD OF DIRECTORS

1.1 The Collective Role of the Board

The collective role of the Board of Directors is to:

- Act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public (Health and Social Care Act 2012)
- Formulate Strategy
- Ensure accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust
- Provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
- Ensure compliance by the Trust with its terms of authorisation, its Constitution, mandatory guidance issued by NHSI, relevant statutory requirements and contractual obligations
- Set the Trust's strategic aims, taking into consideration the views of the Council of Governors and ensuring that the necessary financial and people services are in place for the Trust to meet its objectives, and to review management performance
- Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies
- Set the Trust's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met
- Ensure that the Trust exercises its functions effectively, efficiently, and economically

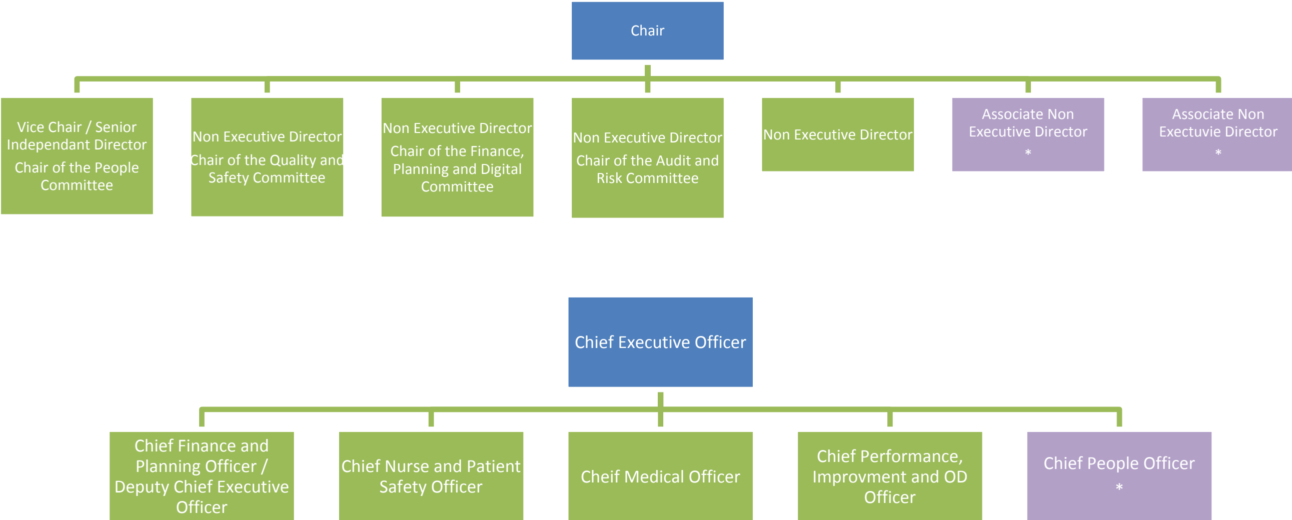
1.2 The Composition of the Board

The Board of Directors comprises:

- A Non-Executive Chair
- No fewer than four and no more than six other Non-Executive Directors
- One of the Non-Executive Directors will act as the Deputy Chair and Senior Independent Director
- No fewer than four and no more than six Executive Directors, including a Chief Executive, a Finance Director, a Registered Medical Practitioner or Registered Dentist and a Registered Nurse or Registered Midwife

At any time, at least half the voting members of the Board (excluding the Chairman) will be made up of Non-Executive Directors.

RJAH Trust Board is constituted as follows:



** Purple non-voting members of the Board*

The Trust has a Foundation Trust Secretary to support the work of the Board. This role will also support the Council of Governors.

1.3 The Operation of the Board

The Board of Directors operates as a unitary body which is collectively responsible for the performance of the Trust and the exercise of its statutory powers. Accordingly, all Directors, whether Executive or Non-Executive:

- Have joint responsibility for every decision of the Board and are required to take decisions objectively in the interests of the Trust
- Are responsible for leading and directing the Trust's activities and for helping to develop proposals on strategy
- Are responsible for monitoring the conduct and performance of management and for constructively challenging the decisions of the Board

1.4 Framework for the Performance Evaluation of the Board, its Committees and Directors including the Chairman

This framework sets out how the performance of the Board of Directors, its Committees, and its Directors, including the Chairman is regularly reviewed.

The collective performance of the board is reviewed on an annual basis and will be independently assessed every 3 years against the board leadership and governance framework set out by NHSi.

The Senior Independent Director leads the annual assessment of the performance of the Chairman in accordance with the process agreed with the Council of Governors (appendix A.1).

The performance of the Non-Executive Directors is assessed annually by the Chairman and includes 360° feedback from all members of the board of Directors (appendix A.2).

The performance of the Chief Executive is assessed annually by the Chairman and agreed with the Remuneration Committee based on agreed criteria (appendix A.3)

The performance of Executive and Directors is assessed annually by the Chief Executive and agreed with the Remuneration Committee based on agreed criteria (appendix.A.3)

1.5 Appointments to the Board

The appointment of the Chief Executive is the responsibility of the Remuneration and Nomination committee made up of the Chairman and Non-Executive Directors. This appointment is subject to approval by the Council of Governors.

Executive Director Appointments (excluding the Chief Executive) to the Board are the responsibility of the Committee made up of the Chairman, Chief Executive and Non-Executive Directors. The Remuneration and Nomination.

Non-Executive Directors are appointed by a Committee of the Council of Governors

The Terms of Reference of these committees are included in the Appendices.

1.6 Standards for NHS Board members

The Board is responsible for ensuring that all of its members meet the “fit and proper person test” as required by the Health and Social Care Act.

The Board has adopted the “Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England”, which has been developed by the Professional Standards Authority (and was reissued in November 2013).

All members of the Board are expected to adhere to these standards.
(The Standards are attached at Appendix B).

In addition to this all managers in the Trust are required to comply with the “Code of Conduct for NHS Mangers” which can be found via Code of Conduct for NHS Managers. Further, all managers are required to comply with the Trusts Standards of Business Conduct Policy (Extract attached at Appendix C)

2. INDIVIDUAL ROLES WITHIN THE BOARD OF DIRECTORS

Non-Executive Roles

2.1 All Non-Executive Directors

The Board of Directors is a unitary body which is collectively responsible for the performance of the Trust and the exercise of its statutory powers.

Within the unitary Board, all Directors, whether Executive or Non-Executive, have joint responsibility for every decision of the Board and are required to take decisions objectively in the interests of the Trust. Non-Executive as well as Executive Directors are responsible for leading and directing the Trust's activities and for helping to develop proposals on strategy. Conversely, Executive as well as Non-Executive Directors are responsible for monitoring the conduct and performance of management and for constructively challenging the decisions of the Board.

As part of their role as members of the unitary Board, Non-Executive Directors have a particular duty to ensure that the decisions of the Board are subject to constructive challenge and to scrutinise management performance in meeting agreed goals and objectives.

In addition, Non-Executive Directors who are determined by the Board to be independent in character and judgement and free from any business or other relationship which could materially interfere with the exercise of their judgement will be responsible, as the members of key committees of the Board, for:

- Monitoring the integrity of financial, clinical and other information
- Ensuring that financial and clinical quality controls and systems of risk management are robust
- Determining appropriate levels of remuneration of executive directors
- Playing a supporting role in appointing and, where necessary, removing Executive Directors, and in succession planning

2.2 Trust Chairman

The Trust Chairman provides leadership for the Board of Directors and the Council of Governors and ensures their effectiveness in all aspects of their role and agenda. Key responsibilities include:

- Ensuring the provision of accurate, timely and clear information to Directors and Governors
- Facilitating the effective contribution of Non-Executive Directors, Executive Directors and Governors and ensuring constructive relations between them
- Ensuring that the Board establishes clear objectives for the delivery of agreed plans and meeting the Trust's terms of authorisation and regularly reviews performance against these objectives

A statement on the division of responsibilities between the Trust Chairman and the Chief Executive, as agreed by the Board of Directors, is attached as Appendix D to this document.

2.3 Deputy Chairman

The Deputy Chairman is appointed from amongst the Trust's Non-Executive Directors by the Council of Governors. Where the Trust Chairman has died or has ceased to hold office, or where he or she is unable to perform his or her duties as Chairman owing to illness, conflict of interest or any other cause, the Deputy Chairman will:

- Preside at meetings of the Board of Directors and the Council of Governors

- Exercise all the authorities vested in the Trust Chairman by the Standing Orders of those bodies, including the right to a casting vote where necessary.

2.4 Senior Independent Director

The Senior Independent Director is to be appointed from amongst the Trust's independent Non-Executive Directors by the Board of Directors, in consultation with the Council of Governors. In addition to his or her responsibilities as a Non-Executive Director, the Senior Independent Director will:

- Lead the Non-Executive Directors in the evaluation of the Trust Chairman's performance as part of a process agreed with the Council of Governors
- Convene a meeting of the Non-Executive Directors, without the Trust Chairman, at least annually and on such other occasions as are deemed appropriate
- Be available to Members and Governors if they have concerns which contact through the normal channels of Trust Chairman, Chief Executive or Deputy Chief Executive/Chief Finance Officer has failed to resolve or for which such contact is inappropriate
- Maintain sufficient contact with, and attend sufficient meetings of, the Governors to listen to their views in order to help develop a balanced understanding of their issues and concerns.

Executive Roles

2.5 Chief Executive and Accounting Officer

The Chief Executive will manage the Trust in accordance with the values, objectives, policies, and specific decisions of the Board of Directors and ensure that all activities are directed towards their achievement. Key responsibilities include:

- Evaluating present and future opportunities, threats and risks in the external environment and current and future strengths, weaknesses, and risks to the Trust
- Producing the annual business plan and ensuring that it is geared to achieving the Trust's vision and strategy
- Managing Executive Directors and Senior Managers and developing effective working relationships and communications with other staff
- Ensuring that the Board of Directors is given the advice and information it needs to perform its duties and that the business of the Board is properly conducted
- Establishing systems of control and limits of delegation and providing the Board of Directors with regular assurance on their effectiveness
- Establishing strong systems for performance management, focused on continuous improvement in the delivery of services, and maintaining close relationships with relevant regulatory bodies
- Promoting effective joint working with external stakeholders and other key partners
- Strategic leadership for the Trust’s Digital infrastructure and services
- Ensuring the Trust has a robust Digital strategy in place to support the objectives of the organisation.

In his or her capacity as the Accounting Officer, the Chief Executive has personal responsibility for:

- The overall organisation, management, and staff of the Trust and for its procedures in financial and other matters ensuring there is a high standard of financial management in the Trust as a whole,
- The Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation
- Financial considerations are fully taken into account in decisions by the Trust
- The propriety and regularity of public finances for which he or she is answerable, the keeping of proper accounts, prudent and economical administration in line with the principles set out in Managing public money, the avoidance of waste and extravagance and the efficient and effective use of the Trust's resources in their charge
- Ensuring that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity, prudent and economical administration, efficiency and effectiveness
- If necessary, informing NHSi of any proposed course of action which might infringe the requirements of financial propriety and regularity, prudent and economical administration, efficiency and effectiveness
- Appearing before the Public Accounts Committee as required to give evidence on any report by the Comptroller & Auditor General on the economy, efficiency and effectiveness with which the Trust has used its resources

A statement on the division of responsibilities between the Trust Chairman and the Chief Executive, as agreed by the Board of Directors, is attached as Appendix A to this document.

2.6 Chief Finance and Planning Officer/Deputy Chief Executive

The Chief Finance and Planning Officer is accountable to the Chief Executive, the Board of Directors and the Council of Governors on all aspects of financial strategy, financial management and estates. Key responsibilities include:

- Providing strategic leadership for finance across the organisation and helping to strengthen its contribution to the Trust’s activities
- Providing comprehensive financial services to the Trust including the production of budget proposals, the development of effective budgetary control systems, the provision of accurate and timely information and advice and the compilation of monthly management returns and year-end accounts for statutory and regulatory purposes
- Managing financial agreements between the Trust and its stakeholders effectively in order to ensure appropriate recovery of costs
- Overseeing all financial systems and internal controls, including the development and modification of accounting systems when required
- Managing relationships with the Trust's internal and external auditors
- Providing strategic leadership for the development of the Trust’s Estate, ensuring its contribution to the Trust’s activities.
- Ensure that there are robust systems in place to provide the Board with high quality data to support performance management and decision making

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

- Overseeing the Trust's operational and financial planning
- Overseeing the Trust's Estates and Facilities along with the implementation of the Estates Strategy
- Deputising for the Chief Executive in his / her absence
- Board responsibility for Health and Safety

2.7 Chief Medical Officer

The Chief Medical Officer is accountable to the Chief Executive, the Board of Directors and the Council of Governors on medical and clinical matters, including compliance with national policy, and will provide professional leadership to all medical staff within the Trust. Key responsibilities, carried out in collaboration with other executive directors, include:

- Developing a culture within the Trust which promotes clinical governance and ensures its effectiveness
- In collaboration with the Chief Nurse and Patient Safety Officer, ensure that the quality of patient care is integral to all the Trust's activities
- Planning and implementing the clinical services strategy for the Trust
- Leading the Trust's relationships with bodies representing general practitioners and with the medical schools associated with the Trust
- Leading on medical workforce planning and developing plans for the Trust and the wider health economy
- Taking the lead on research on behalf of the Trust and developing relationships with universities and the wider research community

2.8 Chief Nurse and Patient Safety Officer

The Chief Nurse and Patient Safety Officer is accountable to the Chief Executive, the Board of Directors and the Council of Governors on nursing matters, including compliance with national policy, and will provide professional leadership to all nursing staff and Allied Health Professionals within the Trust. Key responsibilities include:

- Developing and implementing nursing policies that achieve the Trust's strategic direction
- Fostering a culture that values continuing professional development and strives for excellence in the delivery of patient care
- In collaboration with the Chief Medical Officer, developing the clinical governance culture of the Trust and monitoring its effectiveness
- In collaboration with the Chief Medical Officer, ensure that the quality of patient care is integral to all the Trust's activities
- Board oversight of patient and public involvement in the Trust and managing the Patient Advice and Liaison Service (PALS) and complaints service
- Caldicott Guardian
- Director of Infection Prevention and Control (DIPC)

- Risk Management and Governance
- Safeguarding Executive Lead

2.9 Chief Operating Officer (from July 2022)

The Chief Operating Officer is accountable to the Chief Executive, the Board of Directors and the Council of Governors regarding the delivery of operational performance within the Trust. Key responsibilities include:

- Ensuring the delivery of operational activity in accordance with agreements between the Trust and its stakeholders and national targets
- Provide executive leadership to the units for service delivery.
- Board level accountability for the delivery for operational performance standards and targets and achievement against local and national standards.
- Corporate responsibility as a member of the Trust Board for overall formulation of policy and strategic direction of the Trust.
- Board level accountability for the delivery and management of partnerships and service/business development.
- Developing and implementing operational policies to achieve the Trust's strategic direction.
- Fostering a culture that values continuing professional development and strives for excellence in service delivery and patient experience.
- Meet agreed targets and objectives, and deliver within defined costs, timescales and resources.
- EPRR Executive Lead

2.10 Chief People Officer

The Chief People Officer is accountable to the Chief Executive, the Board of Directors and the Council of Governors on human resource matters. Key responsibilities include:

- Ensuring effective matching of workforce to activity
- Facilitating continuous professional development and learning
- Developing the leadership capacity and capability

2.11 Chief Performance, Improvement and Organisational Development Officer (until June 2022)

The Director of Improvement, Organisational Development and Performance is accountable to the Chief Executive, the Board of Directors and the Council of Governors on organisational development matters and also the ongoing management of performance and the Trust's improvement agenda. Key responsibilities include:

- Ensuring the Trust has adequate oversight of its performance
- Strategic leadership for the Trust's service improvement framework and agenda
- Ensuring the development and implementation of the Organisational Development Strategy
- Design and ensure the effective operation of the Trust's process of continuous improvement

- Including the portfolio of the Chief Operating Officer

Board and Council Support

2.12 Foundation Trust Secretary/Director of Governance

All Directors and Governors have access to the advice and services of the Trust Secretary/Director of Governance, who has the following primary responsibilities:

- Ensuring good information flows within the Board of Directors, the Council of Governors and their Committees and between Senior Management, Non-Executive Directors and Governors
- Ensuring that the procedures and Standing Orders of the Board of Directors and the Council of Governors are complied with
- Advising the Board of Directors and the Council of Governors (through the Chairman) on all governance matters
- Supporting the induction of new Directors and Governors and assisting with their professional development
- Leading patient and public involvement in the Trust and managing the Patient Advice and Liaison Service (PALS) and complaints service

Note: The Director of Digital is the Trust Senior Information Risk Owner (SIRO) ensuring that risks to data security are recognised and managed

3. RESERVATION AND DELEGATION OF RESPONSIBILITIES

3.1 Matters Reserved to the Board

As recommended by the NHS Foundation Trust Code of Governance, the Board of Directors has expressly reserved certain key matters for its collective consideration and decision. The schedule of matters reserved to the Board of Directors is set out in Appendix E to this document.

3.2 Delegation to Officers

Matters which the Board of Directors considers suitable for delegation to individual directors and officers of the Trust are contained in the Scheme of Delegation and Standing Financial Instructions (SFIs), which are regularly reviewed and revised by the Board and the Audit and Risk Committee.

3.3 Delegation to Committees of the Board

The Board of Directors has established the following Committees, all of which are chaired by Non-Executive Directors, to exercise delegated responsibilities on behalf of the Board:

- Audit and Risk Committee
- Quality and Safety Committee
- IPC Quality Assurance Committee (until further notice)
- Finance, Planning and Digital Committee
- People Committee
- Nomination and Remuneration Committee
- Executive Directors Appointments Committee

The membership and key responsibilities of these Committees of the Board are summarised in Appendix F to this document.

4. THE COUNCIL OF GOVERNORS

4.1 The Role of the Council of Governors

The general duties of the Council of Governors are:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

- To represent the interests of the members of the trust as a whole and the interests of the public. (Health & Social Care Act 2012)

The specific statutory powers and duties of the Council of Governors are to:

- Appoint and, if appropriate, remove the Trust Chairman
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors
- Approve the appointment of the Chief Executive
- Appoint and, if appropriate, remove the External Auditor
- Receive the Trust's annual accounts, any report of the External Auditor on them and the annual report
- Approve "significant transactions", including plans to increase the proportion of income received from activities other than the health service in England by 5%

In addition, in preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

In exercising its powers and duties, governors are required by the NHS Foundation Trust Code of Governance to:

- Represent the interests of Trust members and Partnership Organisations in the governance of the Trust
- Act in the best interests of the Trust and adhere to its values and code of conduct
- Hold the Board of Directors collectively to account for the Trust's performance and ensure that the Board of Directors acts in such a way that the Trust does not breach the terms of its Authorisation
- Feedback information about the Trust, its vision and its performance to the constituencies and stakeholder organisations that elected or appointed them.

4.2 The Composition of the Council of Governors

In accordance with the Trust's Constitution, the Council of Governors will consist of 15 governors, to be composed as follows:

- Nine Governors elected by the Public Constituency
- Three Governors elected by the Staff Constituency
- Three Governors appointed by Partnership Organisations, including one Governor appointed by Shropshire Council.

4.3 The Operation of the Council of Governors

Meetings of the Council of Governors will be held at least four times a year, one of which will be an AGM.

The Council of Governors is not permitted to delegate any of its powers or responsibilities to any committee or individual Governor, but is able to appoint committees to assist it in the proper performance of its functions.

The Trust's Constitution provides for the appointment by the Council of Governors of an ad hoc Nomination Committee for the purpose of making recommendations to it on each exercise of its powers to appoint and re-appoint the Trust Chairman and other Non-Executive Directors and to remove another Non-Executive Director (including the Trust Chairman).

4.4 The Role of the Lead Governor

The Lead governor has a role to play in facilitating direct communication between NHSi and the Council of Governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chairperson or the Trust Secretary.

The Lead Governor may also facilitate communication between the Chairman and the Governors where the Governors consider this to be the most appropriate approach.

4.5 Interface between the Board of Directors and the Council of Governors

The Chairman is responsible for ensuring that there is effective communication between the Board of Directors and the Council of Governors.

The Board of Directors provides the Governors with their meeting agenda, prior to the meetings and copies of the minutes once approved.

The Board of Directors ensures that the Governors are given the opportunity to comment on the strategic and operational plans.

There is a process in place for the escalation of disputes between the Board of Directors and the Council of Governors. In the first instance the Senior Independent Director would seek to resolve the dispute. If he / she was unable to resolve this, an ad hoc Dispute Resolution Committee would be appointed, comprising an equal number of Governors and Non-Executive Directors. If this committee were to be unsuccessful the Senior Independent Director would refer the dispute to an independent assessor who was agreeable to both parties.

APPENDIX A: Framework for the Performance Evaluation of the Board, its Committees and Directors including the Chairman

APPENDIX A.1: Process for the Annual Appraisal of the Chairman

Prior to the Non-Executive Directors meeting formally, the Senior Independent Director will consult individually with the Chief Executive, Executive and Non-Executive Directors. The Lead Governor will formally meet with the Senior Independent Director and any other Governor may choose to contribute.

All Board members will participate in a confidential *360°* questionnaire regarding the Chairman's performance.

Criteria

The criteria on which the appraisal will be based will include:

- RJAH annual performance
- Achievement of Board's key strategic objectives
- Leadership and effective working and development of the Board and Council of Governors
- Representational role on behalf of RJAH and stakeholder engagement

At the Non-Executive Directors' meeting the inputs from all sources will be considered and a collective assessment agreed.

The Senior Independent Director will then meet with the Chairman and subsequently confirm to the Board and Council that the appraisal has been conducted.

Timing

The appraisal should be conducted following the end of each financial year. This would normally be in May unless otherwise required.

APPENDIX A.2: Process for the Annual Appraisal of Non-Executive Directors

Process

Prior to the Non-Executive Directors (NED) meeting formally, the Chairman will consult individually with the Chief Executive and seek the views of the Council of Governors via the Lead Governor.

All Board members will participate in a confidential *360°* questionnaire regarding Non- Executive Directors performance which will address contribution and understanding of the following areas:

- The NED demonstrates sufficient understanding of the markets within which the RJAH operates
- The NED understands the strategic needs of the organisation and contributes to the development strategy.
- The NED understands and ensures compliance with regulatory, legal and governance requirements and makes relevant contributions to the management of risk
- The NED has effective relationships with other members of the Board
- The NED consistently behaves in a way congruent with the RJAH brand
- The NED dedicates sufficient time to undertake their role effectively
- The contributions of the NED at the Board meetings are consistent, providing a balance of support and challenge to the executive management team
- The NED is committed to the success of the RJAH and demonstrates passion and energy
- The NED's behaviour is helpful to forming and developing trusting relationships
- The NED's contribution to meetings is high quality and value added, demonstrating clear thinking and good judgement
- The NED effectively communicates any concerns they have, listens appropriately and follow's up proactively
- The NED is sufficiently independent and objective
- The NED challenges constructively and probes when appropriate

Overall, the performance of the NED adds value to the Board.

At the Non-Executive Directors' meeting with the Chairman the inputs from all sources will be considered and a collective assessment agreed.

The Chairman will confirm to the Council of Governors that the assessment has been conducted.

Criteria

The criteria on which the assessment will be based will include:

- RJAH annual performance
- Achievement of Board's key strategic objectives
- Contribution to effective working and development of the Board
- Representational role on behalf of RJAH and stakeholder engagement

Timing

The appraisals should be conducted following the end of each financial year. This would normally be in May unless otherwise required.

APPENDIX A.3: Criteria for the Annual Performance Assessment of the Chief Executive, Executive and Directors

1.1 Directors will be set annual objectives which address the following six areas:

- Annual Corporate Objectives
- Corporate Risks
- Supporting Strategies
- Other e.g. legislative
- Standards of Business Conduct & Trust Values
- Personal Development

1.2 A mid-year review will be undertaken to discuss progress and address any barriers to progress which may have arisen.

1.3 An end of year review will be undertaken to determine the level of performance of the Director as follows:

- Concerned
- Satisfactory performance
- Good
- Very good

1.4 The Chief Executive assesses the performance of the Executives.

1.5 The Chairman assesses the performance of the Chief Executive.

1.6 The remuneration committee will consider the recommendations of the Chairman and Chief Executive as part of the annual pay review process.

APPENDIX B: Standards for Board Members

1. Policy Statement

The Robert Jones & Agnes Hunt Orthopedic Hospital NHS Trust (the Trust) expects that all members of the Board of Directors understand and are committed to the practice of good governance and the legal and regulatory frameworks in which the Trust operates, and will apply the standards for members of NHS boards, as set out by the Professional Standards Authority (2012) and conform to the Fit and Proper Persons Requirements as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 5 and Schedule 4.

2. Application

The policy applies to Directors[1] by which is meant executive and Non-Executive, permanent, interim and associate positions, irrespective of their voting rights at all times when directors are carrying out the business of the foundation trust or representing the foundation trust.

3. Responsibilities

All Board members

- Will abide by the Standards at all times when at the service of the NHS.
- Will understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.
- Will understand that they must act in the interests of patients, service users and the community they serve, and that they must uphold the law and be fair and honest in all their dealings.
- Will complete declarations upon appointment and annually thereafter providing their commitment to these standards.
- Will declare any failure to maintain the Standards, including the requirements of the Fit and Proper Persons

Trust Secretary/Director of Governance

Will ensure appropriate declarations are provided on appointment, and annually thereafter as follows.

On Appointment
Standards for Board Members (Appendix 1)
Fit and Proper Persons Declaration (Appendix 2)

- Bankruptcy and Insolvency Register
- Disqualified Directors

Declaration of Confidence
Senior Managers Code of Conduct

Annual Declarations
Standards for Board Members (Appendix 1)
Fit and Proper Persons Declaration (Appendix 2)
Declarations of Interest

3. Monitoring

Directors will be monitored annually to confirm compliance and non compliance will be reported to the appropriate officer.

[1] As per Regulation 5~: Fit and proper persons: directors

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

APPENDIX C: Standards of Business Conduct Policy

1. Policy Statement

1.1. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (the Trust) is committed to achieving the highest possible standards of corporate behaviour and responsibility. As such, the Trust requires all employees to abide by the standards and principles within this policy.

1.2. The Trust has adopted a set of values which should inform all activities within the Trust, including business conduct.

- Caring
- Excellence
- Friendly
- Professional
- Respect

2. Purpose.

2.1 This policy sets out the overall intent and general principles the Trust will apply in relation to business conduct in order to comply with current legislation:

- Fraud Act 2006
- Bribery Act 2010
- Public interest Disclosure Act 1998
- the principles of public life defined by the Committee on Standards on Public Life (originally the Nolan Committee)
- Research Governance Framework for Health and Social Care 2017

2.1. Failure to comply with this policy may lead to disciplinary action, up to and including dismissal and staff may also be liable for personal prosecution.

3. Scope

3.1. This policy applies to all employees, students and trainees, agency staff and secondees.

4. Principles of Public Life -

4.1. In carrying out their functions, it is the responsibility of all staff to be guided by the Seven Principles of Public Life as follows:

Selflessness: Holders of public office should act solely in terms of the public interest: They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

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

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and by example.

4.2. The means by which these principles should be applied in practice are set out within this policy.

5. Roles & Responsibilities

5.1. It is the responsibility of the Board of Directors to develop and sustain a culture of corporate responsibility and good governance

5.2. It is the responsibility of the Foundation Trust Secretary to maintain the Register of Interests and update it annually (appendix 1), and also to maintain a register of hospitality

5.3. The following staff have been identified as 'decision making' staff and will be required to complete the Register of Interests;

- Executive and Non-Executive Directors or equivalent roles which have decision making powers regarding the spending of tax payers money
- Consultants
- Staff at Agenda for Change band 7 and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of the Trust
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions

5.4. It is the responsibility of the Chief People Officer and Trust Secretary to communicate this policy to all new starters through the Trust induction process including providing a summary copy of the entire policy for staff categories identified in paragraph 5.4 above, (appendix 2), and provide guidance and support regarding its application as and when required, including summary information on procurement standards (appendix 3).

5.5. It is the responsibility of all staff to comply with this policy

6. Candour and Openness

6.1. The Trust is committed to supporting a culture of openness and candour, where errors are reported and learnt from.

6.2. All staff have a duty to comply with guidelines and duties of candour and openness as laid down by their professional bodies, external regulators or by statute, see Duty of Candour policy

7. Prevention of Corruption (Bribery Act 2010)

7.1. The Trust has a responsibility to ensure that all Trust staff are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

- bribing, or offering to bribe, another person (section 1);
- requesting, agreeing to receive, or accepting a bribe (section 2);
- bribing, or offering to bribe, a foreign public official (section 6);
- failing to prevent bribery (section 7).

7.2. All Trust staff are required to be aware of the Bribery Act 2010 and should also refer to paragraphs 16 and17 below for further guidance in relation to this.

8. Anti-Fraud measures

8.1. The Trust is committed to preventing fraud and staff are encouraged to report any concerns about potentially fraudulent activity.

8.2. For further information staff should consult the Anti-Fraud, Bribery & Corruption policy or contact the Local Counter Fraud Specialist (contact details are available on the intranet or via the Trust Secretary).

9. Gifts and Hospitality.

9.1. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

9.2. Where gifts or hospitality are given to individuals within the trust, subject to the guidance below regarding value, the overall principle is that they should firstly be refused, or secondly, if they cannot be refused, they should be made available to all staff within the department .

9.3. Gifts

9.3.1. Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined, whatever their value.

9.3.2. Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared

9.3.3. Gifts of cash and vouchers to individuals should always be declined

9.3.4. Staff should not ask for any gifts

9.3.5. Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust and not in a personal capacity. These should be declared by staff

9.3.6. Modest gifts accepted under a value of £50 do not need to be declared

9.3.7. A common sense approach should be applied to the valuing of gifts (using an actual amount if known or an estimate that a reasonable person would make)

9.3.8. Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50

9.3.9. In cases of doubt consult with your line manager and or the Trust Secretary and include on the gift register.

9.3.10 Further information on the information to provide in your declaration can be found in the Managing Conficts of Interest Policy

9.4. **Hospitality**

9.4.1. Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement

9.4.2. Staff should exercise particular caution when hospitality is offered by actual or potential suppliers or contractors.

9.4.3. Under a value of £25 may be accepted and need not be declared

9.4.4. Of a value between £25 and £75 may be accepted but must be declared

9.4.5. Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given

9.4.6. A common sense approach should be applied to the valuing of meals and refreshments

9.4.7. Material work related hospitality, such as the sponsorship of courses, is covered in the Commercial sponsorship section 14.

9.4.8. Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared

9.4.9. Offers which go beyond modest need approval by senior staff and should only be accepted in exceptional circumstances

9.3.4 All hospitality offered, even if refused, should be recorded in the hospitality register which is held by the Trust Secretary. Further information on the information to provide in your declaration can be found in the Managing Conflicts of Interest Policy

9.3.5 When in receipt of hospitality, staff should comply with the Alcohol and Drugs policy, in particular the Trust expects that all employees will not consume / use alcohol during working hours.

10. Declaration of Interest

10.1. There are occasions when an employees' links to another business or organisation could place them in a position where this could cause a conflict of interests. This link could be by the employees' direct involvement or by having a partner or close relative having an involvement. This link could be in the form of employment, unpaid work or by being a director. The type of organisation which could cause conflict would be ones who supplied (or may wish to supply) goods or services or ones which operated in the field of healthcare. These links could cause conflict if the employee was in a position to influence decisions by the Trust concerning them.

10.2 Where any of these circumstances occur the employee should declare this in the "Register of Interests", this is held by the Trust Secretary (see section 11) Having declared an interest, employees must not enter into business with that individual or organisation unless however the Trust can take steps to mitigate any potential conflict.

10.2.1 For example, a Director may be required to leave a board meeting for any agenda item where there was a potential conflict; or employees would not normally be placed in a position where they were responsible for ordering goods or services from an organisation with which they have links, where this was unavoidable for operational reasons additional safeguards would be put in place.

10.2.2 A potential conflict could also arise if an employee held a position of authority in a health related charity or campaigning organisation.

11. Registers.

The Trust maintains two registers which are held by the Foundation Trust Secretary as follows:

11.1. Register of Interests - This details interests held by managers or their close relatives (i.e. spouse or partner, parent, child or sibling and may include other relatives. Commons sense should be applied when deciding if a relative is a close relative).

Applicable staff (see paragraph 5.3) are required to update, or confirm a nil declaration on an annual basis. If the circumstances of staff or their relatives were to change during the year, so as to pose a potential conflict of interests, they should inform the Trust Secretary straight away. New managers will be asked to declare their interest on appointment.

11.2 Hospitality Register - This holds ad hoc declarations of gifts or hospitality which should be made as and when they occur together with indicative values.

12. Secondary and Other Employment.

12.1 Employees of the Trust must not engage in any secondary or other employment (including self-employment) which may conflict with their work or be potentially detrimental to the Trust. Before taking up any other employment, employees must put their request in writing to their Unit Manager, or Director.

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

12.2 Secondary employment whilst absent from work due to sickness is not acceptable and failure to report secondary employment whilst absent due to sickness may be considered an offence under the Fraud Act.

12.1. Permission to engage in secondary or other employment will normally be granted if the following conditions are satisfied.

12.2. Working hours on other employment are conducted entirely outside of Trust contracted hours of work.

12.3. The employment is not in direct competition with the Trust's business and does not affect the business by, for example, loss of business or the passing on of confidential information.

12.4. The employee provides the Trust with the name and address of the other employer or organisation, an outline of the job role they wish to undertake and the hours they intend to work.

12.5. The work in not inherently hazardous or likely to put at risk the employee, other employees or patients. Staff are reminded that occupational sick pay is not normally payable for an absence caused by injuries whilst working for another employer and may affect their rights to the NHS benefits such as Superannuation Scheme,

12.6. The requirements of the working time regulations are met (including appropriate rest prior to commencement of work for the Trust).

12.7. Work excluded from this policy would generally include unpaid voluntary activities and private practice as specified in Consultant Contract (see below).

12.8. Further guidance can be obtained in the Managing Conflicts of Interest Policy

13. Medical Staff.

13.1. Consultants and Staff and Associate Specialist who are employed under the terms of the new Contract may undertake private practice in accordance with the terms of that contract.

13.2. Staff and Associate Specialist who are employed under the terms of the old contract and associate specialists should refer to the guidance contained in "A guide to the management of Private practice in the NHS" (PM 979)11.

13.3. If a member of medical staff refers a patient to a nursing home in which he/she has an interest, they should declare that interest to the patient.

13.4. Medical staff cannot work for another organisation without the prior agreement of the Trust; following agreement, any such secondary employment should be declared in the register of interests.

13.5. Further guidance can be obtained in the Managing Conflicts of Interest Policy

14. Commercial Sponsorship.

14.1. Research Funding - Employees undertaking research projects must declare any financial interests or potential conflict of interest that may arise from the research activity in accordance with the Research Governance Framework 2005.

14.2. Posts - The sponsorship of any post by an outside organisation must have the prior approval of the Chief Executive and be included in the declaration of interests.

14.3. Courses and Conferences - Sponsorship for Trust events such as; conferences, training, publications, team meetings and social events must be approved in advance by a Divisional Manager or Director.

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

14.4. Sponsorship for attendance by non-medical staff on a course must be approved in advance by a Unit Manager or Director and attendance at courses abroad must have prior approval from the Chief of People. The Trust study leave form allows for this approval process to be followed.

14.5. Sponsorship for attendance by medical staff on a course must be approved in advance by the Chief Medical Officer and attendance at courses abroad must have prior approval from the Chief People Officer. The Trust study leave form allows for this approval process to be followed.

14.6. Where the sponsorship includes the costs of travel/accommodation the recipient must declare that they are aware of their obligations under this policy and will act in such a manner as not to confer a commercial advantage onto the sponsoring company.

14.7. All sponsorship of courses and conferences must be declared on the hospitality register together with estimated value.

14.8. Further guidance can be obtained in the Managing Conflicts of Interest Policy

15. Supplies and Contractors

15.1. All Trust staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Purchasing and Supply (Appendix 3).

15.2. All Trust staff must treat prospective contractors or suppliers of services to the Trust equally and in a non-discriminatory way and act in a transparent manner.

15.3. Trust staff involved in the awarding of contracts and tender processes must take no part in a selection process if a personal interest or conflict of interest is known. Such an interest must be declared to the Trust Secretary as soon as it becomes apparent. Trust staff should not at any time seek to give undue advantage to any private business or other interests in the course of their duties.

15.4. The Trust has duties under European and UK procurement law and staff must comply with standing financial instructions (SFIs) in relation to all contract opportunities with the Trust.

15.5. Trust staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to officers' and members' benefit schemes offered by the NHS or trade unions.

15.6. Trust staff invited to visit organisations to inspect equipment for the purpose of advising on its purchase will be reimbursed for their travelling expenses in accordance with the travel expenses policy laid down by the Trust. Such expenses should not be claimed from other organisations to avoid compromising the purchasing decisions of the Trust.

15.7. Further guidance can be obtained in the Managing Conflicts of Interest Policy

16. Use of Trust Property.

16.1. Trust property or facilities should not be used for personal activity or benefit. This includes: -

16.1.1. Use of telephone (though limited use in extenuating circumstance is permissible).

16.1.2. Use of email. The "RJAH" email address should not appear in any literature or correspondence not directly related to Trust Business. This does not prevent employees from using e-mail to conduct related business in another capacity e.g. correspondence from staff side representatives acting in a trade union capacity or correspondence related to an appropriate professional organisation or membership.

16.1.3. Photocopying or printing.

16.1.4. Trust Postal System.

16.2. Trust premises, facilities or equipment should only be used for private business with prior approval, and arrangements must be made for the Trust to be reimbursed for the cost of providing these facilities.

16.3. Photographs and graphics on the Trust website are also Trust property and should not be reproduced without permission.

16.4. In the case of any doubt, an employee should speak to their line manager.

17. Use of Trust Identity.

When employees are engaged in activities outside of their formal employment, they should not use the Trust name, logo, email address or any other reference to the Trust to promote those activities without the prior approval of the Chief Executive.

18. Political/ Campaigning activities.

18.1. Any political or campaigning activity should not identify an individual as an employee of the Trust, beyond any statutory declarations required.

19. Links to Other Policies.

19.1. Staff should familiarise themselves with the relevant Trust policies and procedures which are held on the Trust intranet. In particular it is important that staff are familiar with the Standing Financial Instructions, and Scheme of delegation.

19.2. If at any stage they have any queries concerning these policies they should refer the matter to their line manager.

- Openness (Whistle blowing)
- Research Misconduct and Fraud Policy
- Alcohol and Drugs Abuse policy
- Anti-Fraud, Bribery and Corruption Policy
- Standing Financial Instructions
- Email, Intranet and Social Media Use Policy
- Duty of Candour Policy
- Managing Conflicts of Interest Policy

20. Communication.

20.1. A copy of the policy is available on the Trust intranet site, and copies are available in different formats on request, from the human resources department.

20.2. Newly appointed staff will be informed of the policy and procedure as part of the corporate induction process.

21. Monitoring

The declaration of Interests and the Hospitality registers are reviewed on a quarterly basis by the Audit and Risk Committee.

Managers are responsible for ensuring that their staff complies with good standards of Business Conduct.

APPENDIX D: DIVISION OF RESPONSIBILITIES BETWEEN THE TRUST CHAIRMAN AND THE CHIEF EXECUTIVE

The following division of responsibilities between the Chairman and the Chief Executive has been agreed by the Board of Directors.

Key Responsibilities

Chairman:

- Managing the business of the Board of Directors and the Council of Governors so as to ensure their effective performance
- Promoting the highest levels of integrity, probity and corporate governance and ensuring that these standards are embodied in the conduct of the Board of Directors and the Council of Governors
- Ensuring that the Board as a whole is able to play a full and constructive role in the development of the Trust's strategy and business aims
- Ensuring that the Board pays sufficient attention to the development of the Trust's business and the protection of its reputation

Chief Executive:

- Executive management of the Trust's business consistent with the strategic and business objectives agreed by the Board as a whole
- Ensuring that the affairs of the Trust are carried out in accordance with the highest standards of integrity, probity and corporate governance and that these standards are embedded at all levels
- Ensuring that the strategy and business aims set by the Board are aligned with statutory, regulatory and contractual requirements
- Formulating annual objectives, budgets and operational plans to deliver the strategy and business objectives set by the Board

Detailed Responsibilities

a) Board of Directors

Chairman:

- Setting the Board's agenda and managing the conduct of its business
- Ensuring that all Directors receive accurate, timely and clear information on performance, the issues, challenges and opportunities facing the Trust and matters which are reserved to the Board for decision
- Facilitating the effective contribution of all Directors and ensuring constructive relationships between Executive Directors and Non-Executive Directors
- Ensuring that Non-Executive Directors receive full, formal and tailored induction and participate in the Board development programme
- Ensuring that the Board undertakes and acts on formal and rigorous

Chief Executive:

- Leading, motivating and directing the other Executive Directors and Senior Managers
- Ensuring that the Board is given the advice and information it needs to carry out its duties effectively and (in consultation with the Chairman) that the business of the Board is properly conducted
- Promoting the effective contribution of Executive Directors and Senior Managers to the proceedings of the Board and its Committees
- Contributing to induction programmes for new Directors and ensuring that management time is made available for this purpose
- Providing input to the evaluation of the performance of the Board and its Committees

evaluation of its own performance and that of its Committees

- Appraising the performance of Non-Executive Directors and acting on the outcomes of performance evaluation where necessary
- Appraising the performance of Executive Directors in their corporate and functional roles.

b) Council of Governors

Chairman:

- Leading the Council of Governors and setting its agendas
- Ensuring that governors receive accurate, timely and clear information that is appropriate for their duties
- Ensuring that Governors receive full, formal and tailored induction and are enabled to update their skills, knowledge and familiarity with the Trust
- Leading the Council of Governors in periodically assessing its collective performance
- Ensuring constructive relationships between the Board of Directors and the Council of Governors and that the views of governors and members are communicated to the Board

Chief Executive:

- Facilitating the work of the Council of Governors and its Committees, ensuring that they have sufficient resources and are able to meet sufficiently regularly to discharge their duties
- Ensuring that the Council of Governors is given the advice and information it needs to carry out its duties effectively and (in consultation with the Chairman) that the business of the Council of Governors is properly conducted
- Contributing to induction and development programmes for Governors and ensuring that management time is available for this purpose.
- Providing input to the assessment of the performance of the Council of Governors
- Ensuring that the views of governors and members are taken into account in the conduct of the Trust's business and the development of its strategic aims

c) Stakeholders

Chairman

- Being a visible and accessible figurehead for the Trust's staff and the leading champion of its vision, values and objectives
- Taking the lead at ceremonial events and other corporate formalities
- Promoting mutual understanding with external partners and stakeholder bodies through dialogue with their Non-Executive or elected leads
- Supporting the Chief Executive in contacts with MPs and other political figures
- Taking the lead at public meetings and events and with voluntary

Chief Executive

- Performing the role of senior line manager and employer
- Taking the lead on employee relations and internal communications on operational matters
- Fostering good working relationships with external partners and stakeholders through the conduct of business with their Executive Officer Leads
- Taking the lead on contact with MPs and other political figures, with the participation of the Chairman as appropriate
- Taking the lead on communications with the media,

groups, as the public face of the Trust, with the participation of the Chief Executive as appropriate
- Acting as a confidential sounding board for the Chief Executive on key issues and decisions and providing advice, support or challenge as appropriate

with the participation of the Chairman as appropriate

- Informing and consulting the Chairman on key issues and decisions and ensuring that the Chairman is aware of emerging opportunities and threats to the achievement of objectives

d) Accountability

Chairman

- Accountable to the Board of Directors and the Council of Governors for the effective conduct of their activities

Chief Executive

- Accountable to the Chairman (acting on behalf of the Board) and to the Board direct

e) Reporting Lines

Chairman

- The Chairman is not responsible for the executive management of the Trust. Other than the Chief Executive and (in respect of matters relating directly to the Board of Directors or the Council of Governors) the Trust Secretary, no Executive Director, senior manager or other member of staff reports to the Chairman other than through the Board

Chief Executive

- The Chief Executive is responsible for all executive management matters relating to the Trust. All members of executive management report, directly or indirectly, to the Chief Executive.

The appointment and removal of the Trust Secretary is a matter for the Chairman and the Chief Executive jointly

APPENDIX E: SCHEDULE OF MATTERS RESERVED TO THE BOARD OF DIRECTORS

The matters set out in the schedule below are specifically reserved for the collective decision of the Board of Directors.

1.	**STRATEGY AND MANAGEMENT**
1.1	Responsibility for the overall management of the Trust
1.2	Approval of the Trust's long-term objectives and business strategy
1.3	Approval of the annual operating and capital expenditure budgets and any material changes to them
1.4	Oversight of the Trust's operations ensuring: • competent and prudent management • sound planning • an adequate system of internal control • adequate accounting and other records • compliance with its licence, constitution, mandatory guidance issued by the independent regulator, relevant statutory requirements, and contractual obligations • the quality and safety of healthcare services, education, training, and research delivered by the Trust • the application of the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies
1.5	Review of performance in the light of the Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken
1.6	Extension of the Trust's activities into new business areas
1.7	Any decision to cease to operate all or a material part of the Trust's business
1.8	Any decision to undertake transactions which have been designated as “Significant transactions”,* subject to approval by the Council of Governors
1.9	Any decision to increase by 5% or more the proportion of its total income attributable to activities other than the provision of goods and services for the purposes of health service , subject to approval by the Council of Governors
1.10	Ratify decisions made under emergency powers
2.	**CORPORATE STRUCTURE AND STATUS**
2.1	Major changes to the Trust's corporate structure
2.2	Major changes to the Trust's management and control structure
2.3	Any changes to the Trust's status as an NHS Foundation Trust
2.4	Any proposal to establish a subsidiary company, joint venture or other corporate vehicle for the purpose of carrying out any current or proposed activity of the Trust
2.5	Any proposal involving a merger of the Trust with or takeover of the Trust by another organisation
2.6	Any acquisition or disposal of land
2.7	Any application to a planning authority for planning permission
2.8	Any proposal involving the Trust operating in another organisation (whether within the NHS

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	or not) in the provision of services
2.9	Any use of the RJAH name or brand by another organisation for any purpose
3.	**FINANCIAL REPORTING AND CONTROLS**
3.1	Approval of the quarterly financial report to the Independent Regulator
3.2	Approval of the annual report and accounts, including the corporate governance statement and the remuneration report
3.3	Approval of any significant changes in accounting policies or practices
3.4	Approval of treasury policies, including foreign currency exposure and the use of financial derivatives
3.5	Receive Annual Audit Letter
4.	**INTERNAL CONTROLS**
4.1	Ensuring the maintenance of a sound system of internal control and risk management including: • receiving reports on, and reviewing the effectiveness of, the Trust's risk and control processes to support its strategy and objectives • undertaking an annual assessment of these processes • approving an appropriate statement for inclusion in the annual report • Approving Standing Financial Instructions
5.	**CONTRACTS**
5.1	Major capital projects and Business Cases
5.2	Contracts which are material, strategically or by reason of size, or length of commitment entered into by the Trust in the ordinary course of business Contracts, other than NHS, with a value per year in excess of £250k
5.3	Contracts entered into by the Trust which are not in the ordinary course of its business
6.	**COMMUNICATION**
6.1	Approval of formal submissions to the Department of Health, the Independent Regulator, the Care Quality Commission and other relevant NHS bodies concerning the Trust's compliance with applicable targets and standards
7.	**BOARD MEMBERSHIP AND OTHER APPOINTMENTS**
7.1	Nomination of a Deputy Chairman for formal appointment by the Council of Governors
7.2	Appointment of the Senior Independent Director in consultation with the Council of Governors
7.3	Establishment, Membership and chairmanship of Board committees
7.4	Nomination of Board representatives to any joint committee of the Board of Directors and the Council of Governors that may be established from time to time for any purpose
7.5	Appointments to the boards of any subsidiary company, joint venture or other corporate vehicle established by the Trust for the purpose of carrying out any current or proposed activity
8.	**DELEGATION OF AUTHORITY**
8.1	Approval of the statement on the division of responsibilities between the Chairman and the Chief Executive, which should be in writing
8.2	Approval and review of the terms of reference of Board committees

8.3	Receiving Chair Assurance reports from Board committees on their activities
9.	**CORPORATE GOVERNANCE MATTERS**
9.1	Approval of the Trust Constitution, in conjunction with the Council of Governors
9.2	Undertaking at least annually a formal and rigorous review of the Board's own performance and that of its committees and individual directors
9.3	Determining the independence of Non-Executive Directors
9.4	Review of the Trust's overall corporate governance arrangements
9.5	Receiving reports on the views of the Trust's members, patients, carers and members of the public
10.	**POLICIES**
10.1	Approval and revision of Trust-wide Policy Management guidance
10.2	Approval of key policies of general application throughout the Trust, including: • codes of conduct • health and safety policy • whistle blowing • business continuity • risk management
11.	**OTHER**
11.1	Approval of the appointment of the Trust's principal professional advisers, with the exception of the external auditor
11.2	Decisions relating to overall levels of insurance for the Trust, including proposals for the purchase of commercial directors' and officers' liability insurance and indemnification of directors
11.3	Approve the arrangements relating to the discharge of the Trusts responsibilities as a corporate trustee for funds held on trust
11.4	This schedule of matters reserved for board decisions

Matters which the Board considers suitable for delegation are contained in the terms of reference of its committees and in the scheme of delegation.

In addition, the Board will receive reports and recommendations from time to time on any matter which it considers significant to the Trust.

*A Significant Transaction means a transaction which relates to;

- For UK Healthcare: investments, divestments or other transactions comprising > 25% of the assets, income or capital of the NHS Foundation Trust.
- For non-healthcare related and/or international; investments, divestments or other transactions comprising > 25% of the assets, income or capital of the NHS Trust
- or if a trust is in significant breach, any investment/divestment comprising >10% of the assets, income or capital of the trust

APPENDIX F: MEMBERSHIP AND KEY RESPONSIBILITIES OF BOARD COMMITTEES

Committees of the Board							
	Audit and Risk	**People**	**Quality and Safety**	**IPC Quality Assurance**	**Finance, Planning and Digital**	**Remuneration / Appointment (Exec)**	**Remuneration / Appointment (Non-Exec)**
Terms of Reference Requirement	4 NEDS 0 Execs	4 NEDS 4 Execs	4 NEDS 4 Execs	4 NEDS 3 Execs	2 NEDS 3 Execs	Chairman, CEO & 5 NEDS	Chairman, Senior Director & 4 Governors
Frequency of meetings	Quarterly *4 per year*	Monthly *Except Aug & Dec*	Monthly *Except Aug & Dec*	Monthly *Until further notice*	Monthly *Except Aug & Dec*	As required	As required
Quorum	2 NEDS 0 Execs	1 NED 2 Execs	1 NED 2 Execs	1 NED 2 Execs	1 NED 2 Execs	*CEO role* Chair & 3 NEDS *Exec Role* Chair, CEO, 2 NEDS	*Chairman* Senior Director & 4 Governors *NED role* Chairman & 4 Governors
Non-Executive Director / Associate Non-Executive Director Membership (Attendance is required and makes up quorum, * denotes an open invitation)							
Harry Turner, Chairman	*	*	*	*	*	✓	✓ (NED role)
Paul Kingston, Non-Executive Director	✓	✓	✓	✓		✓	✓ (Chair role)
Chris Beacock, Non-Executive Director	✓	✓	✓	✓		✓	✓
Sarfraz Nawaz, Non-Executive Director	✓	✓			✓	✓	✓
Martin Newsholme, Non-Executive Director	✓		✓	✓	✓	✓	✓
Penny Venables, Non-Executive Director		✓	✓	✓		✓	✓
David Gilburt, Associate Non-Executive Director		✓			✓	✓	✓
John Pepper (July 22), Associate Non-Executive Director			✓	✓	✓	✓	✓
Executive Membership (Attendance is required and makes up quorum, * denotes an open invitation)							
Chief Executive Officer	*	*	✓	✓	*	✓ (Exec role)	
Chief Finance and Planning Officer	✓	*	*	*	✓		
Chief Nurse and Patient Safety Officer	✓	✓	✓	✓	*		
Chief Medical Officer	*	✓	✓	✓	*		
Chief Performance, Improvement and OD Officer (until June 22)	*	✓	*	*	✓		
Chief Operating Officer (from July 22)	*	*	✓	*	✓		
Chief People Officer	*	✓	*	*	*		
Governors Membership (Attendance is required and makes up quorum, * denotes an open invitation)							
Lead/Public/Staff or Appointed Governor							✓
In Attendance (Attendance is required but does not make up quorum)							
Trust Secretary/ Director of Governance	✓	✓	✓	✓	✓		✓
Director of Digital	*	*	*	*	✓		

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Terms of Reference for the Committees:

Audit and Risk Committee - F1
Quality & Safety Committee – F2
Finance, Planning and Digital Committee – F3
People Committee – F4
Executive Appointments Committee – F5
Executive Remuneration Committee – F6
Non-Executive Appointments Committee – F7
Non-Executive Remuneration Committee – F8

APPENDIX F1: Audit and Risk Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of no less than three members. At least one of the members should have recent relevant financial experience. A quorum shall be two members. The Board will appoint a Committee Chair and Deputy Chair from the Committee members. The Chairman of the Trust Board shall not be a member of the Committee.

3. Attendance

The Chief Finance and Planning Officer, Trust Secretary/Director of Governance and Head of Financial Accounting, as well as appropriate Internal and External audit representatives will be expected to attend each Audit Committee meeting.

The Chief Medical Officer, Chief Nurse and Patient Safety Officer, and Chief Performance, Improvement and OD Officer will attend as required.

At least once a year the Committee will meet privately with the Internal and External Auditors.

The counter fraud specialist or representative will attend a minimum of two committee meetings a year.

The Chief Executive Officer and other Senior Leaders may be invited to attend, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that director.

The Chief Executive Officer may be invited to attend the meeting at which the draft Annual Governance Statement is discussed with the Audit and Risk Committee and the process for assurance which supports it.

In relation to Part one of the meeting (Risk Management section) the following attendance is required:

A medical representative is required to attend each meeting.

The Head of Clinical Governance will be expected to attend each meeting.

The Managing Directors will ensure unit representation at each meeting and will attend, where possible with the Unit Clinical Chair, Assistant Chief Nurse/Professions and Clinical Governance Lead

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

The Director of Digital, Chief Pharmacist, Operational Director of Finance, Head of People Services and Director of Estates and Facilities will have an open invitation and will be required to attend (by invitation) for discussion regards their department.

The Chair of the Board is not a member of the Audit and Risk Committee and will not attend unless invited by the Chair of the Audit and Risk Committee to attend certain meetings or for specific agenda items either to form a view and understanding of the Committees operations or to provide assurances and explanation to the Committee on certain issues.

The Chief Finance and Planning Officer shall agree the agenda with the Chair of the Audit and Risk Committee and other attendees. The Assistant Trust Secretary will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Access

The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

5. Frequency

The Committee will meet at least four times per year, including at least one meeting a year with both the internal and external auditors but without the members from the Board. The external auditors or internal auditors may request a meeting if they consider that one is necessary.

6. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee is authorised by the Board of Directors to make executive decisions regarding the management of risk. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

7. Reporting

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting, this will be no later than the Board meeting in the following month. A Chairs Assurance Report of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted to the private session of the Board. This is in line with the committee reporting process agreed by the Board.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance

arrangements and the appropriateness of the self-assessment against the Care Quality Commission (CQC) regulations.

The Committee will undertake an annual self-assessment, which will be presented to the Trust Board, along with the Annual Report of the Committee's activities.

8. The Duties of the Committee can be categorised as:

Governance and Internal Control

The Audit and Risk Committee reviews the establishment and maintenance of an effective system of internal control across the Trust. The Audit and Risk Committee provides an oversight of the activities of internal audit, external audit, the local counter fraud service and the assurance on internal control, including compliance with the law and regulations governing the Trust's activities.

The Audit and Risk Committee oversee the annual audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal controls with respect to risk management in place. An annual Head of Internal Audit Report is presented to the Audit and Risk Committee.

In particular, the Committee will review the adequacy of:

All control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission (CQC) regulations), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

The underlying assurance processes that indicate the degree of the achievement of corporate objectives and the appropriateness of the above disclosure statements.

The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.

The policies and procedures for all work related to fraud and corruption as required by NHS Protect and best practice.

The policies and procedures promoting an anti-bribery and corruption culture. This will include the "Whistle blowing" and Standards of Business Conduct policies and the Declaration of Interests and Hospitality registers

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Audit and Risk Committee will have oversight of the effectiveness of the Governance of Board Committees.

Information Governance

The Audit and Risk Committee are responsible for maintaining an oversight of Information Governance principally by monitoring the progress against the Information Governance toolkit including data security and the protection toolkit.

The Audit and Risk Committee has a specific role with regard to data quality to review the process put into place by the Trust to ensure the accuracy of key data. This will be achieved through a regular report on data quality presented by the Information Manager at each meeting and additional reports by exception where required. Members of the committee may request further assurance where necessary.

The Quality & Safety Committee has a specific role to review data governance issues relating to patient information, in particular in investigating any Patient Identifiable Data SI's.

The Audit and Risk Committee has a duty to ensure that these specific matters have been referred to the appropriate committee and dealt with appropriately.

Internal Audit
The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive Officer and Board. This will be achieved by:

Considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

Reviewing and approving the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.

Considering the major findings of internal audit investigations (and management's response), and ensure co-ordination between the Internal and External Auditors.

Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust. Conducting an annual review of the effectiveness of Internal Audit and providing feedback to the Board and the Internal Auditors.

Counter Fraud Service
The Committee will ensure that there is an effective Counter Fraud function that meets NHS Protects standards. It will approve the Counter Fraud Annual plan, receive the Annual report and receive regular progress reports into any special investigations.

External Audit
The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

Considering the appointment of the external audit service, the audit fee and any questions of resignation and dismissal, in accordance with the procedures governing NHS Foundation Trusts as appropriate

Discuss and agree with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.

Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

Review all External Audit reports, and any work carried outside the annual audit plan, together with appropriateness of management responses.

Conduct an annual review of the effectiveness of External Audit and provide feedback to the Board and the External Auditors.

Risk Management

Promote systems which provide assurance and improve the quality of care, safety and experience of patients, carers, staff and visitors to the Trust

Exercise oversight of the systems of governance and risk management and seek assurance that they are fit-for-purpose, adequately resourced and effectively deployed to concentrate on matters of concern

Oversee the effective management of risks as appropriate to the purpose of the committee

Seek assurances that the Trust complies with its own policies and all relevant external regulations and standards of governance and risk management (CQC framework)

Review of relevant external reports including CQC and ensure action plans are devised and performance managed to address any identified deficiencies in clinical governance

Satisfy itself and the Board that structures, processes and responsibilities for identifying and managing risks to patients, staff and the organisation are adequate

Ensure that standards and procedures relating to risk are embedded throughout the Trust, with mechanisms through the committee for detailed scrutiny of high and significant areas, including consultation with appropriate Trust staff

Provide leadership to ensure risk is identified and managed proactively in accordance with the Board's risk appetite

Champion and promote highly-effective risk management practices and ensure that the risk management process and culture are embedded throughout the organisation

Maximise the delivery of objectives through an effective control system

Keep risk under prudent control at all times and minimise over exposure to risk

Improve the standard of decision making on risk management

To receive and review the BAF bi-monthly and agree additions to the BAF

To raise awareness and understanding of Governance and risk management at all levels and among all staff within the Trust.

Ensure Unit responsibility for effective governance and risk management is in place and adhered to through local Unit meetings and the receipt and review of Unit Risk Registers to monitor the effectiveness of risk mitigation and escalation

To ensure all risks are scored appropriately via the Risk Matrix

Develop an effective reporting mechanism to allow escalation of risk and governance issues from an operational level and to ensure the risk profile of the whole Trust can be consolidated and to ensure that this profile takes into account the level of risk identified through both a proactive process (i.e., risk assessment with assessment with forward planning) and also through reactive processes (i.e. incidents, complaints and claims).

To provide the Board with assurance that effective governance processes are in place across the organisation and that risks are being discussed and appropriate control

The Audit and Risk Committee shall be made aware of the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust.

These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. CQC, NHS Resolutions, NHSi etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

The Audit and Risk Committee shall receive details of Single Tender Waivers as approved by the Chief Executive or delegated Executive Director.

The Audit and Risk Committee shall receive a schedule of losses and compensations and approve appropriate write-offs.

The Audit and Risk Committee shall review the Registers of Declarations of Interest and Gifts and Hospitality.

Management
The Committee shall request and review, as appropriate, reports and positive ssurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The Committee will receive a summary report detailing progress made against their unit risk register and a review of the work of committees with delegated responsibilities for specific areas or risk. Reports are received MSK Unit, Specialist Unit, Clinical Support Unit and Support Service Unit along with a Corporate Report

Policies
The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Framework. These will include:

- Counter Fraud Policy
- Management of Conflicts of Interest Policy

Other Matters
Financial Reporting:

The Audit and Risk Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

Changes in, and compliance with, accounting policies and practices;
Unadjusted mis-statements in the financial statements;
Letters of representation;
Major judgmental areas; and
Significant adjustments resulting from the audit

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Reference Costs
The Committee shall review the process for producing the annual reference costs and confirm that the Trusts return is compliant with the given procedures prior to submission.

APPENDIX F2: Quality and Safety Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality and Safety Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non-Executive Directors
- One Associate Non-Executive Director
- The Board will appoint a committee chairman and deputy chairman from the non-executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman or deputy Chairman
- Chief Executive Officer – invited to attend as required
- Chief Medical Officer
- Chief Nurse and Patient Safety Officer

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee chairman from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to chair meetings in the absence of the chairman.

An open invitation will be extended to the Trusts Chairman.

A quorum will be one Non-Executive members and two Executive members.

3. Attendance

The Trust Secretary/Director of Governance and the, Head of Clinical Governance and Quality will be expected to attend each meeting. The Chair of the Committee may attend at the invitation of the Chair of the Trust.

Senior Managers and Unit Representative will be required to attend the meeting when presenting a paper.

The Chief Nurse and Patient Safety Officer shall agree the agenda with the Chair of the Committee and other attendees. The Assistant Trust Secretary will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Frequency of meetings

The Committee will meet at least 10 times a year for regular business. The Chairman of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations to the full board, within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

The Chair of the Committee will report to the Board in as soon as practically possible following the Committee meeting; this will be no later than the Board meeting in the following month. A summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented via a Chairs Report.

The Committee will undertake an Annual self-assessment, which will be presented to the Trust board, along with an Annual Report.

7. Key responsibilities

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".
- The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust to:
    - Promote safety and excellence in patient care
    - Identify, prioritise and manage risk arising from clinical care
    - Ensure efficient and effective use of resources through evidence based clinical practice
- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.
- To consider NHSi Quality Governance Framework in the delivery of its key responsibilities
- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.
- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.
- To receive reports from the following committees:
    - Safeguarding Committee
    - Infection Control Committee
    - Research Committee
    - Clinical Effectiveness Committee
    - Patient Safety Committee
    - Patient Experience Committee
    - Medical Devices Committee
    - Health and Safety Committee
- The Quality & Safety Committee shall review the Quality Accounts before submission to the Trust Board
- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy

Clinical outcomes

- Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
- Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.

Incident reporting and investigation

- Monitoring the effectiveness of the Trust's systems for reporting and investigating Serious Incidents (SIs), near misses and other incidents.
- Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.

Patient experience

- Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
- Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.

Approve and review of CQUIN requirements

Patient Information Governance

- Monitoring the arrangements to ensure the security of personally identifiable data.

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

APPENDIX F3: Finance, Planning and Digital Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Planning and Digital Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum (See attached schedule)

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Two Non-Executive Directors
- One Associate Non-Executive Director (non-voting member)
- The Board will appoint a Committee Chair and deputy Chair from the Non-Executive Members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the Chair or deputy Chair
- Chief Finance and Planning Officer
- Chief Performance, Improvement and OD Officer (until end of June 2022)
- Director of People – invited to attend as required
- Chief Executive Officer – invited to attend as required
- Chief Operating Officer (from July 2022)

The Board of Directors will appoint a Committee chairman and deputy chairman from the Non-Executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the chairman.

An open invitation will be extended to the Trusts Chairman.

A quorum will be two Non-Executive members and two Executive members.

3. Attendance

Other Executive Directors and Managing Directors will be required to attend when appropriate. The Trust Secretary/Director of Governance and Director of Digital will attend each meeting.

The Chief Finance and Planning Officer shall agree the agenda with the Chair of the Committee. The Assistant Trust Secretary will organise the collation and distribution of the papers, record the proceedings of the Committee and keep a record of matters arising and issues to be carried forward.

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4. Frequency of Meetings

The Committee will meet at least ten times a year for regular business. The Chair of the Committee may call additional meetings.

When appropriate committee meeting will take place as a virtually in line with the virtual board good governance guidance.

5. Authority

The Committee is authorised by the Board to provide an objective view of the financial and performance position of the Trust and will act to oversee the delivery of achieving financial, activity and operational performance targets, making any decisions delegated to it and if appropriate, report and make recommendations to the Board, within its terms of reference.

The Committee is distinct and separate from the Audit Committee and will act to minimise any possible areas of overlap between these two Committees,

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the

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attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

The Chairman of the Committee will report to the next Board meeting following the Committee meeting. A summary of the main issues of the discussion, drawing attention to any issues that require Board or Executive action, will be presented. In addition to this the approved minutes of the meeting will also be submitted. This is in line with the Committee reporting process agreed by the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Board, along with an Annual Report.

7. Key Responsibilities

The Finance, Planning and Digital Committee supports and advises the Board on all aspects of the Trust's Annual and Long Term Financial Plans and recommends adoption of the plans to the Board of Directors.

Strategy

- To consider and approve the key planning and financial assumptions to be used in the five year strategy and annual operational plan.
- Oversight of strategic issues related to income e.g. changes to tariff, commissioning intentions, tendering for new services, risks from competition and market share.
- To consider recommendations of investment and disinvestment of Trust sub-specialty / service reviews ensuring strategic steer in keeping with the Trust strategy and objectives.
- Capital planning oversight, ensuring forward planning, regular review and recommendations including acquisitions and disposal of assets, in line with the Trust strategy and objectives.
- To consider, evaluate and if appropriate recommend for Board approval commercial developments and partnerships opportunities in keeping with the Trust strategy and objectives.
- To consider and recommend Board approval of material business cases as defined by the Trust SFI's (currently investments above c£250k)
- Consider post project evaluation reports on significant capital investments. This will include all schemes over £250k and other schemes which are considered to represent a significant risk to the Trust.
- To consider and recommend Board approval of the Trust's Digital Strategy
- Oversight of the Trust's digital risks

Oversight and Scrutiny

- Receive regular reports on financial performance including the overall financial performance against plan and associated risk rating, performance of Capital programme and the performance of activity against contract
- To evaluate progress and recommend further actions from the review of in year financial, CIP, activity, RTT and productivity performance information, including SLR review
- Review the Trust's investment register of cash investment as required
- To evaluate progress of service transformation and investment plans, ensuring establishment of models of best practice in line with the Trust strategy.
- Promoting sustainability and receiving sustainability KPIs

- To receive routine Chair Assurance Reports from designated working groups e.g. Capital Management Group, Procurement Steering Group, Digital Steering Group, ICS Sustainability Committee, MSK Programme Board

- Receive relevant internal audit reports.

- To provide oversight in respect of all aspects of business planning, partnerships and development.

- To provide oversight to the Trust annual plan and its subsequent delivery.

- To oversee the delivery of the Trust's digital strategy

- To receive deep dives for scrutiny and further assurance into key performance areas. At the time of the meeting, the Committee will decide which deep dive will be presented at the following meeting.

Policies/Strategies

- The Committee shall approve such policies and strategies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy.

- Review progress made in delivering key enabling strategies such as (but not limited to) Estates, Procurement, and IT raising any significant risks regarding their delivery to the Board.

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APPENDIX F4: People Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the People Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors and Executive Directors of the Trust and shall consist of;

- Three Non-Executive Directors
- The Board will appoint a Committee Chair and Deputy Chair from the non-executive members of the Committee and appoint a Non-Executive Director to attend meetings in the absence of the Chair or Deputy Chair
- Chief Executive Officer
- Chief of People
- Chief Nurse and Patient Safety Officer
- Chief of Performance, Improvement and Organisational Development Officer
- Chief Medical Officer

In exceptional circumstances a deputy may attend in place of an Executive Director.

The Board of Directors will appoint a Committee Chair from the Non-Executive members of the Committee and a Non-Executive Director will be nominated to chair meetings in the absence of the Chair.

An open invitation will be extended to the Trusts Chairman.

A quorum will be one Non-Executive member and two Executive members.

3. Attendance

The Trust Secretary/Director of Governance, Head of People and the Trust Board Advisor will be expected to attend each meeting. The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Director of Digital, Chief Pharmacist, Unit Representative, People Services Business Partners, Freedom to Speak Up Guardian will only be expected to attend when a relevant paper is being presented. A time slot will be allocated to those individuals to support the logistics of the meeting.

The Chief of People shall agree the agenda with the Chair of the Committee and other attendees. A member of the Executive office secretariat will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

4. Frequency of meetings

The Committee will meet monthly (excluding August and December) for regular business. The Chairman of the Committee may call additional meetings.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations to the full board, within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

The Chair of the Committee will report to the next Board meeting following the Committee meeting. A

summary of the main issues of the discussion, drawing attention to any issues that require full Board or Executive action, will be presented via a Chairs Assurance Report this is in line with the committee reporting process agreed by the Board.

The Committee will undertake an annual self-assessment and annual report, which will be presented to the Audit Committee which has delegated responsibility from the Trust Board.

7. Key responsibilities

- The purpose of the People Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes and controls in place throughout the Trust to:
    - Promote excellence in staff health and wellbeing
    - Identify, prioritise and manage risks relating to staff
    - Ensure efficient and effective use of resources
- To ensure the Trust is meeting it statutory and regulatory requirements in relation to workforce management.
- To oversee the development and implementation of the People Plan and any related workforce plans
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies
- To receive an agreed level of workforce data and trend analysis to inform and analyse workforce issues
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'
- To receive reports from the following committees:
    - Staff Experience Group
    - Equality Diversion and Inclusion Group
    - Learning and Development Group
    - Resource Committee
- The Committee shall approve such policies as the Board has not reserved to itself and as required by the Trust's Policy Control Policy
- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising People Services issues of significance

APPENDIX F5: Executive Directors Remuneration and Appointments Committee Terms of Reference

Constitution

The Board hereby resolves to establish Committee of the Board to be known as the Executive Directors Remuneration Committee and Appointments Committee
The Committee is a Non-Executive Committee of the Remuneration Committee and has no executive powers other than those specifically delegated in these Terms of Reference.

Purpose

To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the board.

When appointing the Chief Executive, the Committee shall be the Committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing other Executive Directors the committee described in Schedule 7, 17(4) of Act

The Committee shall ensure there is a formal, rigorous and transparent procedure for the appointment of new Directors and that Directors are 'fit and proper' to meet the requirements of the general conditions of the Trusts provider licence.

Membership

The membership of the Committee(s) shall vary according to the nature of the business to be discharged at a particular meeting as follows:

<u>For the appointment and remuneration of the Chief Executive</u>

Chairman of the Board
Non- Executive
Directors

The quorum is the Chairman and three Non-Executive Directors.

<u>For the appointment of remuneration any other Executive Director</u>

Chairman of the Board
Chief Executive
Non-Executive Directors

The quorum is the Chairman, Chief Executive and two Non-Executive Directors.

Secretary to the Committee

The Chief People Officer will act as the secretary to the committee(s) and will facilitate and attend all meetings of the committee. S/he will agree the agenda with the Chair of the Committee and other attendees organise the collation and distribution of the papers and keep a record of decisions and recommendations taken.

Attendance

The Committee may request an Independent advisor to attend.

Executive Directors may be requested to attend when the committee considers such issues as succession planning.

The Director of People will attend to facilitate the meeting and provide technical advice if required

Frequency of meetings

Ad hoc

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

Key Responsibilities

- As Requested by the Board, review the structure, size and composition of the board and make recommendations for changes as appropriate.
- As Requested by the Board, give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise requires within the board of directors to meet them.
- When considering the appointment of Executive Directors, the Appointment Committee must ensure that statutory roles are maintained and will take into account the views of the board of directors regarding the qualifications, skills and experience required.
- The Committee is responsible for ensuring that any Director nominated for a Board position, is "fit and proper" to undertake the role. The requirements, checks and declarations are shown at Appendix F5.1.
- Setting the remuneration of all Executive Directors, including salary and any performance related elements / bonuses or allowances and provision for other benefits including cars
- Ensuring the contractual terms of Executive Directors are in accordance with national policy and guidance, particularly in relation to the termination of employment, notice periods and pension benefits
- Determining whether a proportion of Executive Directors' remuneration should be linked to corporate and individual performance and, if so, approving an appropriate scheme of performance related remuneration.

Process for the Identification and Nomination of Chief Executive or Executive Directors

The process to be followed for the appointment of a new Chief Executive or Executive Director has been agreed by the Trust Board, and is included in appendix F5.2.

Suggestions for improvement to the process will be feedback to the Trust Board as appropriate, and the process will be periodically updated where agreed.

Reporting

The Chair of the Committee will report to the next meeting of the Board following the Committee, summarising the main issues of the discussion and drawing to the Board's attention any issues that require disclosure to the full Board or require Executive action.

Details of the Committee and the appointments made will be included in the Trust's Annual Report. When the Committee has met to appoint Chief Executive, the Chairman will prepare a report of the proceeding for the Governors, to assist them in approving the appointment.

Approved by Trust Board

Appendix F5.1: Fit and Proper Person requirements, checks and declarations

- NHS Employers – Employment Checks Requirements
    - Identity
    - Right to Work
    - Professional Registration and Qualifications
    - Employment history and reference
    - Criminal record and barring
    - Work health assessment
- Current and previous directorships
- Conflicts of interest
- Declaration to abide by Standards for Members of NHS boards
- Declaration to abide by Trusts Standards of Business Conduct
- Declaration to maintain confidentiality

The following may not become a member of the Board of Directors

- A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- A person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it.
- A person who within the preceding five years has been convicted in the British islands of any offence if a sentence of imprisonment (whether suspected or not) for a period of not less than three months (without the option of a fine) was imposed on him or her).
- A person who has been barred from acting as a governor of an FT or disqualified as a director.
- A person with a history of any action against the principles of the NHS Constitution

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

Appendix F5.2: Process for the Identification and Nomination of Chief Executive or Executive Director

The standard approach to advertising and recruitment for executive appointments shall be as follows:

- Identify skills gap based on assessment of requirements of the post
- Liaise with the Remuneration Committee to confirm terms & conditions
- Update role description and person specification to reflect skills gap being addressed
- Consideration will be given to the use of agencies to assist with recruitment processes were appropriate
- Advertise through
  - Local and or National newspapers (Shropshire; North Wales; Cheshire)
  - NHS Careers Website/NHS Employers executive vacancies
  - Trust Web Site through link to NHS Careers
  - Email shot to FT Members
  - Email shot to Trust Staff
- Pre-screening - Dependent on the number and standard of applications received the Committee will give consideration to the use of ability and psychometric testing in order to determine a short list for interview Committee (this may be via teleconference)
- Appoint Independent Adviser with appropriate professional background.

<u>For the Appointment of the Chief Executive</u>

Chairman of the Board
Minimum of three Non- Executive Directors
Independent Adviser (non-voting)

<u>For the appointment of any other Executive Director</u>

Chairman of the Board
Chief Executive
Minimum of two Non-Executive Directors
Independent Adviser (non-voting)

- Interview panel - Prior to the interview, panel members to be allocated areas of questioning, with sample questions to support them together with a scoring matrix to ensure decisions are based on a robust assessment of each applicant
- Interview panel recommendation for appointment of a Chief Executive will be made to the Executive Director Appointment Committee (sitting without the Chief Executive) and subject to the approval of the Council of Governors
- Interview panel recommendation for appointment of an Executive Director will be made to the Executive Director Appointment Committee
- Conditional offer made subject to completion of ‘fit and proper’ person checks

Suggestions for improvement to the process will be feedback to the Trust Board as appropriate, and the process will be periodically updated where agreed.

APPENDIX F6: Non-Executive Directors Remuneration and Appointment Committee Terms of Reference

Constitution

The Non-Executive Directors Remuneration and Appointment Committee (the Committee) is constituted as a standing committee of the Council of Governors. Its constitution and terms of reference shall be set out below, subject to amendment at future meetings of the Council of Governors.

Purpose

The Committee is responsible for appointing Non-Executive Directors, including the Chairman, to the Board of Directors.

The Committee shall ensure there is a formal, rigorous and transparent procedure for the appointment of new Directors and that Directors are 'fit and proper' to meet the requirements of the general conditions of the Trusts provider licence.

The Committee will also periodically be satisfied that plans are in place for orderly succession for appointments to Non-Executive positions, so as to maintain an appropriate balance of skills and experience on the board.

The Committee will recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the chair (except in respect of his own remuneration and terms of service) and the chief executive and any external advisers.

The Committee will agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

Membership

The membership of the Committee shall have a majority of governors, and will be chaired by the Chairman or by the Senior Independent Director in his absence, and will consist of the following

For the appointment and remuneration of the Chairman

Lead Governor
Senior Independent Director of the Board
2 public governors
1 staff governor and/or 1 appointed governor

For the appointment and remuneration of any other Non-Executive Director

Chairman of the Board
Lead Governor
2 Public Governors
1 Staff Governor and/or 1 Appointed Governor

Secretary to the Committee

The Trust Secretary/Director of Governance will act as the Secretary to the Committee, and will facilitate and attend all meetings of the committee. She will agree the agenda with the Chair of the Committee and other attendees organise the collation and distribution of the papers and keep a record of decisions and recommendations taken.

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

Conflicts of Interest
The Chair of the Trust or any Non-Executive Directors present at Committee meetings will withdraw from discussions concerning their own remuneration of terms of service.

Attendance

The Committee may request on Independent advisor to attend. Director of People will attend to facilitate the meetings and will be available to give technical advice if required.

Frequency of meetings

Ad Hoc

Authority
The Committee is authorised by the Council of Governors to act within its terms of reference and constitution as set out in this document. The Committee is authorised by the Council of Governors, subject to funding and Board approval, to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary. The Committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its function.

Key Responsibilities

- When considering the appointment of non-executive directors, the appointments committee, on behalf of the council of governors, will take into account the views of the board of directors regarding the qualifications, skills and experience required for each position.

  The skills and experience needed across the Non-Executive Directors of the Board, to ensure a broad range of appropriate knowledge and experience to ensure sufficient challenge to the executive team are determined as follows:

    - Legal
    - Financial
    - Business Strategy
    - Human Resources
    - Clinical/Research
    - Marketing/PR

- The Committee is responsible for ensuring that any Director nominated for a Board position, is “fit and proper” to undertake the role. The requirements, checks and declarations are shown at Appendix F6.1.

- In adhering to all relevant laws and regulations the Committee will establish levels of remuneration which:
    - Are sufficient to attract, retain and motivate Non-Executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;
    - Reflect the time commitment and responsibilities of the roles;
    - Take into account appropriate benchmarking and market-testing, which ensuring that increases are not made where trust or individual performance do not justify them; and
    - Are sensitive to pay and employment conditions elsewhere in the trust (not foregoing that non-executive directors are not employees)

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

Process for the Identification and Appointment of Non-Executive Directors

The process to be followed for the appointment of a new Chairperson or Non-Executive Director has been agreed by the Council of Governors, and is included in appendix F6.2.

Suggestions for improvement to the process will be fedback to the Council of Governors as appropriate, and the process will be periodically updated where agreed.

Reporting

Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to members of the Council of Governors, unless a conflict of interest, or matter of confidentiality exists.

The Committee will report to the Council of Governors after each meeting.

The Committee shall receive and agree a description of the work of the Committee, its policies and all Non-Executive Director emoluments in order that these are accurately reported in the required format in the trusts annual report.

Details of the Committee and the appointments made will be included in the Trust's Annual Report.

Appendix F6.1: Fit and Proper Person Requirements, Checks and Declarations

- Criminal records checks
- Current and previous directorships
- Previous employment referencing
- Verification of relevant qualifications
- Conflicts of interest
- Reside within a constituency of the Trust
- Be a member of the Trust
- Declaration to abide by Standards for Members of NHS boards
- Declaration to abide by Trusts Standards of Business Conduct
- Declaration to maintain confidentiality

The following may not become a member of the Board of Directors

- A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- A person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it.
- A person who within the preceding five years has been convicted in the British islands of any offence if a sentence of imprisonment (whether suspected or not) for a period of not less than three months (without the option of a fine) was imposed on him or her).
- A person who has been barred from acting as a governor of an FT or disqualified as a Director.
- A person with a history of any action against the principles of the NHS Constitution

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

Appendix F6.2: Process for the Identification and Appointment of Non- Executive Directors

The standard approach to advertising and recruitment for NED appointments shall be as follows:

- Identify skills gap based on assessment of NEDs current skills and experience
- Amend generic role description and person specification to reflect skills gap being addressed
- Appoint Independent Adviser
- Liaise with Non-Executive remuneration Committee to confirm terms and conditions
- Advertise through :
  - Local and or National newspapers (Shropshire; North Wales; Cheshire)
  - Trust Web Site
  - Email shot to FT Members
  - NHS Careers Website
  - Email shot to Trust Staff
- **Applications via on-line form together with covering letter to Director of People**
- Long list (i.e. sift out inappropriate applications by Director of People /Chairman)
- Short list agreed by Appointments Committee (this may be via teleconference)
- Nominations committee interview panel - Prior to the interview, panel members to be allocated areas of questioning, with sample questions to support them together with a scoring matrix to ensure decisions are based on a robust assessment of each applicant.
- Appointment Committee recommendation for appointment made to the Council of Governors for approval
- Conditional offer made subject to completion of 'fit and proper' person checks

Suggestions for improvement to the process will be feedback to the Council of Governors as appropriate, and the process will be periodically updated where agreed.

Shropshire Telford & Wrekin Integrated Care System

Green Plan

2022-2025

www.stwics.org.uk

Shropshire, Telford & Wrekin
Integrated Care System

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Welcome

Our activities as a species on Earth are having a profound impact on the environment with **irrevocable consequences** -

biodiversity loss and mass extinction, plastics in our food chain, acidification of our seas and climate change that will bring about frequent and often disastrous weather events. We must therefore maintain momentum in minimising our contribution to carbon in the atmosphere, products that persist in nature, and the destruction of other species due to loss of natural habitats. Extreme weather events and infectious diseases are now a very real and tangible part of our lives. Human activities have already set in motion these occurrences and therefore, we must adapt.

The UK typically experiences 10 severe storms per annum, and some of the most severe heatwaves experienced over the last 60 years have been in the last ten years or so (Kendon, et. al, 2021). These incidents will clearly have an impact on our communities' health and wellbeing - be it through heatwaves, flooding, or storms. Moreover, the buildings and infrastructure we use to provide care must do so throughout these events, enabling the business that our clinical and support services colleagues deliver to continue uninterrupted — particularly because of the impact that major incidents have on our service delivery.

We must, then, adapt our services to ensure that we mitigate for emerging risks brought about by climate change and loss in biodiversity.

The Shropshire, Telford and Wrekin Integrated Care System (STW ICS) has thus far reached significant milestones in its journey to realising Net Zero. We must ensure that we speed up our efforts now, in a joined-up approach, to meet targets set out by NHSEI in the document Delivering a Net Zero NHS (2020). We are fortunate enough to be situated in one of the most beautiful areas of the UK, and because of this are reminded daily how precious our world is, and that we must take responsibility for caring for the environment we live and work in.

This document is a representation of our system's organisations, the STW ICS, three-year plans to do just that.

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

It is not the strongest, nor the most intelligent of species that survives, but the one that is most adaptable to change.

Charles Darwin (1808–1882)
naturalist, biologist and geologist, born in Shrewsbury

Introduction

Shropshire, Telford and Wrekin Sustainable Transformation Partnership (STP) became an **Integrated Care System (ICS)** from 1st April 2021.

In an integrated care system, NHS organisations, in partnership with local authorities and other partners, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve.

Our ICS footprint covers 1,347sq miles, but is one of the smallest in terms of population, covering around 500,000 people. We have one Clinical Commissioning Group covering the area of Shropshire, Telford & Wrekin. The CCG is responsible for buying NHS services for local people. We have two acute hospitals, sited less than 20 miles apart, with services delivered by one acute trust, Shrewsbury and Telford NHS Trust (SaTH). There is also a specialist orthopaedic hospital, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), which provides elective orthopaedic surgery, sited in the northwest of the county. Additional providers include a community trust (SCHT), a mental health trust (MPFT) which covers Shropshire and Staffordshire, and the region is served by the West Midlands Ambulance Service University NHS Foundation Trust (WMAS). In summary, our ICS System partnership consists of;

- NHS Shropshire, Telford and Wrekin Clinical Commissioning Group,
- The Shrewsbury and Telford Hospital NHS Trust -SaTH
- The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust -RJAH
- Midlands Partnership NHS Foundation Trust -MPFT
- Shropshire Community Health NHS Trust -SCHT
- Shropshire Council- SC
- Telford and Wrekin Council - TW
- The Primary Care Network including GPs
- West Midlands Ambulance Service - WMAS
- The voluntary sector and other core partners involved in transforming the provision of health and care services across Shropshire, Telford and Wrekin for those we serve.

The ICS has two unitary authorities: Shropshire Council and Telford & Wrekin Council. The area covered by Shropshire Council is 3,197 square kilometres, or 1,234 square miles. This is 91.7% of the ceremonial county of Shropshire, with the remainder being covered by Telford & Wrekin Council. The footprint has a number of towns, but no major cities. Shropshire has an estimated population of around 310,000 and Telford & Wrekin has an estimated population (for the borough) of around 170,000. Of these, around 150,000 live in Telford itself, making it the largest town within the ICS and it is one of the fastest-growing towns in the United Kingdom. In the Shropshire Council area, Shrewsbury is the largest town with a population of 70,600 with the second largest being Oswestry with a population of just 16,600.

Our ICS area is one of a handful that borders Wales and provides some hospital services for people from the Welsh health system who are external to the ICS footprint. Some residents of mid-Wales therefore rely on the services at SaTH and RJAH.

Each organisation within the ICS currently has their own Green Plan, with their own specific Action Plan. This document outlines the achievements already made, our ambition as a system, and how we aim to achieve these ambitions. We see our journey to net zero as a collaboration of the organisations in our system to approach with a broader view of delivering care to our communities.

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

Both Telford and Wrekin, and Shropshire Councils have a target to be 100% net zero carbon by 2030

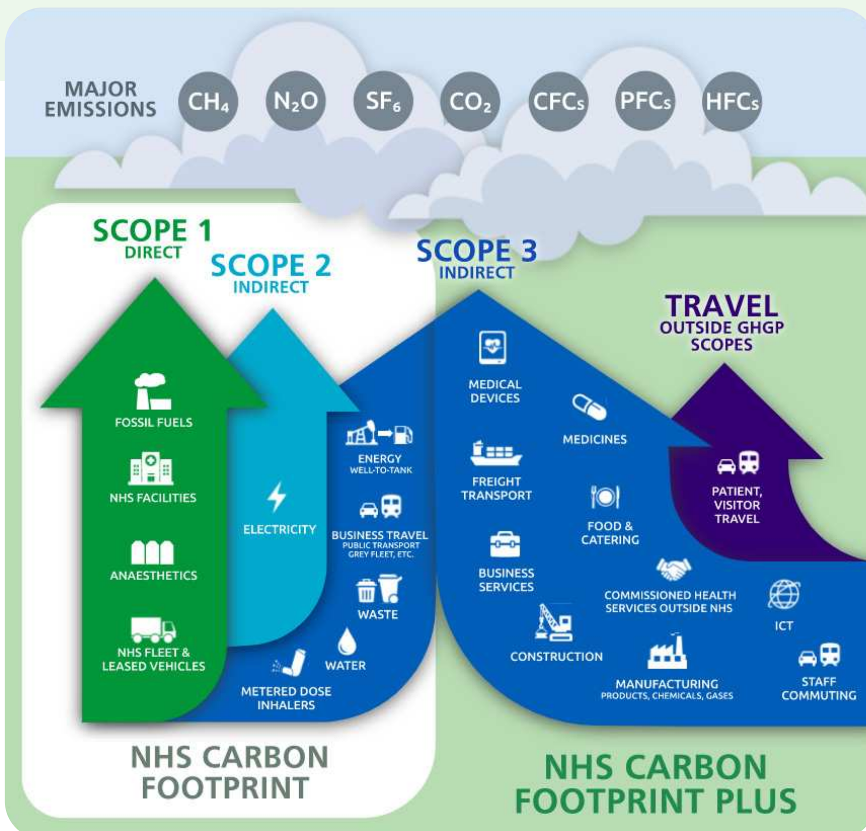
The NHS aims to provide health and high-quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 has brought, protecting patients, our staff, and the public. The NHS also needs to respond to the health emergency that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

Clearly, there will be financial investment required across the system. We aim to return on these investments over the lifetime of the output projects, or where this is not possible, for them to be cost-neutral. This may not always be possible so we must be careful in how we initiate projects and consider the benefits they provide in a holistic approach.

The two key net zero targets for the NHS set in the 'Net Zero' (NHSEI, 2020) paper:

1. 100% by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032

2. 100% by 2045 for the NHS Carbon Footprint Plus (see below), with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039.



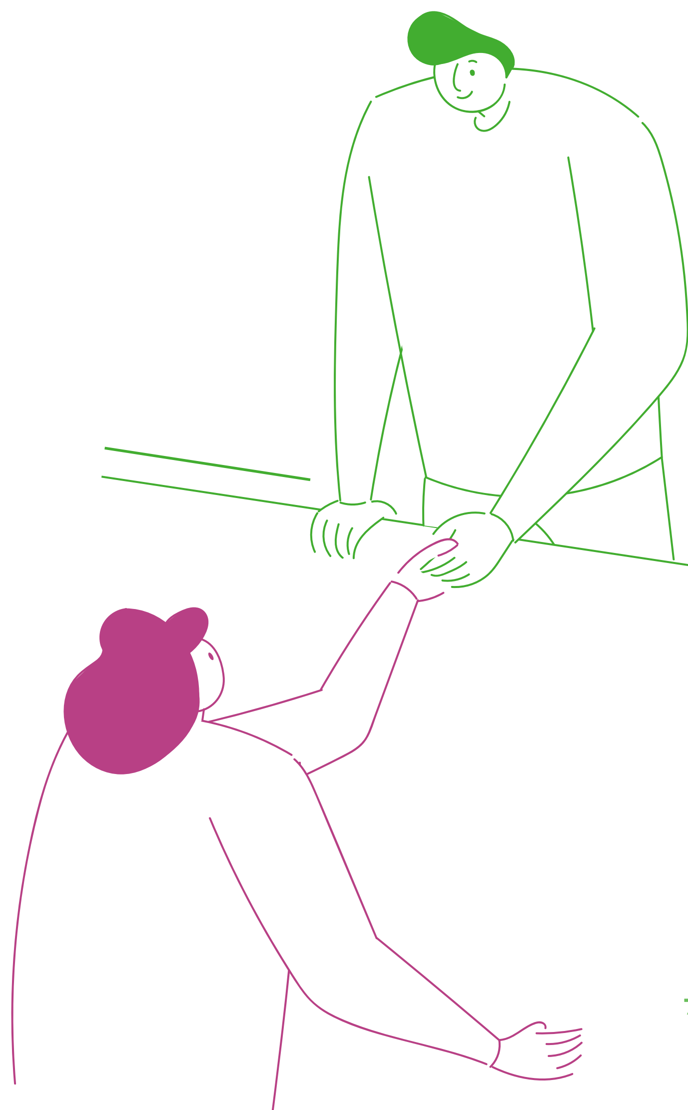
Integrated Care System Vision

We will **work together** with the people of Shropshire, Telford & Wrekin to develop innovative, safe and high-quality services, attracting and retaining the best staff to deliver world class care that meets our current, and future, rural and urban needs.

We will support people — in their own communities — to live healthy and independent lives, helping them to stay well for as long as possible. Creating partnerships to find solutions that work better for the people we serve and those who provide care.

As the world faces up to a climate emergency, we are committed to delivering an internationally recognised system known for its environmentally friendly services that make the best use of our resources. We want this journey to net zero carbon to provide population health benefits to our communities and staff throughout the process and capitalise on financial benefits where possible.

Our journey is towards local sustainability while being sensitive to global sustainability and delivering on net zero. Our approach will be one of collaboration between our member organisations to ensure we achieve our targets comprehensively and systematically together in good time, realising all of the benefits that come with it environmentally and in terms of health and service provision.



Key Milestones — Our progress so far

Our journey to **net zero** has already started at our organisational levels. Our key milestones are:

An overall system reduction in reliance on fossil fuels of circa **1,066,000 kWh** for PV arrays

Achieved by the installation of renewable on site energy

Around £**2.98**m saved from reduction in journeys

Achieved and quantified by MPFT:

- moving outpatients clinics to telephone/video calls, delivering over **80,000** virtual consultations
- adapting agile (hybrid) working for our colleagues
- planning our services better

Adapted our sites to accommodate local wildlife

Achieved by

- Installing swift and bat boxes
- Sited beehives on some of our hospital sites
- Encouraged a diverse range of plants and fauna in our green spaces.

Diverting around 440 tonnes of waste from landfill each year

Achieved by RJAH in the period April 2020 — March 2021, 100% of RJAH waste was diverted from landfill = saving of 440 tonnes waste, breakdown below:

Area	Weight (tonnes)
Incineration (Clinical) Waste Volume	102.49
Alternative Treatment (Clinical) Waste Volume	76.05
Offensive Waste Volume	119.87
Recycling Waste Volume	53.07
Domestic Waste Volume	78.20
Food Waste Volume	14.39

Achieved by

- segregation of waste
- collaborating with waste partners to adopt practices that make energy from waste

Completely eliminated Desflurane from our clinical practices

Achieved by adopting alternative methods such as less environmentally harmful anaesthetic gases and **Total Intravenous Anaesthetics (TIVA)**

Each metric outlined in the document covers more of the achievements we have made in further detail.

The Next Three Years and Beyond

The next three years will be fundamental in **building collaboration** and establishing early investment to maximise benefits later.

There are many early interventions we must address, but establishing our benchmarks is a priority. To do this, we aim to determine the overall system carbon footprint from scopes 1 & 2 emissions by April 1st, 2023, with scope 3 emissions later in 2023. We will also review waste metrics, travel and medicines. This will give us a point of reference in which to measure our progress. Some organisations within the system have already completed a carbon foot-printing assessment, so we intend to complete a joint exercise for those who have not, to capitalise on economies of scale.

Adopting a collaborative approach to both the actions at organisational and system levels will ensure we maximise benefits and realise any financial saving opportunities. It will also provide consistency in reporting and some resilience in terms of team member movement.

Therefore, our key actions are to identify opportunities in the system where we can share learning, optimise efficiencies, and capitalise on collaborative working.

To do this, we will:

1. Establish our system baseline positions
2. Ensure that we have the right people delivering our net zero agenda
3. Consider how we can deliver care in a sustainable, balanced way
4. Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services
5. Encourage our communities to avoid contributing to our carbon output
6. Focus on our supply chain's commitments to achieving net zero
7. Develop decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count
8. Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
9. Adapting our services to meet the challenges of climate change and extreme weather events
10. Encourage biodiversity at our properties

Our Green Plan structure follows the NHS England Guidance:

LEADERSHIP AND WORKFORCE

SUSTAINABLE MODELS OF CARE

DIGITAL TRANSFORMATION

TRAVEL AND TRANSPORT

ESTATES (Hard Services)

FACILITIES (Soft Services including Waste)

MEDICINES

FOOD & NUTRITION

SUPPLY CHAIN & PROCUREMENT

ADAPTATION

This structure will form the basis of our strategy. Each subheading discusses the progress made so far (and our baselines, where applicable), our key targets, timeframe and how we intend to achieve this. We also feel that it is important to include Biodiversity under its own subheading because a broad and diverse environment locally, nationally and internationally is central to tackling the key issues addressed in this document.

Leadership & Workforce

Our people are central to delivering our care services **sustainably.**

Currently, many of the organisations in our system manage sustainability through various roles such as sustainability managers, energy managers or waste managers (or a combination of these). Whilst we already have excellent examples of collaboration and governance through the ICS Climate Change Working Group, there are opportunities to focus the co-ordination of collaborative working to drive efficiencies between the organisations - both environmentally and financially.

All our staff have a responsibility for contributing to achieving net zero, and can help by:

- Where practical, and meeting the service needs, work from home wherever possible
- Use greener methods of transportation such as 'active travel', and where this is not possible, use public transportation and carpools
- Minimise waste, reuse if safe to do so and use recycling facilities provided
- Holding local sustainability working groups
- Challenge colleagues where socially and sustainably responsible behaviours need improvement
- Increase awareness by discussing with colleagues and teams
- Sensible use of technology to enable remote working and drive efficiencies — for example, embracing the use of electronic devices for delivering services in the community or holding a MS Teams meeting rather than traveling to meet face-to-face.
- Raising sustainability awareness to our colleagues, service users and communities by participating in campaigns, Sustainability Days, Sustainability Competitions, and so on.
- Collaboration with schools and nurseries to promote sustainability as part of their curriculums; providing advice and help with planning activities to teachers, administrators, business managers.

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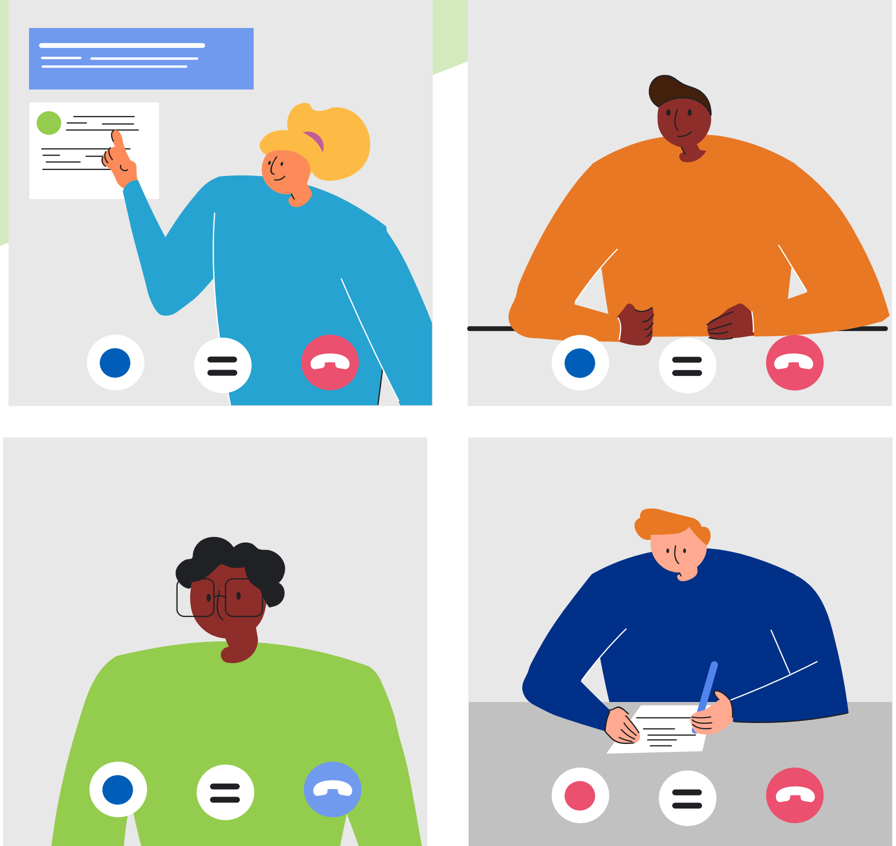


Sensible use of technology to enable remote working and drive efficiencies.

As job descriptions throughout the whole workforce are reviewed and refreshed on a routine basis, we must ensure that sustainability & waste management are highlighted as an essential requirement to the day-to-day responsibilities of each colleague, expecting sustainability as 'business as usual' facet of our work practices.

Our ICS board lead for sustainability is Shropshire Council's Chief Executive.

In 2022 we will look to identify a Sustainability Lead for the ICS — a person accountable to the board lead and responsible for providing support to the respective organisations within the ICS, holding those organisations to account and ensuring that their respective action plans are being addressed in the agreed timeframes.

Some of the organisations in our system already have colleagues in senior leadership positions who have completed carbon literacy training. This training is a formally recognised certificate which we intend to roll out for senior leaders in the whole system using a train-the-trainer model, capitalising on collaboration, to improve our understanding of how we can tackle our emissions by changing behaviours and embedding carbon performance in our service delivery. A by-product of this training would encourage and identify climate and carbon champions in all service areas.

Collaborative Opportunities

1. Individual and System Baseline Carbon Foot-printing (we have a stronger position for negotiation through economies of scale)
2. Introduce a network of Net Zero Carbon Champions (staff, service users and members of the public)
3. Improvement in comms by sharing regular cross-system sustainability-related information, such as benchmarks and how colleagues can change behaviours to have a collective impact on our carbon footprint
4. Share training to provide consistent approaches, and capitalise on economies of scale

We will recognise the fantastic work and milestones achieved by our colleagues throughout the system through nominations at national level sustainability awards and at local levels through internal nominations for individual recognition.

Sustainable Models of Care

Delivering the best care is our business — it's what we do. As a system we have huge opportunity to organise our services in such a way that patient care improves whilst we **make carbon efficiencies.**

We must consider the location of our services to suit — utilising existing buildings, collaborating on projects that improve care across our membership and ensuring we have the right services in the right places.

We are harnessing technologies to reduce the need to invite patients to sites, often through 'virtual' consultations. For example, MPFT has completed over 80,000 of these appointments since March 2020 — demonstrating an estimated £3m saved in travel. There is therefore much opportunity for the system, where it is clinically safe to do so, to adopt this approach.

In 2015, NICE published guidelines on medicines optimisation, advising that the environmental impact of each bed day is 63.7kg of CO_2e, 0.6m3 of direct fresh water used (98.6 m3 of indirect freshwater use) and 8.15kg of waste produced. From 1,271 (700 SaTH, 174 RJAH, 24 Ludlow, 25 Bridgnorth, 348 MPFT) bed spaces in the system, this translates to a total of 81tCO_2e, 762.6m^3 direct fresh water, 125,321m^3 indirect fresh water and 10,359kg of waste (per day).

We must encourage our patients to live balanced, healthy lifestyles, and geographically we must provide this care that is accessible for all engaging in active travel. The **#TogetherWeMove** movement is a charity-led initiative encouraging active travel, exercise and the benefits that come with this.

There are also opportunities to signpost patients, staff and service users to energy efficiency advice outlets, such as Beat the Cold and Keep Shropshire Warm.

Collaborative Opportunities

Align individual digital technology to offer Care Closer to Home to reduce bed days

Partner to develop and deliver the Shropshire Joint Health and Wellbeing Strategy, specifically: -

- reducing stigma of mental illness
- reduce inequalities that are the cause of ill health
- influence planning decisions regarding fast food takeaways and green spaces
- support people as they are discharged from hospital
- promote the health, wellbeing and social change needed to improve health in Shropshire

Signposting to energy efficiency advise to patients, staff, public, financial help with energy bills, improve their health and wellbeing, etc. directly or via charities (e.g. Beat the Cold, Keep Shropshire Warm **#WeMoveTogether**).

There are further opportunities to embed carbon reduction into the services that are commissioned from health through the PH grant

All Shropshire Council commissioned activity will seek to identify opportunities to reduce carbon admissions; including locality-based models of care, reducing the need for paper and moving to digital solutions, incentivise sustainable transport solutions. The same is true for Telford and Wrekin Council; increasing its environmental evaluation criteria weightings to encourage suppliers to use sustainable practices and to reduce carbon emissions in the supply chain. This is an opportunity for the NHS organisations in the system to both support and adopt best practices.

The development of a new Wellbeing Centre in Shrewsbury will provide opportunities to introduce innovative ways of working and delivering health care, including related green initiatives. There are further opportunities to embed carbon reduction into the services that are commissioned from health through the PH grant — the commissioned services are primarily from ShropCom— Drugs and Alcohol (DAT), School Nursing, Health Visiting, health checks commissioned from primary care, and some weight management programmes commissioned from SaTH. Building this integration into our zero-carbon journey will enable us to adapt as we need to and expedite the carbon reductions.

Digital Transformation

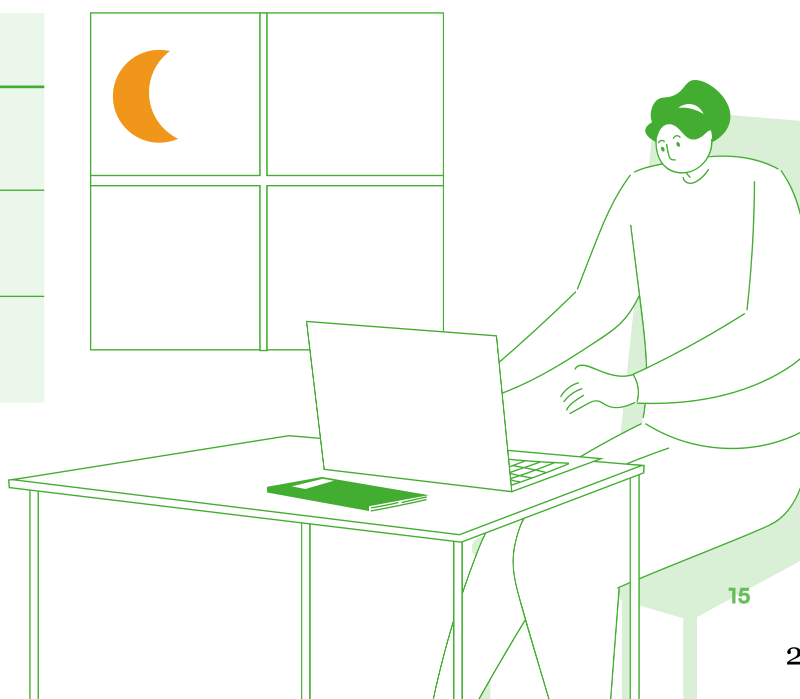
With the advent of SARs-CoV-2 and the subsequent COVID-19 pandemic, our **organisations had to adapt** to continue to provide services whilst protecting patients and staff.

To do so, our IT teams worked around the clock to enable more colleagues to work from home or working remotely to provide services where this did not impact business needs - as discussed in the Sustainable Models of Care chapter, for example, assisting with moving to online consultations.

This inadvertently reduced our carbon footprint significantly, within the space of just a few weeks. There is now real opportunity to further drive down our key carbon emissions through harnessing digital infrastructure, particularly in delivering patient care but also as colleagues return to site.

We are building resilience in the event of major incidents, outbreaks, and enabling colleagues to perform flexibly and efficiently by improving communications — for example, pivoting to VOIP telephones and integrating telephone services with Microsoft Teams. Digital exclusion, the term used for inequalities in access to digital technology, is a barrier to providing care in our communities; particularly with respect to our ambition to provide 25% of outpatient activity and we will aim to review progress with this in mind and exploring options to support our communities to overcome this.

Collaborative Opportunities
Enable ability for staff to work from other stakeholders locations if closer to home or patients
Encouraging staff across the system to use Ecosia to contribute to biodiversity around the world.
Joint booking systems for clinical and non-clinical spaces



Collaboration between council and NHS organisations may also benefit our services; particularly where we share building spaces. whereby staff can work from nearest office space throughout the entire system. A joint space booking system is currently being investigated to cover the entire system both for non-clinical and clinical space. Councils also have a role to play in working with NHS partners in the system to develop and enhance digital solutions to support people to live safe and well at home, to ensure the right care, at the right time in the right place in needed and care is not being overprescribed.

Electronic Patient Records (EPR)

The recent NHS Long Term Plan has an expectation that all services should have met 'a level of core digitalisation by 2024'. The move to EHRs supports this as well as helping with compliance with the General Data Protection Regulation (GDPR) as well as the visibility of patients notes improves care. WMAS and SCHT are already using an electronic system, RJAH are implementing for go live in 12 months, SATH in 18 months.

Work From Home and Agile (Hybrid) Working

The Covid-19 crisis has kickstarted a movement to agile (hybrid) working, and where service delivery is not impacted there are clear benefits to continuing this model:

- Improved wellbeing for staff due to reduced commuting, better work-life balance, local emissions reductions and so on.
- Reduction in carbon from commuting, less local pollution, improved access to parking for site visitors,
- Reduction in utilities usage, such as water, electricity and gas on site

Improving building services monitoring and control

Adopting the latest technologies in Building Management Systems (BMS) will provide significant and often direct carbon emissions at local level. Although frameworks exist for service providers in this industry, there is real opportunity to collaborate on maintenance contracts where similar systems are being employed across multiple sites, and to support transition to improved equipment. Organisations can link and pool expertise through peer meetings to ensure that benefits of BMS systems are being maximised.

Work underway, by Shropshire Council, to help staff with insulations and loan scheme for solar and battery installation in their homes.

There is an opportunity for all organisations to adopt Ecosia

Ecosia

The free-to-use search engine that donates approximately 80% of its profits to fund tree planting projects around the world.

University College London Hospital (UCLH) have recently rolled this out and provided a case study. In the first full month (February 2022) of Ecosia being used trust wide UCLH has funded the planting of 2,238 trees. UCLH employs 11,000 staff, which is a tree planting rate of: 2238/11000 = 0.203 trees funded per staff per week. Although the exact rate of tree planting will vary between organisations, this gives an approximation for potential tree planting impact. If the system adopts this approach, the number of trees planted could reach close to 84,000 per year (34,345 staff x 0.203 x 12 = 83,664)

It is important to note that Ecosia does allow for 'carbon offsetting', so the carbon sequestered from tree's planted cannot be used in any official carbon accounting. Nor does NHSEI encourage tree planting as a route to net zero, rather, this method will be a tool for us to contribute to biodiversity in some of the most environmentally important areas across the globe — South America, Africa, Europe and East Asia.

Journeys, Transport and Active Travel

Business Travel and Staff Commuting are one of the major contributors to Trust Scope 3 emissions. Trusts are tasked with **outlining plans to reduce the carbon emissions** arising from Travel and Transport.

Fig 3: Greenhouse gas emissions by sector, 2019, by proportion (BEIS, 2020)

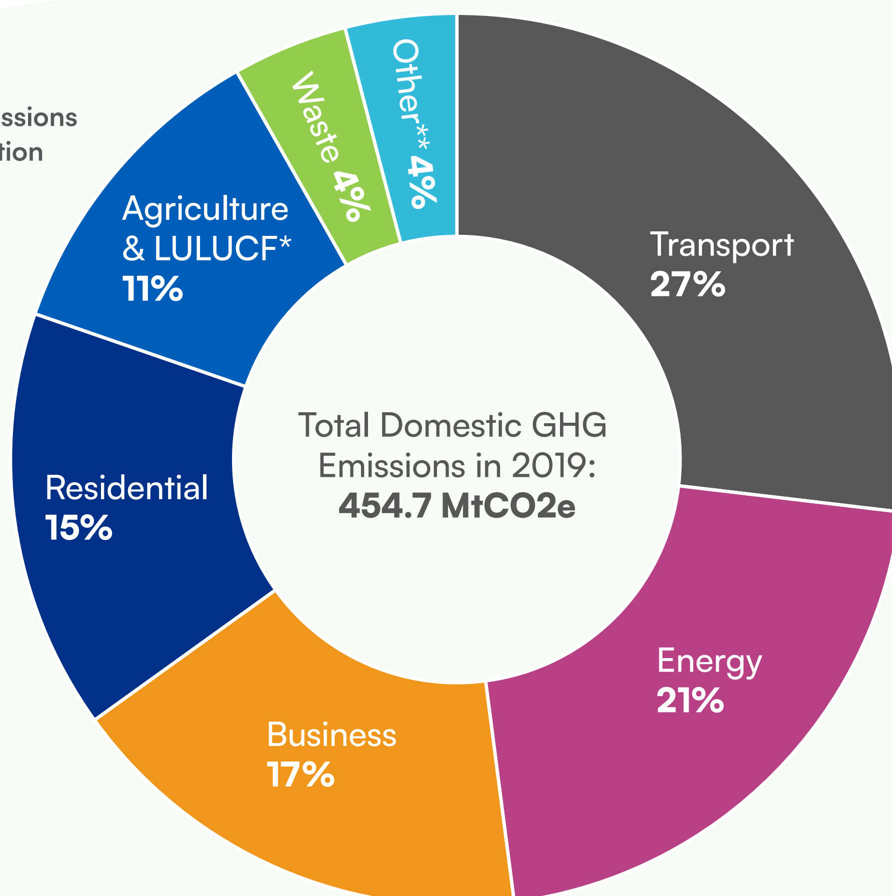
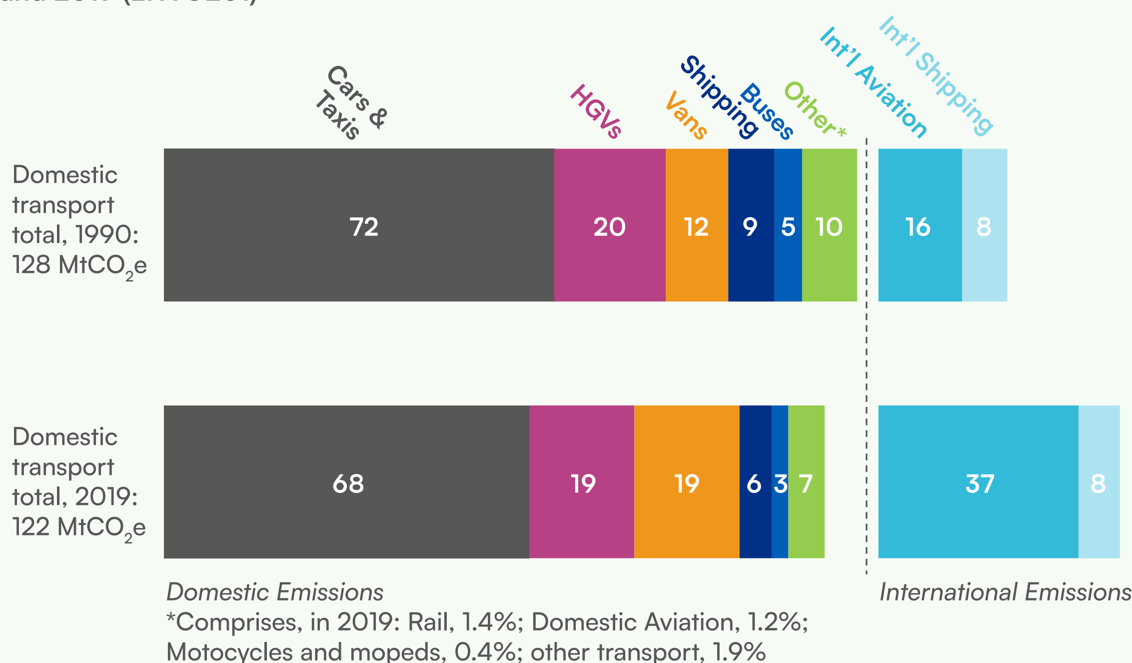


Fig 4: Greenhouse gas emissions by transport mode, 1990 and 2019 (ENVO201)



*Comprises, in 2019: Rail, 1.4%; Domestic Aviation, 1.2%; Motocycles and mopeds, 0.4%; other transport, 1.9%

Source: www.gov.uk/government/statistics/transport-and-environment-statistics-autumn-2021/transport-and-environment-statistics-autumn-2021

The NHSi Greener NHS Fleet Data Collection tool can completed by all non-ambulance NHS provider Trusts and was created to enable reporting on fleet carbon emissions and to understand the vehicle landscape to support planning for the necessary transition to zero emissions vehicles.

This uses vehicle registration numbers (VRNs) to look up emissions data. Understand operated vehicles and how these may be replaced.

Organisations will need to identify a named individual who will complete and submit the return on their behalf. Multiple people can respond for each organisation.

After identifying the responsible individual, they should:

1. Register for OKTA: **https://apps.model.nhs.uk/register**
2. Register for the data collection: **https://forms.office.com/r/PUq5Bre4rz**
3. Start collating the data required
4. Access and submit to the DCF portal: **https://dcfdatacollections.improvement.nhs.uk**

Data collection portal opens: Friday 1st April 2022
Data collection portal closes: Tuesday 24th May 2021

Investing in low emission fleet and reviewing the organisations transport of goods, patient transport, work patterns and location of services are also beneficial. For example, Telford & Wrekin Council are looking to implement an optimum flexible working pattern to reduce the carbon impact of staff travel and enable reduction in required office space as well as developing a Corporate Travel Plan to minimise car travel between offices.

The current process of renewing the Local Transport Plan (LTP4) for Shropshire will provide opportunities to generate co-benefits for both health and carbon performance.

Shropshire Council health and transport colleagues are working together to improve the health impact of the new Shropshire LTP, along with the LCWIP — Local Walking and Cycling Infrastructure Plan and the Bus Strategy. The actions will increase access to public and active travel and help to mitigate any negative health impacts.

Additional effort and investment is required to:

- Reducing barriers to using active travel
- Reduce Business Milage
- Develop and appraise Travel Plans to assess progress and quantify emissions saved
- Replace fleet with low emission (LEV/ULEV/ZLEV) alternatives

Travel plans can make a real contribution towards encouraging and promoting alternatives to the car.

Organisation can utilize the Clean Air Hospital Framework — a free resource available to help clean up their air.

This is a self-assessment tool designed to benchmark and shows areas to improve air quality across sites and in the local community.

The framework is focused on seven key areas:

1. Travel
2. Procurement and supply chain
3. Construction
4. Energy
5. Local air quality
6. Communication and training
7. Hospital outreach and leadership

Increasing 'Active Travel' and use of public transport are some of the interventions which some of the organisations in the ICS have already underway. For example, improvements to availability of shower facilities and increased cycle storage, as well as improving footpaths and lighting and introducing salary sacrifice schemes for cycle purchase or season tickets. Not only improving staff fitness but improving site emissions. SATH have, to date, 38 electronic vehicles on lease (another 19 on order) and 60 bicycle purchases via salary sacrifice.

Car sharing just once a week will help to reduce the amount of traffic on our roads, improve the local environment and our health. Similarly, walking once a week has obvious health benefits and helps to reduce the amount of traffic on our roads.

There are currently two Air Quality Management Areas (AQMAs) in the Shropshire Council area, in Shrewsbury and Bridgnorth, where action is required to address poor air quality. Traffic management measures and new infrastructure, together with support for a move to ULEV transport options are likely to result in a reduction of particles and other more harmful emissions

Telford & Wrekin Council are implementing discounts available from Arriva and West Midlands Trains to staff. Arriva also offers discount on monthly season tickets to NHS Staff

Staff commuting contributes to Trust Scope 3 emissions, therefore, any action taken now will begin to reduce our contributions.

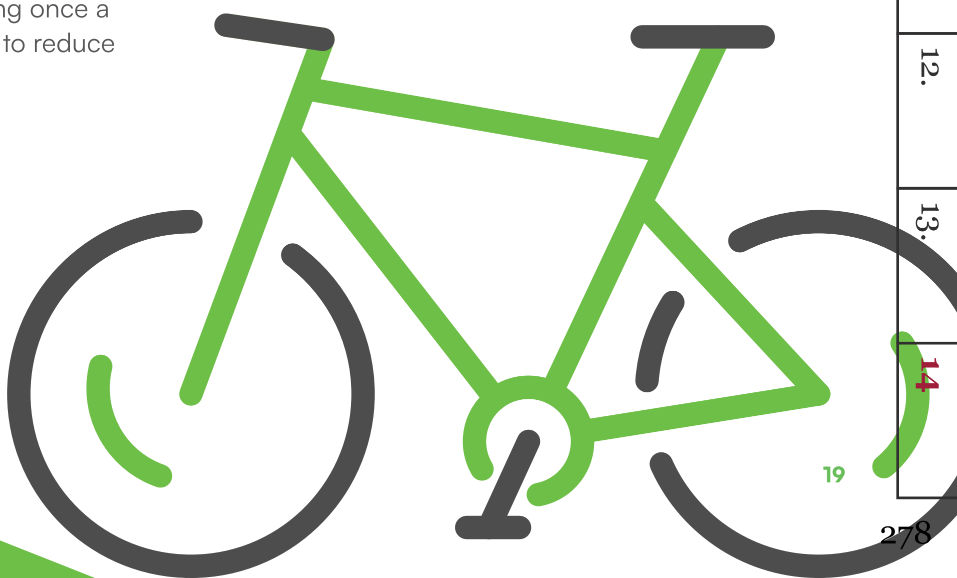
Currently SaTH have 60 bikes purchased under salary sacrifice, a bicycle user group and cycle champion promoting the service and benefits amongst staff.

Collaborative Opportunities

Develop a system-wide Green Travel Plan which will in turn influence organisations' Green Travel Plan — focusing active travel, business travel and grey fleet

Manage the combined Non-patient transport service contract (due to start Mar22)

Set up regular meeting between key staff from each stakeholder to share ideas, developments and successes.



Estates (Hard Facilities Management)

NHS England's guidance, **Estates 'Net Zero' Carbon Delivery Plan**, advises a four-step approach to decarbonising estates.

Taking this holistic approach will enable organisations in our system to make easier, quicker wins in the short term, gradually building to net zero. Our Estate has a significant role in reducing our Scope 1 emissions and organisations within our system have made huge progress with reducing our direct emissions burden by installing photovoltaic (PV) solar panels, replacing lighting for LEDs, replacing boilers and associated equipment with ultra-efficient alternatives, improving installation to buildings and pipework, and for indirect (scope 2) emissions, switched to REGO energy from the national grid (electricity supplied to the grid from renewable energy sources). We have achieved electrical savings of at least 1,066,000 kWh/annum through the installation of PV solar panels, protecting future finances from expected grid cost inflation and price rises from the supply crisis.

Some examples of the efforts so far include:

- The installation of photovoltaic (PV) solar panels to many buildings,
- Replacing boilers with ultra-efficient equipment; for example, RJAH have been able to reduce their gas consumption by up to 1.8mWh per year,
- Installing LED lights across multiple sites,
- Improving the insulation, or U-Value, of our buildings so that it takes less energy to reach required temperatures,
- All our organisations will purchase only renewable (REGO) electricity from the national grid by April 2022,
- Replacing antiquated Building Management Systems (BMS) with smarter controls

We're taking responsible measures to not only reduce our carbon emissions, but to realise financial benefits using the philosophy that less kWh used means less money spent - making every kilowatt count. We're also pro-actively accessing public grants and funding available such as the Public Sector Decarbonisation Scheme (PSDS); for example, Shropshire Council are implementing low carbon heating and lighting through this funding on one site to reduce energy use by over 65% and carbon emissions by 15 tonnes per year. Similarly, Telford and Wrekin Council are initiating an air source heat pump and thermal upgrade, saving 115 tonnes CO2e.

Our Estate has a significant role in reducing Scope 1 emissions

The four-step approach to decarbonise the NHS estate by 2040
(Source: Estates 'Net Zero' Carbon Delivery Plan, NHSEI)

Includes indicative numbers to illustrate the scale of the challenge to decarbonise the NHS estate by 2040. These are not actuals.

The above infographic, published in the NHSE 'Estates 'Net Zero' Carbon Delivery Plan, estimates that every £1 million invested across the NHS in the actions listed will deliver a 1.33ktCO2e saving per year. The cumulative capital costs of these investments would be offset by equal revenue savings over only 3.8 years. By generating a proportion of the energy we consume at our sites, we are protecting our finances against inflationary and market price rises of importable utilities. There is opportunity to collaborate on large scale projects between our organisations and a key action is to explore the development of a PV farm on Shropshire Council land near to RJAH.

There are other exciting and potentially ground-breaking opportunities for the system to adopt emerging technologies that could see a reduction of direct and indirect carbon emissions in the near-to-medium-term. We will explore these opportunities and some member organisations may lead case studies with a view to adapting infrastructure at other sites.

The NHS organisations in our system collectively consumed over 116,000,000 kWh

We intend to collaborate between our organisations at a local level; sharing building space, day services are being reviewed with view to offer building-based services to a wider group across all ages. This space utilisation will in some cases reduce the burden on capital budgets and have an impact on carbon output, as well as reducing our consumption of building products which further contribute to climate change.

The NHS organisations in our system collectively consumed over 116,000,000 kWh (NHSEI, 2021) in natural gas in the year 2020-21. These scope 1 emissions are a key challenge that we will aim to reduce over the next three years.

However, we are already mitigating and reducing our reliance on grid energy by utilising Combined Heating and Power (CHP) technology to use fossil fuels in the most ethical way:

- Approximately 13,800,000 kWh electrical generation from CHP across all NHS sites in the system
- Approximately 13,900,000 kWh thermal energy generation from CHP across all NHS sites in the system.
- Approximately 18,600,000 kWh grid energy consumed across all NHS sites in the system in 2020-21, but our organisations are transitioning to on-site generation. Some examples of this are:
  - RJAH generate around 440,000 kWh pa
  - Telford & Wrekin Council produce a combined 498,000 kWh from PV solar arrays across multiple sites
  - MPFT generate around 128,000 kWh pa

Source: NHSE ERIC Data Collection, 2021

Collaborative Opportunities
Share benefits of installation of EV charging points through joint tender exercises
Give early warning to peers on grants, loans and other schemes that may benefit our reduction of scope 1 emissions
Share benefits of adopting emerging technologies and offer unique access to case studies.
Explore feasibility of shared power generation and consumption from PV farms, district heat networks and other renewable technologies.

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Facilities (Soft Facilities Management)

In our current economy, we take materials from the Earth, make products from them, and eventually throw them away as waste — the process is linear. In a circular economy, by contrast, **we stop waste being produced in the first place.** The world's economy is only 9% circular. We must be bolder about saving resources.

LINEAR ECONOMY

TAKE MAKE DISPOSE

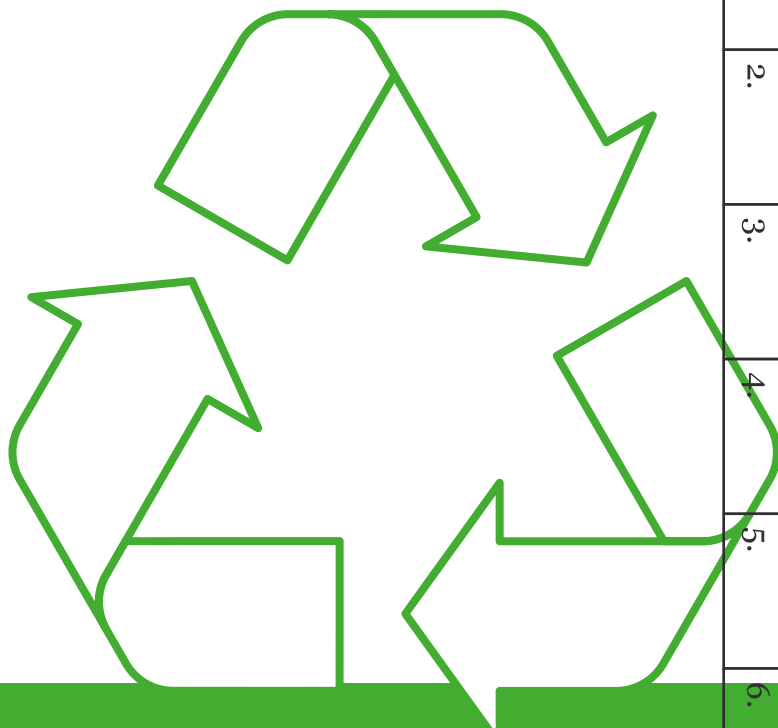
ENERGY FROM FINITE SOURCES

CIRCULAR ECONOMY

ENERGY FROM RENEWABLE SOURCES

As the area the sites depend on to maintain a pleasant, healthy and safe working environment are instrumental in the day-to-day operations it is a key priority that we work to reduce waste as well as air & water pollution to improve local environments.

WMAS have already made some major benefits from changing their cleaning to a single multi use, low packaging product as well as successfully piloting & beginning to roll out Domestic Waste recycling in its office locations. RJAH regularly divert 100% of domestic & clinical waste from landfill.



Waste

The management of healthcare waste is an essential part of ensuring that healthcare activities do not pose a risk or potential risk of infection and are securely managed. UK-wide guidance provides a framework for best practice waste management.

The management of waste in the NHS falls into 3 main categories:

Domestic — generated as a result of the ordinary day-to-day activities

Clinical (including sharps) — waste produced from healthcare that may pose a risk of infection, e.g. swabs, bandages, dressings; or may prove hazardous, for example medicines.

Offensive — non-infectious but may be unpleasant to anyone who encounters it e.g. nappies, feminine hygiene products, used but uncontaminated PPE.

WMAS has undertaken a survey for the implementation of recycling processes for the control and segregation of domestic waste. Following which they plan to introduce recycling at all sites across the Trust to fall in line with the successful introduction of Mixed Recycling at the Erdington Hub.

The initial trial of introducing Mixed Recycling at one of our major Hubs has resulted in the sites waste production being at 50% recycling, which is a 6,000kg saving in CO_2e,

MPFT no longer purchase single use plastic stirrers and straws and are looking into alternatives to single use plastics in catering & reduce use of cups, cutlery, gloves & aprons in other areas.

Collaborative Opportunities
Set up quarterly meeting between facilities managers from each stakeholder to share ideas, developments & successes.
Share ways to improve waste management practices & improve specifications for tendering
Develop or update organisations Food & Drink Strategy - starting with aims to improve staff & patient nutrition & hydration as well as ways to reduce carbon
Combined procurement for provision of food & drink & use of local supply chains
Combined procurement of environmentally friendly catering items (e.g. takeaway containers, cups & cutlery)

Upon renewal of MPFT waste contracts requirements will be reviewed to ensure more efficient recycling of waste & are investigating using re-usable sharps and pharmaceutical boxes/bins. As well as displaying “bring your own bottle” notices and the introduction of bespoke MPFT water bottles and reusable bamboo cups.

SATH, RJAH & SCHT utilize the same contracts meaning 98% of domestic waste is incinerated & converted into electricity for homes near the plant in Shrewsbury. Clinical & offensive waste is either safely processed & sent to energy recovery (by a third party) or burnt. SATH also use reusable sharps containers.

Medicines

Medicine optimisation as well as safe & effective use in health & social care can **contribute to Scope 3 emission reductions.**

Progress so far against key national targets:

Anaesthetic Gases

Measures already taken by all the ICS members have successfully eliminated the use of Desflurane.

Inhalers

Carbon emissions from inhalers have been assessed as responsible for approximately 3% of all NHS carbon emissions. The majority of emissions come from the propellant contained in pressurised metered dose inhalers (pMDIs). pMDIs contain propellants known as hydrofluorocarbons (HFCs), powerful greenhouse gases, which are used to deliver the medicine rather than the medicine itself.

Source: NHS England and NHS Improvement. Delivering a 'Net Zero' National Health Service. Published October 2020. & NICE. Inhalers for asthma (patient decision aid). Published 23 May 2019. Last updated 01 Sept 2020.

pMDIs account for 71.6% of all inhaler device types prescribed in England, 68.8% in Wales and 66.6% in Scotland Source - NHSBSA Apr-Jun 21.

The NHS England Long Term Plan published in January 2019, outlined the national targets of reducing the carbon footprint of health and social care in line with the Climate Change Act targets of 51% by 2025.

Many people will be able to achieve the same benefit from DPIs. DPIs have lower average estimated carbon footprints of 20 g CO2e per dose (two puffs) compared O2 to pMDIs which are estimated at 500 g CO2e per dose (two puffs).

The Shropshire, Telford and Wrekin Health Economy Formulary review is) already well underway updating the respiratory section to produce a green inhaler formulary to provide guidance to all prescribers and to support PCNs to deliver the IIF targets in a cost-effective manner. The draft formulary is currently with specialist consultation to ensure there are no clinical gaps before approval and launch.

There are key national targets which the ICS is working towards:

1. The IIF ES-01 has a target for pMDI prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October 2021 (range: 35% to 44%). This aims to reward increased prescribing of DPIs and SMIs where clinically appropriate with a target of 25% of non-salbutamol inhalers prescribed will be pMDIs by 2023/24.
2. The IIF ES-02 indicators has a target for the mean carbon emissions per salbutamol inhaler prescribed on or after 1 October 2021. This aims to reduce the mean propellant carbon intensity of salbutamol inhalers prescribed in England to 11.1 kg per salbutamol inhaler prescribed by 2023/24

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Shropshire, Telford and Wrekin Current Performance

Commissioner Benchmarking	Total Items	Carbon footprint per inhaler kgCO2e	Total carbon footprint gCO2e (K = thousands)	Carbon footprint per 1,000 patients gCO2e (K = thousands)
NHS Shropshire, Telford and Wrekin CCG	46,645	25.1	1,651,348K	3,177K

Currently STW CCG prescribes 55.66% on non-salbutamol inhalers as pMDI, ranking 57th/133 CCGs or health boards in England and Wales. Target is 25%

	pMDI (excluding salbutamol)		DPI & SM I (excluding salbutamol)		Grand Total
Commissioner Benchmarking	Total Items	% of Total Items	Total Items	% of total Items	Total Items
NHS Shropshire, Telford and Wrekin CCG	36,619	55.66%	29,177	44.34%	65,796

Source: Medicines Management, Shropshire, Telford and Wrekin CCG

Local Authority transport measures can influence air quality &Shropshire Council are acting to improve air quality through the air quality strategy and through reduction of emissions in the Local Transport Plan 4 **(https://shropshire.gov.uk/roads-and-highways/local-transport-plan-ltp4/)**. This can lead to reduction in the numbers of asthma cases diagnosed and to reduction in the number of asthma attacks.

Other actions in our progress include:

- Monitoring how local prescribing data on the inhaler carbon footprint compares to the national data using the PrescQIPP inhaler carbon footprint data tool and visual data pack to and identify where local improvements can be made to ensure timely progress is being made.
- Optimising prescribing to improve both patient outcomes and reduce carbon impact of inhaler choices by;
  - Reviewing patients regularly; demonstrating, checking and improving inhaler technique.
  - Discussing lower carbon footprint inhalers during reviews or when a change in treatment is clinically necessary.
  - Ensuring newly initiated treatments have a low carbon impact and switching existing therapies to lower carbon impact options where clinically appropriate
  - Reducing SABA overuse and increasing the percentage of patients on the Quality and Outcomes Framework (QOF) Asthma Register who were regularly prescribed an inhaled corticosteroid over the previous 12 months (target for IIF RESP-01 indicator in PCN DES is range 71% to 90%)
- Increase use of leukotriene receptor antagonists where clinically appropriate
- Wherever possible use combination inhalers for patients on dual or triple inhaled therapy.

Support prescribers through education in lowering inhaler carbon footprint, sharing data, reviewing respiratory prescribing guidelines to include lower carbon footprint inhalers, and how to optimise prescribing ensuring lower carbon footprint inhaler options are included in medicines formularies and ensure stock availability with suppliers.

Reduce waste through encouraging patients to; return their used or unwanted inhalers to a pharmacy (for either recycling where available, or environmentally safe disposal); to look after their inhalers and not over-order & increasing the use of re-usable inhalers.

Other opportunities for medicine optimisation include reductions in Polypharmacy (most defined as the use of five or more medications daily by an individual) could decrease the risk of avoidable hospital admissions.

Avoidable medicines-related admissions to hospitals may equate to nearly 2 million bed days in England per year *(Source: Environmental impact report: Medicines optimisation Implementing the NICE guideline on medicines optimisation (NG5)*

We also need to begin to discuss with suppliers to assess and reduce blister pack carbon footprint and recycling opportunities. For example, the Association of the British Pharmaceutical Industry tool can be used to provide a quick approximation of the carbon impacts

www.abpi.org.uk/r-d-manufacturing/abpi-blister-pack-carbon-footprint-tool

Avoidable medicines-related admissions to hospitals may equate to nearly 2 million bed days in England per year

Supply Chain & Procurement

Over 60% of the total NHS Carbon Footprint sits within the supply chain, therefore, **suppliers and procurement will play a pivotal role** in reducing our emissions.

To ensure a better quality of life now and for future generations, we need to look seriously at the way we use the earth's resources, operate our businesses and live our lives. A sustainable approach recognises the broader impacts of our actions and aims to minimise any adverse effects.

Sustainable procurement requires taking environmental and social factors into account in purchasing decisions. For example, looking at what products are made of, where they come from, and who has made them and, therefore, minimising the environmental and social impacts of the purchases we make.

MPFT are looking to increase sustainable procurement principles within their procurement, collaborating with other NHS Trusts and other organisations to improve knowledge and understanding of sustainable procurement and to seek shared opportunities and benefits, consolidate orders to reduce deliveries, improve stock rotation to avoid product expiry.

Collaborative Opportunities
Set up quarterly meeting between procurement team members from each stakeholder to share ideas, developments and successes
Develop ICS Procurement Workplan for projects which would benefit from joint working
Engage and work with local suppliers, where possible within current rules, to reduce delivery miles

In January 2020, a Greener NHS which sets out a path to a 'net zero' NHS and as a result the below targets have been set:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

We must demonstrate leadership in sustainable procurement and will work with our supply chains to achieve this by addressing specific aspects of sustainable procurement such as:

- Reducing fossil fuel usage to minimise climate change
- Reducing usage of hazardous materials
- Reducing waste
- Ensuring fair pay and working conditions through the supply chain
- Reducing use of transport
- Reducing the use of Single Use Plastics
- Move to working with suppliers to minimise packaging, use reusable containers for deliveries and manufacture using renewable energy

A more sustainable product can be described as:

- Fit for purpose and providing value for money
- Energy and resource efficient
- Reusable and recyclable or durable, easily repairable or upgraded
- Ethically sourced (i.e. Wasn't made in a socially irresponsible way)
- Doesn't deplete natural, non-renewable resources
- The production, distribution, and/or consumption uses as little energy as possible and minimizes/responsibly disposes of waste.

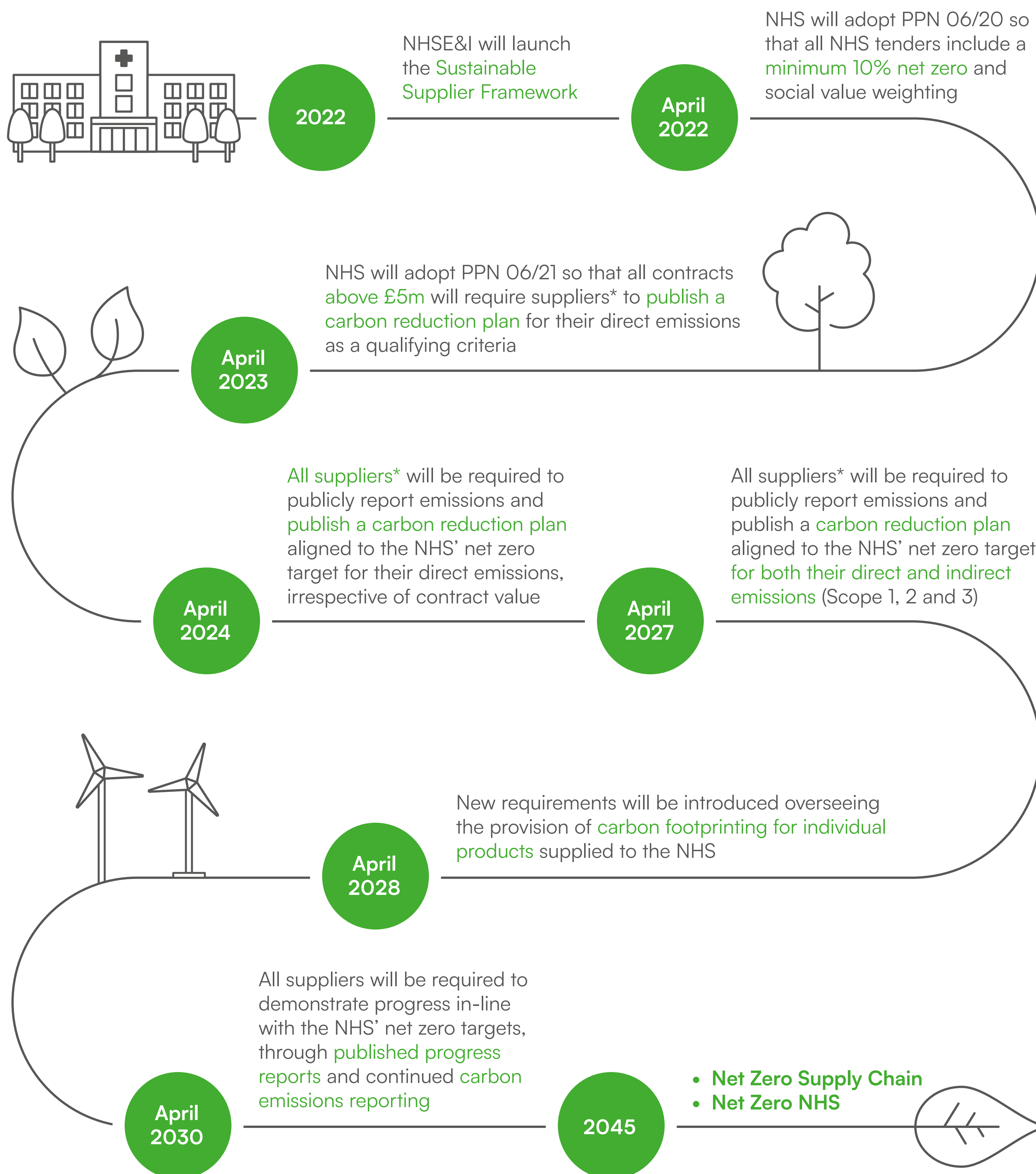
The benefits of moving to an ICS model

The shift to the ICS way of working will provide the foundation for scale procurement across the NHS with significant monetary and non-monetary benefits, achieved through unlocking efficiences and improving operational performance across the system.

Benefit	Description
Improved resilience	C-19 taught us that working together is essential to mitigate risk. Working together across the ICS and at greater scale (where appropriate) provides greater protection from supply failures, price increases and quality defects
Reduced total cost	The ICS represents a publicised and policy driven way of driving 'at scale' procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and reduced repetition
Greater value	The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients
Better supplier management	Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories
Optimised workforce	The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access morediverse roles across the system
Improved capability	Working together frees up capacity to give us time to develop and leverage specific skills and expertise
Great careers	ICS provides a great platform for career growth with a more diverse set of challenges and opportunities across the commercial life cycle.
Empowered culture	The ICS provides an opportunity to fundamentally change and shape the way we work across the system and into the future

Source: NHSEI Commercial Directorate procurement Target Operating Model "ICS Based Procurement Guidance" January 2021 https://future.nhs.uk/PTOMHub/view?objectId=122643621

Building Net Zero into NHS procurement



*To account for the specific barriers that Small & Medium Enterprises and Voluntary, Community & Social Enterprises encounter, a two-year grace period on the requirements leading up to the 2030 deadline, by which point we expect all suppliers to have matched or exceeded our ambition for net zero.

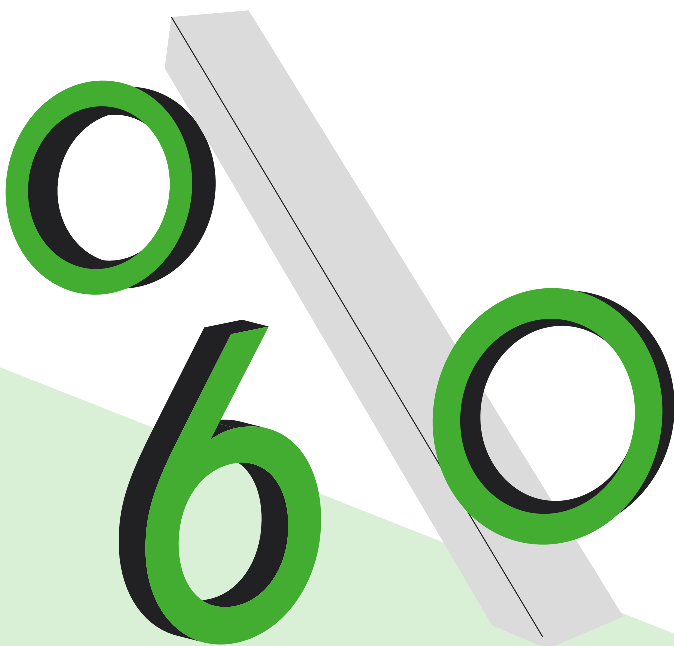
Source: www.england.nhs.uk/wp-content/uploads/2021/09/item4-delivering-net-zero-nhs-updated.pdf page 7

Food & Nutrition

"It is estimated that food and catering services in the NHS accounts for approximately **6% the NHS' Carbon Footprint Plus**" — *Source NHS England Greener NHS website*

Members need to consider ways to reduce the carbon emissions from the food made, processed and served within our organisations. Members currently have various solutions, but it is essential work on reducing overall food waste and ensuring provision of healthier and seasonal menus. Making menus seasonal and adaptable can save money as buying items in season is more cost effective.

Challenging the amount of food waste and reducing the carbon emissions of the food consumed as well as changing to healthier items can have a large impact.



Collaborative Opportunities
Set up quarterly meeting between catering staff and dieticians from each stakeholder to share ideas, developments and successes
Look to award joint contracts to enable utilisation of fresh food sourced locally, where applicable
Share strategies to minimise food waste
ICS members to join the Shropshire Good Food Partnership and Marches good food group

MPFT have a 4 year plan to provide healthier eating for whole hospital community, achieve Soil Association Food for Life Catering MARC - bronze standard, introduce on the day ordering to reduce waste. Food provided in in-patient wards will be purchased and produced in sustainable way. As well as looking to re- instating greenhouse and plots to grow in hospital gardens/health centres, community outside space etc.

Shropshire Good Food Partnership are working across Shropshire taking a food systems approach to improve sustainability, amongst other objectives, in the local food system. Engagement by ICS partners with the local food system is an opportunity to reduce food miles and to engage with producers who are using sustainable forms of food production.

Food production is responsible for one-quarter of the world's greenhouse gas emissions.

UK Agriculture contributed 10 per cent to total greenhouse gas emissions in 2018, including 70% of nitrous oxide emissions, (generated by synthetic fertilizer use), and nearly half of total methane emissions.

Greenhouse gas emissions across the food supply chain:

Land Use Change

Aboveground changes in biomass from deforestation, and belowground changes in soil carbon

Farm

Methane emissions from cows, methane from rice, emissions from fertilisers, manure, and farm machinery

Animal Feed

On-farm emissions from crop production and its processing into feed for livestock

Processing

Emissions from energy use in the process of converting raw agricultural products into final food items.

Transport

Emissions from energy use in the transport of food items in-country and internationally

Retail

Emissions from energy use in refrigeration and other retail processes

Packaging

Emissions from the production of packaging materials, material transport and end-of-life disposal

Source: https://ourworldindata.org/food-choice-vs-eating-local

It is also important to utilize each patient contact to promote healthy and sustainable lives, inc. diet and exercise options.

Biodiversity

Biological diversity, or biodiversity can be described as "**the variety of life on Earth**, it includes all organisms, species, and populations; the genetic variation among these; and their complex assemblages of communities and ecosystems." (Benn, 2010)

Biodiversity is incredibly important for sustaining life on the planet; the interdependency we have with the species of flora, fauna, animals, birds, insects and micro-organisms is vital in sustaining our existence through absorbing carbon and regulating environmental change such as climate and disease, providing renewable sustenance at all levels of the food chain, and balancing species population.

It is important, then, that the activities we carry out in providing the services we are commissioned to deliver do not negatively impact our local, national and worldwide ecosystems.

What are we doing to sustain biodiversity?

There are great examples of encouraging biodiversity in our Integrated Care System. SaTH are collaborating with local beekeepers to provide hives at the Shrewsbury site, as well as bat boxes and Swift boxes to divert such creatures away from buildings whilst providing space for them to live, in addition to planted trees and improved gardens and courtyards with native plants to attract pollinators. RJAH are planting 100 trees across the site around the Captain Sir Tom Moore Path of Positivity, an area for patients (including those bed-bound) and staff to enjoy the local wildlife.

In 2021, TWC gave away 14,525 free trees to residents and organisations in Telford and Wrekin as part of our Trees4TW project.

Collaborative Opportunities
Share funding models / share information on available grants for investment in surveys introduction of habitats
Work together develop or update organisations ICS Green Space Strategy

What will we do now?

Look to ensure any impact of development is replaced e.g. trees, wild areas or hedges removed are replaced nearby.

As discussed in Digital Transformation, by adopting Ecosia as our default search engine, we are indirectly contributing the planting of trees and in turn promoting biodiverse habitats in areas outside of Shropshire, Telford and Wrekin.

We will ensure that the local habitats of our native species are considered during capital works to ensure that any works we complete have a positive impact on local wildlife.

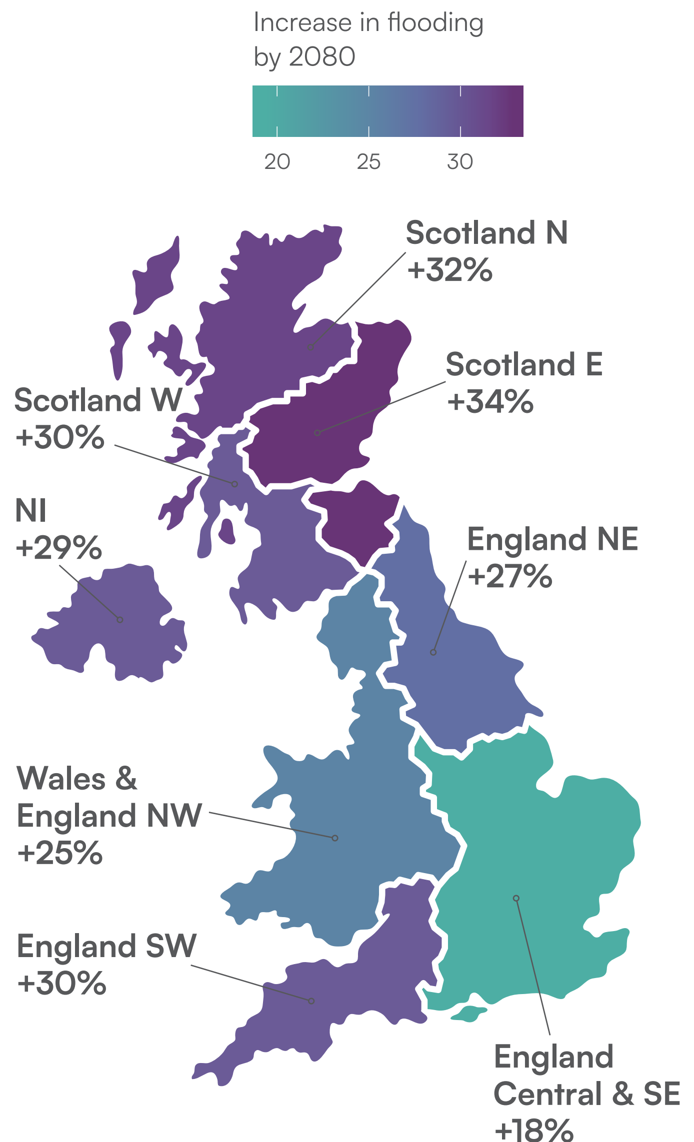
We will adopt methods already employed by some organisations in the system to provide beehives, bat and swift boxes where appropriate and plant trees and plant species in our green spaces.

Adaptation

The care we provide must be **consistent throughout major incidents** such as wildfires, floods, heatwaves, droughts and infectious diseases.

Sustained extremes in weather and climate are likely to become the status quo in the UK, and varied sources and data indicate that:

- Wildfires are likely to increase 14% by 2030, 30% by the end of 2050 and 50% by the end of the century (UNEP, 20
- Flooding will increase by 15-35% by 2080, with Shropshire, Telford and Wrekin likely to experience an increase of around 25% (figure, left) (Visser-Quinn, 2021)
- Heatwave frequency, length and average temperatures are significantly increasing -their average length more than doubling — increasing from 5.3 days in 1961-90 to over 13 days in the decade 2008-2017 (Met Office, 2018)
- Sustained droughts are more common. From September 2010 to March 2012 many parts of England experienced the driest 18 months for over 100 years (Environment Agency, 2017)
- The emergence of SARS-CoV-2 and subsequent Covid-19 crisis in 2020 set a precedent for future outbreaks and how the country will address subsequent variants and other pandemics.



Source: Heriot-Watt University

Although it is unrealistic to expect a service to continue in the event of localised flooding or incidents that incapacitate certain service delivery for some organisations, there may be opportunity to provide contingency, support or mutual aid from the wider system. Preparedness for infectious disease outbreaks is not covered in detail this document, although it is recommended that there be a systematic approach to building resilience to future pandemics and infectious disease outbreaks - for example, the mutual aid between NHS organisations in the system during the Covid-19 pandemic.

How we adapt now to the climate crisis will have significant influence on the investments required later, so it would be prudent to intervene at an early stage. The Department of Health publication for resilience in estate planning (HBN 00-07) offers guidance and all our NHS organisations should adopt this approach when producing Estates Plans. Some of the guidance is transferrable for council estates planning, and other documents such as the CIBSE guidance suite is relevant and applicable.

Collaborative Opportunities
Shared working spaces and agile (hybrid) working to generate carbon and climate resilience benefits
Mutual aid
A co-ordinated Clinical Strategy
A co-ordinated Estates Strategy

Action Plan

The action plan developed below outlines **collective goals** not only at system level, but at organisation level with the support from the ICS.

The target dates and completion of the actions will be monitored by the ICS Climate Change Working Group and assurances/escalations will be provided to ICS Board. Executive leads are to be agreed for each area over the next 12 months.

Leadership & Workforce

Action	What resource is needed?	How will we measure our progress?	Target date
Explore options for a Sustainability Lead for the ICS	1 WTE to be banded	Once postholder is in role	April 2022
Establish a baseline carbon footprint	Funds for external consultancy to deliver	System-wide carbon footprint figure	March 2023
Make carbon literacy training available for senior leaders, expecting at least one from each organisation to have completed by April 2023	Funds for training provider to deliver training	Once one senior leader from each organisation has completed the training	April 2023
Green Plan to be reviewed and actions measured within 12 months, with a view to amend accordingly	Central co-ordination/Climate Change Working Group to review	Updated version of Green Plan to be published April 2023	April 2023
Develop benchmarks on system performance to demonstrate assurance and/or areas for further development	Central co-ordination/Climate Change Working Group to review	Quarterly benchmark reporting to Climate Change Working Group	October 2022
Ensure that sustainability behaviours are considered when reviewing job descriptions	Communications and engagement with human resources/people services	Job descriptions updated to include sustainability behaviours	April 2023

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Sustainable Models of Care

Action	What resource is needed?	How will we measure our progress?	Target Date
Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely	ICT equipment and training, engagement with clinical teams	All outpatients services delivering ≥25% of activity	April 2023

Digital Transformation

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations encouraged to adopt Ecosia as their default internet search engine	Engagement with IT departments to add Ecosia as an extension to MS Edge	IT departments to provide collective data (against UCLH data benchmark)	October 2022
Promote the option of agile (hybrid) working where there is no negative impact on service delivery	Engagement with IT departments, it is anticipated that no significant extra equipment be required as those that could work from home did so during the covid-19 crisis and were provided with equipment then	IT departments to provide collective data (against benchmarks during covid-19 crisis)	April 2023

Travel & Transport

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations will need to identify a named individual who will complete and submit the return NHSEI Greener Fleet Data Collection tool	Time and named individual	Successful and routine return of data to NHSEI	April 2022
ICS to develop a system Green Travel Plan, ensuring a hierarchy of travel starting with active travel	Central co-ordination, climate change working group for peer support	Document to be published April 2023	April 2023
Ensure that, for new (fleet) purchases and (fleet) lease arrangements, the system (and organisations) solely purchases and leases cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs)	It is anticipated that this transition will occur when existing contracts are renewed, so those organisations still in contract by April 2023 will aim to move to ULEVs/ZEVs once those contracts end. Electric Vehicle (EV) charging infrastructure will be required at base sites	All contracts transitioned at their end	April 2023

Estates

Action	What resource is needed?	How will we measure our progress?	Target Date
NHS Organisations to ensure they procure only REGO energy from grid as soon as their existing contracts allow	Small cost pressures to utilities (typically less than £2/mWh additional)	All organisations to confirm at Climate Change Working Group	April 2022
Organisations to commit to invest in on-site renewable energy, insulation, and energy efficient technologies (such as LED lights) as part of their Estates Strategies	Capital commitment during schemes, although there would be an expectation of ROI	Sustainable technologies specified in all organisations' Estates Strategies	April 2025
Where possible, invest in emerging renewable technologies	Capital investment where there is attractive ROI	Successful completion of projects	April 2025
As a minimum, adopt BREEAM as a benchmark for constructing sustainable buildings, with a shared design benchmark to follow on from the work from Shropshire Council	Could be absorbed in capital projects	Successful BREEAM validation on capital projects	April 2023
Develop a heat decarbonisation plan for the system	External consultancy and central co-ordination, climate change working group for peer support	Document to be published October 2023	October 2023
Replace any habitat removed during developments	Could be absorbed in capital projects	External verification	April 2023

Facilities

Action	What resource is needed?	How will we measure our progress?	Target Date
Explore options to appoint a system waste manager	1 WTE to be banded	Once postholder is in role	October 2022
Organisations to assess waste management practices against better-performing peers and adopt where reasonably practicable (i.e. segregation)	System Waste Manager to co-ordinate	Quarterly benchmarking to climate change working group	April 2023
Organisations to aim to divert 100% household waste from landfill	Review contracts and amend when renewing, where applicable	Quarterly benchmarking to climate change working group	April 2023
Organisations to sign up to the single use plastic pledge (catering)	Cost pressure to some catering budgets — opportunities to collaborate on procurement	All organisations to confirm through the climate change working group	April 2023

Facilities (continued)

Action	What resource is needed?	How will we measure our progress?	Target Date
Reduce food waste through smarter working (i.e. patient ordering strategies, management of stock, etc)	Could be pursued through existing catering structures	Quarterly benchmarking to climate change working group	April 2024
Adopt, where clinically safe to do so, environmentally friendly domestic cleaning chemicals	Could be pursued through existing procurement structures	Organisations to report through climate change working group	April 2023

Medicines

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to encourage use of low-carbon alternatives to inhalers and similar environmentally harmful medicines (where it is clinically safe to do so)	Continue specialist consultation before launch of green inhaler formulary	All organisations to confirm via the climate change working group	April 2023
Organisations to consult with their clinicians to agree alternatives to environmentally harmful anaesthetic gases such as Sevoflurane, Isoflurane and Nitrous Oxide	Engagement clinicians and Medicines Managements teams	All organisations to confirm via the climate change working group	April 2024

Supply Chain & Procurement

Action	What resource is needed?	How will we measure our progress?	Target Date
Adopt PPN 06/20 so that all NHS tenders include a minimum 10% net zero and social value weighting on contracts >£5m per annum	Add to pre market engagement process	An NHS wide TOMs (Themes, Outcomes and Measures) reporting portal is being developed	April 2022
Procurement staff to complete training on Social Value in tenders	Staff time, although free training available via: **www.govcommercialcollege.co.uk**	Staff appraisals	December 2022
Ensure process/contract for reuse of Walking Aids is in place	Introduction of process and minimal ongoing staff resource to prepare for reissue	Reduction in expenditure	March 2023
Ensure reusable surgical instruments have been investigated and implemented as appropriate	Validating and introducing process by clinicians / H&S	Reduction on expenditure	March 2023
Review procurement procedures to embed awareness of sustainable in procurement processes	Amend with regular reviews	Processes embedded	December 2023

Supply Chain & Procurement (continued)

Action	What resource is needed?	How will we measure our progress?	Target Date
Ensure the whole life cycle impacts of the procurement	Include in pricing exercise and evaluation	Expenditure better managed	December 2023
Begin to communicate NHS Net Zero targets for Scope 3	Carry out via contract management	Awareness improved	March 2024
Promote the value of human rights and equality within our supply chain	Carry out via contract management	Awareness improved	March 2024
All suppliers will be required to publicly report emissions and publish a Carbon Reduction Plan for their direct emissions and social value included in the evaluation and award, irrespective of contract value. *SME and Voluntary Sector have a 2-year grace period to adhere to this	National requirements	Awareness improved	April 2024

Food & Nutrition

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to expand plant-based menu options, reduce meat-based menu options and hold 'meat-free' days regularly	Amend menus, there may be a need for new suppliers/ contracts	Use of meat-based items	April 2023
Organisations to employ seasonal menus to enable provision of fresh food sourced locally	Amend menus, may be a need for new suppliers/contracts	Use of more fresh produce	April 2023
Organisations to attain sustainable catering accreditation (i.e. Soil Association Food for Life Catering MARC)	Tie commitment and small cost pressure for validations, in house awareness and inspection	MARC Accreditation	April 2025
Organisations to develop a strategy to minimise food waste	Co-ordination and peer review via climate change working group	Quarterly benchmarking to climate change working group	April 2024

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Biodiversity

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to consider the impact of capital estates projects on local wildlife and ensure neutral or positive impact by developing green spaces in proximity to the works	Could be absorbed in capital projects	External verification	April 2023
Organisations to 'rewild' green spaces by planting diverse range of trees and plant species	External funding, for example the Queen's Green Canopy	Organisations to report via climate change working group	April 2025
Develop an ICS Green Space Strategy	Central co-ordination/ Climate Change Working Group to review	Document to be published September 2023	September 2023

Adaptation

Action	What resource is needed?	How will we measure our progress?	Target Date
Ensure our NHS organisations consider HBN 00-07 when developing Estates' Strategies	Engagement with Estates teams	HBN 00-07 to be specified in Estates strategies	April 2023
Organisations to ensure contingency plans are in place in the event of adverse weather and major incidents to provide business continuity, staff and patient safety and care provision	Engagement with whole organisations to ensure comprehensive and joined-up approach	Organisations to escalate concerns via climate change working group	April 2022

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Acronyms

Acronym	Definition
CO2e	CO2e accounts for carbon dioxide and other gases such as methane and nitrous oxide
DPI	Dry Powder Inhaler
EPR	Electronic Patient Records
GHG	Greenhouse Gases
ICB	Integrated Care Board
ICS	Integrated Care System
MPFT	Midlands Partnership NHS Foundation Trust
MS	Microsoft
NICE	National Institute for Clinical Excellence
pMDIs	Pressurised Metered Dose Inhalers
PV	PhotoVoltaic (Solar panels that convert the Sun's energy into useful electrical power)
QIPP	Quality, Innovation, Productivity and Prevention
REGO	Renewable Energy Guarantees of Origin
RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ROI	Return on Investment
SATH	The Shrewsbury & Telford Hospital
SC	Shropshire Council
SCHT	Shropshire Community Health NHS Trust
SM	Salmeterol
STW CCG	Shropshire, Telford & Wrekin Clinical Commissioning Group
TW	Telford & Wrekin Council
WMS	West Midlands Ambulance Service

Further Information

If you have a general enquiry about Shropshire, Telford & Wrekin Integrated Care System(ICS), please email **stw.stp@nhs.net**

Visit us online **www.stwics.org.uk**

Our partnership is made up of the following organisations: