The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 25.11.2021

MEETING
25 November 2021 11:00

PUBLISHED
24 November 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	25/11/21		11:00

Item	Owner	Time
1. Part One - Public Meeting		
1.1. Declarations of Interest	Chair	
1.2. Minutes of the Previous Meeting (September 2021)	Chair	11:00
1.3. Matters Arising	Chair	
2. Presentations		
2.1. Path of Positivity Presentation	Chief Performance, Improvement and OD Officer cer	11:05
2.2. National Patient Safety Strategy Presentation	Chief Medical Officer	11:15
3. Chief Executive Update (verbal)	Chief Executive	11:25
3.1. Virtual Visit Letters		
4. Quality & Safety		
4.1. Chair Report: Quality and Safety Committee (verbal)	Non Executive Director	11:35
4.2. Patient Experience Strategy	Chief Nurse and Patient Safety Officer	11:40
4.3. Learning from Deaths Quaterly Report	Chief Medical Officer	11:50
4.4. Infection Control Quaterly Report	Chief Nurse and Patient Experience Officer	11:55

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Location	*Date*	*Owner*	*Time*
Teams	25/11/21		11:00

Item	Owner	Time
5. People Update		
5.1. Chair Report: People Committee	Non Executive Director	12:00
5.2. Equality and Diversity Annual Report and Workforce Report	Chief of People Officer	12:05
6. BREAK		12:15
7. Performance & Governance		
7.1. Chair Report: Finance, Planning and Digital Committee (verbal)	Non Executive Director	12:25
7.2. H2 Plan (verbal)	Chief Performance, Improvement and OD Officer	12:30
7.3. Performance Report (M7)	Chief Performance, Improvement and OD Officer	12:35
7.4. CQC Update (verbal)	Trust Secretary/Chief Nurse and Patient Safety Officer	12:45
7.5. Board Assurance Framework	Trust Secretary	12:50
7.6. Board Programme 2022/23	Trust Secretary	12:55
7.7. Questions from the Governors	Trust Secretary	

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Location	*Date*	*Owner*	*Time*
Teams	25/11/21		11:00

Item	Owner	Time
8. Policies		
8.1. Matters Reserved for the Board	Trust Secretary	13:00
8.2. Policy Framework	Trust Secretary	13:05
9. Items from October:		13:10
9.1. Performance Report (Month 6)		
9.2. Chair Report: Quality and Safety Committee	Non Executive Director	
9.2.1. Patient Experience and Complaint Annual Report	Chief Nurse and Patient Safety Officer	
9.2.2. Health and Safety Annual Report	Chief Nurse and Patient Safety Officer	
9.3. Chair Report: People Committee	Non Executive Director	
10. Any Other Business	All	13:25
10.1. Questions from the Public		
11. Next meeting: 27th January 2021		

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC BOARD

23 SEPTEMBER 2021

MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Stacey-Lea Keegan	Interim Chief Executive Officer	SK
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer	SEA
Craig Macbeth	Chief of Finance and Planning Officer	CM
Ruth Longfellow	Chief Medical Officer	RL
Kerry Robinson	Chief of Improvement, Performance and OD Officer	KR
Harry Turner	Non-Executive Director	HT
Rachel Hopwood	Non-Executive Director	RH
Paul Kingston	Non-Executive Director	PK
Chris Beacock	Non-Executive Director	CB
David Gilburt	Non-Executive Director	DG
Alison Tumilty	Non-Executive Director	AT

In Attendance

Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Chief of People	SS
Greg Moores	Interim Director of People	GM
Hilary Pepler	Trust Board Advisor	HP
Nia Jones	Managing Director for Specialist Service Unit	NJ
Alyson Jordan	Managing Director for Support Services Unit	AJ
Jo Banks	Managing Director for MSK Unit	JB
Dawn Forrest	Managing Director for Clinical Support Unit	DF
Prasanth Kandepalli	SAS Doctor	PKa

Governors in Attendance

William Greenwood	Governor	WG
Russell Lucock	Governor	RLu
Kartina Morphet	Governor	KM
Colin Chapman	Governor	CC
Jan Greasley	Governor	JG
Phil White	Governor	PW

FC welcomed everyone to the meeting and in particular Alison Tumilty, Non-Executive Director who joined the Trust in September 2021.

MINUTE NO	TITLE
23/09/1.0	**APOLOGIES** All members of the meeting were present.
23/09/2.0	**MINUTES OF PREVIOUS MEETING** The minutes of the previous meeting were accepted and approved as an accurate record of the meeting.
23/09/3.0	**MATTERS ARISING** None
23/09/4.0	**DECLARATIONS OF INTEREST** HT informed the Board that the merge of two organisation has been completed and is now the Midlands Hospice Partnership. FC congratulated HT on the merger.
	PRESENTATIONS
23/09/5.0	**PATIENT STORY**

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	SEA introduced this months' patient story. SEA explained that Marcus has been a patient under the care of MCSI for many years following major trauma. He is a member of the patient panel as well as a member of the accessible care standards group. The video is a description of his journey at the Trust. A summary of the video included: • In July 2002 Marcus was in a motorcycle accident and airlifted to Stoke Hospital • Following surgery, Marcus was transferred to Wrekin Ward on MCSI - the staff were marvellous • Marcus underwent further surgery at the Trust which made a big difference to his ability to use a wheelchair • Marcus spent 8months at the Trust on Gladstone Ward which he enjoyed • Staff ago above and beyond their role to support and care for the patients • The outpatient's care has been supportive and Marcus hasn't been admitted to the RJAH since being discharged • 'If it wasn't for the people at the hospital, I wouldn't be where I am today' *Marcus* SEA noted it was pleasing to hear about the staff making a difference to Marcus on his rehab care. It's an invaluable and a powerful story. On behalf of the Board, FC asked for thanks to be shared with Marcus and encouraged the members of meeting to reflect upon his story. It was agreed the video can be shared with the MCSI staff for information. SK added that it was great to see Marcus being involved in the patient panel and influencing care which the Trust thank him for.
23/09/6.0	**STAFF STORY – ROLE OF SAS DOCTORS** RL introduced PKa to the Board and thanked him for taking the time to share his story with the public. RL explained that PKa has worked at the Trust for 12 years and is an essential member of the staff, he joined the meeting to speak about the role of a specialist doctor and the importance of the job role, not only in the Trust but in the wider NHS. The highlights from the presentation included: • SAS - Staff grade, Associate specialist and Specialty doctors • At least four years of postgraduate training - two of which are in a relevant specialty • Diverse group with individual and often highly specialised skills • Essential part of the medical workforce • Focus predominantly on providing direct patient care and less on the non-clinical responsibilities • Teaching, service development, research, management, and leadership • Historically SAS doctors' role and expertise have been under recognised and undervalued, however the Trust has been helpful in supporting our training and Continuous professional development needs • The Trust contracts of employment have adhered to national terms • The Trust continues to support the professional activities by allocating session for audit education, appraisal, and teaching. • Our role is acknowledged and respected by all colleagues in the organisation • There is an on-call rota at RJAH Orthopaedic Hospital Foundation Trust FC thanked PKa for the excellent and relevant insight of the SAS doctor which included an oversight of the skills and competency doctors bring to clinical care. FC thanked PKa for reminding the Board of a great firm.

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	CB echoed the comments of FC and noted the crucial role for the NHS. CB continued to explain that the NHS would collapse without this role and therefore it has been great to hear how much PKa enjoys working at the Trust. It is important to support the workforce as a happy workforce, is a productive workforce. Similarly, RL thanked PKa for the presentation and asked him to share thanks and appreciation to all colleagues on behalf of the Board. FC added that the Trust are delighted PKa is part of the team. The role of the SAS doctor is recognised along with PKa essential contribution to the delivery of care within the Trust and NHS. PK thanked the Board for the continued support and noted his gratitude to RJAH.
	CHIEF EXECUTIVE UPDATE
23/09/7.0	**CHIEF EXECUTIVE UPDATE** SK provided an update to the Board which included the following: • **100 years** – The Trust marked the 100 years of being on the Gobowen site. A ceremony burial of the time capsule was arranged by the League of Friends. • **Celebration of Achievement Awards** – the shortlisted nominees will be shared soon. SK encouraged members of the meeting to vote for the Patient Choice Award and Staff team/Individual awards. • **Royal Garden Party** – the Trust nominated three members of staff to celebrate the NHS 73rd Birthday celebrations which took place at Buckingham Palace Gardens and was hosted by the Duke of Cambridge. • **Appointments** – welcome to Professor Martyn Snow, Consultant Orthopaedic Surgeon who has been recruited as part of a joint appointment with Keele University. • **Nursing Associates** – welcome to the first cohort of 11 trainees. The Trust is working closely with Staffordshire University. • **Partnership working** – the physio department continue to work closely with SaTH and ShropComm on a rotational post for patient pathways. • **Para-Olympics** – congratulations to the men's wheelchair rugby team who won gold against USA. 4 members of the team have been patients at the RJAH. • **Health Hero Winner (August)** – Meryl Owen, Healthcare Assistant has been commended for support in research and for going above and beyond supporting colleagues • **Health Hero Winner (September)** - Tracey Edwards, housekeeper has been recognised for going above and beyond her role, supporting the covid centre and uniforms outside of her usual role. FC thanked SK for the update and congratulated the rugby team, noting the fantastic achievement. FC quired whether the vaccination hub had commenced the delivery of the booster jab, to which SEA confirmed yes, alongside the Flu jab. There will be information circulated via the communications teams.
	QUALITY AND SAFETY
23/09/8.0	**CHAIR'S ASSURANCE REPORT QUALITY AND SAFETY COMMITTEE** CB presented the Quality and Safety Assurance Report and highlighted the following: • The meeting was well attended and quorate • The Committee received an update on the MRSA action plan, pressure ulcer action plan and report (which included audits) • Received and discussed the infection control annual report.

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	Further assurance is to be sought to ensure that staff members are provided with adequate training and support to respond to distressed patients who seek advice from the Trust. It was noted that there are a considerable number of patients contacting the Trust in a distressed manner due to the current situation with long waiting lists. The Trust needs to understand the scale of the potential problem and therefore have asked for an update in the October meeting. It was noted that there is overlap with this agenda item as it also aligns to the People Committee and therefore this will be jointly monitored and progressed by the Chairs of both meetings. FC thanked CB for highlighting the issue and sharing the positive diagram of the Committees. The Trust continue to work hard to ensure oversight across the Board and eliminate the risk of missing information across the assurance Committees. SEA echoed CB comments and explained there are an increased number of phone calls, the safeguarding team are supporting staff with the difficult and challenging conversations. FC added that the initial communication and ensuring the telephone is answered is an important first step in the assurance programme. The Board noted the report.
23/09/9.0	**INFECTION CONTROL ANNUAL REPORT 2020/21** SEA presented the report which provides an overview of the work completed within the last year, this included the progress on the plans and highlighting the key achievements and success. The report is structure against the 10 criteria hygienic code, which provides evidence of compliance and assurance to the Board. SEA highlighted the following: • Prevention and Control of Covid-19, with small number of outbreaks, intervention map outlined within the report - page 9 • Continued compliance with 0 MRSA bacteraemia for the 15th year • 0 cases of c diff • A reduction in hospital acquired infections by 33% - the reduction in activity was acknowledged • 83% uptake for the flu jab which saw an increase from 66% from previous years • Full site environmental IPC audits undertaken by IPC team – actions outlined, quality management system, escalation process in place which will support assurance • Describes the challenges faced with the year due to Covid-19 • Highlights close working between the IPC, estates, and facilities teams, along with the wider nursing team especially in relation to the rapidly changing national guidance's • Key areas of focus are reported in page 41 of the report and will continued to be monitored through the IPC Committee with upward reporting to the Quality and Safety Committee CB thanked the Trust for the excellent report and the assurance provided, but noted it is difficult to not review the report in line with the recent MRSA outbreak within the Trust. CB shared his frustration that on page 17-19 of report (43 – 45 pack) there are issues identified which have also been recently raised by NHSI/E and queried the response to the identified issues. FC agreed with CB comments. The road map of the Covid-19 response, the powerful tool of information (page 35 pack) The map demonstrates the extend of the work that has been completed. In hindsight, the statements on page 43-45 pack raises questions. It was suggested that another column is to be included which confirms actions implemented to which the Trust agreed.

	SEA thanked CM and FC for the valid comments. SEA explained that the Trust have a quality management system where the actions plans are logged, this supports with oversight and ensure actions are being completed, audits are at one point in time and therefore a regular audit cycle is required – this remains a key focus. The IPC review is being undertaken as a result of the outbreak; this will support the levels of assurance are correct going forward. FC explained that nothing in the report from the external assessor was a director contribute to the MRSA outbreak. It was regarding the process and procedures rather than aspects of estates, storage, and cleaning however, these need to be addresses. HT shared CB views and referred to the chart on page 35 which outlines the mitigations implemented from Covid-19 and reviewed government guidelines. HT asked, as the Trust move forward, of those best practices, what are the Trust going to keep and do we need to capture? The Board discussed the noted resistance for non-mask wearing (in other organisations) as the uniform policy doesn't require them too. HT encouraged the Trust to consider the changes for the future and ensure they are formally written via policies and procedures. FC thanked HT for his comments and brought page 67 to the Boards attention, highlighting the key areas of focus for this year. The Trust agreed to reflect on the practices and consider which ones will be part of working practice going forward. FC summarised the discussion - a great report which reads well however it is difficult not to review in light of the recent outbreak which is being well managed.
	PEOPLE UPDATE
23/09/10.0	**CHAIR'S ASSURANCE REPORT PEOPLE COMMITTEE** PK presented the People Committee Assurance Report and highlighted the following: • The meeting was well attended and quorate • Noted Guardian of Safe Working Hours report • Received an update on consultant capacity project work, staff survey, MCSI improvement plan • Received the STW people plan which the Committee remains closely sighted on • Considered and approved the uniform policy • No major concerns to be highlighted AT queried who the Freedom to Speak Up Non-Executive Director is, FC confirmed this is Hilary Peplar, Trust Board Advisor. The Committee note the report.
23/09/11.0	**GUARDIAN OF SAFE WORKING HOURS** RL thanked Consultant Orthopaedic Surgeon, Mr Chris Marquis who is the lead for the Trust. RL highlighted the following: • Quarterly report presented to the Board • There are a total of 18 trainees within the Trust • No exception reports recorded – this demonstrates the Trusts compliance with ensure safe working hours • There have been no fines or working reviews scheduled • There is an increased requirement to maintain training in line with restarted elective activity • There is a noted decrease in attendance at the junior doctor's forum since the pandemic and the team are working hard to encourage engagement FC queried the vacant shifts numbers on the MCSI within the report. RL explained there has been a long-standing issue with vacancies on MCSI therefore rotating trainees, locums and SAS doctors are supporting when required.

	The Board noted the report and commended the Trust for the continued compliance.
23/09/12.0	**FREEDOM TO SPEAK UP REPORT** SS thanked Liz Hammond, Trust lead for compiling the report. SS highlighted the following: • Note the challenging time • Working hard to support staff and encouraging staff to speak up • Through the People Committee, looking to develop the process • Introducing Trust Champions • Closer working with the system which will encourage learning across the system • Looking to develop the current app, which will allow 2-way communication • People Committee receive timely assurance - on a monthly basis • Need to ensure issues are being handled and investigated correctly and timely PK explained the Trust would like to raise the profile and therefore a meeting has been arranged to triangulate the issues. A robust policy is required, and the Trust have agreed to review the current policy. AT queried that reporting rate against other organisations and quired if there is a risk of under reporting within the Trust. AT continued to ask if the Board is clear that the Tryst is following best practice and in relation to the national guardian's perspective? FC highlighted that similar to the Trusts' Health and Safety report, there would need to be an increase in reporting to ensure this isn't a low reporting issues due to the low numbers. This isn't a reflection of the Trusts support and behaviours in supporting staff. A culture of management bullying has been addressed in depth over the past few years, there is more work to be completed but this has come on a long way. SS explained that the staff survey results shows the positive response in bullying and harassment within the Trust. SS highlighted the percentage of an ominous reporting, there is a focus needed to reduce this as it is difficult to give feedback to individuals and close the issues without knowing who the person is. In relation to best practice, SS confirmed the Trust is in a reasonable place but there are always areas to improve. The Trust will continue to investigate how to actively work with the system to share learning and best practice. HP welcomed the fact this is being discussed. There are issues with the size of the Trust within in the reporting as people become anxious of being known, there is to be an improved confidence in the system. There is more to be completed and supporting people to understand the processes and understand the experience will be beneficial. The Board noted the report and welcomed an update on the process soon.
	PERFORMANCE AND GOVERNANCE
23/09/12.0	**CHAIR'S ASSURANCE REPORT EXTRAORDINARY AUDIT COMMITTEE** DG presented the Audit Committee assurance report and highlighted the following: • A meeting scheduled to review the value for money report presented by Deloitte, external audit. • A positive report was received which the Committee gained full assurance. • The workplan for the Audit and Risk Committee was considered as well as the Quality and Safety Committee following the distribution of agenda items from the Risk Committee. • The Committee agreed to a process in place to ensure policies are reviewed timely and an escalation process when required. DG commended the Executive team and

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	staff for the continued hard work for bringing the policies are up to date. FC thanked DG for his involvement. The Board noted the assurance report.
23/09/13.0	**CHAIR'S REPORT FOR FINANCE, PLANNING AND DIGITAL COMMITTEE** RH presented the Finance, Planning and Digital Committee assurance report and highlighted the following: • The meeting was well attended • Focusing on being assured relating to controls rather than the performance measure • Received a deep dive on specialist unit efficiency targets • Asked for a deep dive to be completed at the People Committee relating to annual leave and out of job plan activity • Received the finance report and H2 planning • Approved the Green Plan – thank you to Simon Everett for attending the Committee to present and Medical Photography for the professional document • EPR update was received • Thank you to SR for updating the BAF and preparing the Committee annual report and self-assessment for consideration FC suggested the Green Plan is shared with the public Board. ACTION: to arrange a presentation The Board noted the assurance report.

23/09/14.0	**PERFORMANCE REPORT MONTH 5**
	KR reminded the Board that all areas are aligned to an assurance Committee and therefore have been reviewed ahead of presentation at the meeting. The following points were highlighted:
	
	Caring for Staff
	• Sickness Absence
	  ○ Metric showing normal variation but now exceeded target for three consecutive months, currently 1% above target.
	  ○ Long term sickness above target for three consecutive months
	  ○ Focusing on wellbeing conversations
	  ○ There is a noted increase of staff isolating and therefore being supported to work from home
	
	Caring for Patients
	• Serious Incidents
	  ○ One serious incident has been reported. The level of harm is currently being determined and the investigation process will be followed.
	  ○ A formal report will be presented to the Quality and Safety Committee upon completion of the investigation.
	
	AT queried how does the Trust mitigate the potential increase in serious incidents due to the increased waiting times? SEA explained that there is a proactive harms review process where patients are reviewed and monitored.
	
	HT commended the Trust on the well written report, and queried the data quality reporting age. KR explained that data quality group which reports to the audit committee along with a rolling data quality programme. The actions have been highlighted to provide assurance and the information.
	
	DG suggested a colour coding if used when presenting the data quality information.
	ACTION: colour coding key to be included on the front sheet.
	
	Operational Update
	• Total Outpatient Activity
	  ○ 82.74% of baseline target (19/20); underachieving the regulatory target of 85%

	○ % Virtual below 25% target at 18.86% ○ DNA rate consistently failing target ○ The outpatient manager is working alongside the Consultants to aid in reducing the DNA rate ○ A virtual receptionist is supporting virtual clinics. • Total Elective Activity ○ 71.47% of baseline target (19/20); underachieving the regulatory target of 85% ○ Underachieving the regulatory target of 85% completing 121 cases below the requirement. ○ Annual leave was higher than expected in month ○ Deep dives have been completed in demand and capacity modules – changes have been made to job plans. • September Forward look ○ Similar forecast to August is expected ○ 820 elective spells have been secured ○ The OJP element is not as high as planned – there are issues with alignment of theatres and consultants. ○ Spinal's consultant is working with his colleagues to organise the spinal disorders cases ○ Reviewing the theatre planning ○ Managing Directors have a meeting with the clinical leads to support forward planning ○ Focusing on improving the virtual clinics and improving patient communication including digital letters for patients FC thanked the team for the update and encouraged the work to improve the activity. It was suggested a report was to be presented on H2 to provide clarity on performance going forward. PK reminded the Board of the work being completed to review complexity of patients. AJ confirmed there has been a noted reduction in cases per session. *Caring for Finances* • CM reminded the Board that the Trusts finances are not impacted by the reduction in activity • There has been an impact on securing the elective recovery fund for August this is due to the changes implemented later within the month • The mitigations to offset the shortfall include ○ cost based was less than expected due to the reduced activity, ○ non-NHS income source has continued to perform well ○ the efficiency programme continues to report above 2% • The Trust a due to achieve the M1 which is the end of H1 plan. The Trust anticipate exceeding the H1 plan by approx. £1.6m which ensures the Trust is in a strong position • The plan will be reset for H2, the Trust are still awaiting the guidance in relation to this, and further information will be shared with the Board when available DG suggested the H2 planning is to be recorded on the risk register due to the high level of uncertainty relating to finances. CM commented that the block framework will continue into H2 however the unknown is relating to the £5.4b monies which has been aligned to H2 and distributed throughout the systems. FC agreed for the Finance, Planning and Digital Committee to discuss the risk and review the Board Assurance Framework at the next Committee meeting. The Committee noted the performance report.
23/09/15.0	**SYSTEM OVERSIGHT FRAMEWORK** KR informed the Board that the single oversight framework has been replaced with the system oversight framework which was published in June 2021. The framework reinforces the plan of a system led delivery of integrated care. The previous themes include:

	• Quality of care • Access and outcomes • Prevention of ill health • Finances and use of resources • People, leadership and capability • Local strategic priorities – this is a new theme incorporated with a view of greater partnerships within the system KR highlighted that the statutory roles and responsibilities of NHSE/I and NHS Trust remain unchanged. It was noted that the performance report for Board and the assurance Committees has been amended to ensure the same reporting is issued for both the Trust and the regulator. KR explained that STW are in the recovery support programme. The Trust will receive a rating as a Trust as well as a system. PK noted the expected rating is to be different to the system and suggested that intime the Trust reflects on whether information is required to be placed on to the risk register. FC thanked KR for the interesting paper which outline the transition for the Trust. The Board noted the report.
23/09/16.0	**WELL LED REVIEW** SR presented the final report following the Trusts well led review highlighting the factual inaccuracies which have been noted. An action plan has been devised to address the recommendations. SR informed the Board that there were no recommendation repeated from the previous well led review. FC suggested a presentation on the well led review recommendations is shared with the Board in the future to provide further clarity into the areas where action is required. ACTION: well led presentation to be provided to the Board. The Board noted the report.
23/09/17.0	**GOVERNORS UPDATE** SR informed the Board that the Governors have been involved in the following: • Governors' surgery has recommenced this month. • Involvement in the Chair recruitment including establishing the Nomination Committee who will recommend the appointment of the Chair in November 2021.
23/09/18.0	**AOB** None
23/09/19.0	**QUESTIONS FROM THE PUBLIC** None
	DATE OF NEXT MEETING IN PUBLIC: Thursday 25 November 2021 11.00 via Teams
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

23 SEPTEMBER 2021

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
None		
Actions from Last Meeting	**Lead Responsibility**	**Progress**
CHAIR'S REPORT FOR FINANCE, PLANNING AND DIGITAL COMMITTEE – GREEN PLAN To arrange the green plan presentation at public Board.	Trust Secretary	Complete
INTEGRATED PERFORMANCE REPORT Data Quality information - colour coding key to be included on the front sheet.	Chief Performance, Improvement and OD Officer	Complete
WELL LED REVIEW Well Led presentation to be provided to the Board.	Trust Secretary	Complete – agreed for a quarterly update to be provided.

Virtual Visits – September 2021

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Stacey Keegan, Interim Chief Executive	Paper Category:	Strategy
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

A Virtual Visit event was held on 30th September 2021, where Trust Board members were invited to 'visit' areas across the organisation using virtual technology.

2.2. Summary

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

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

The Trust held the third Virtual Visit event on 30th November 2021, where members of the Trust Board were invited to 'visit' departments within the Trust.

The exercise is designed to improve the 'Ward to Board' relationship and offers a platform for the senior leaders to have a better understanding of issues which staff have faced during recent times.

3.2. Thank You Letters

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

3.3. Next Steps

The Board of Directors is asked to:

- Note the Virtual Visit event report

3.4. Conclusion

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

The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

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6th September 2021

By email

Dear Leonie, David, Gillian, Claire, and Rachael

Re: Virtual Visit to Theatres

Thank you for your time on Thursday 30th September where you took Shelley, Allen, Simon, and myself through all the good work you are undertaking within theatres.

The virtual journey with the iPad to show theatres and how it operates and all the good work you have put in place was an absolute pleasure to see. Talking us through the support you provide to other services within your areas e.g. TSSU in such a proactive positive way was excellent. We particularly liked the relaxation and mental health support boards you have in place; it would be good to share this with other areas.

Thank you for highlighting the issues with space particularly the implant room and how best to store the implants in a safe way. I have taken this as an action to the estates and facilities team along with the staff break out area and fast track of theatre staff through Denbigh's and a potential "own space".

I have spoken with Jo Banks, Managing Director for your area regarding the staffing of auxiliary orderly staff to identify any support that can be provided.

Really pleased to hear about the overseas recruitment and that it is going well.

Theatre 6 has been a discussion point for a while, and it was good to "see it" and I took the action for Estate and Facilities to complete the decoration ASAP.

The other point of discussion around registrar's availability and changes to the rota; I will email both Rob Banerjee and E-rostering Team to investigate further.

Simon was particularly interested in the digital elements you raised and will ensure that the tablets/iPad requested and digitalisation of the logbooks for the 26 machines will be checked thoroughly and where improvements/support can be provided.

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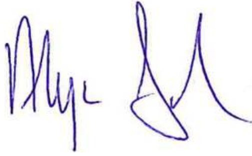
Thank you all for taking the time to spend and share your good work, ideas, professionalism, and we will update you on our actions.

We thoroughly enjoyed the visit and took away a lot of key learnings to share with others as well as actions to deliver to you. Keep up the good work and lovely to see you all at your best.

Kind regards



Alyson Jordan

Managing Director, SSU

Cc: Shelly Ramtuhul

Simon Adams

Allen Edwards

NHS

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Monday 11th October 2021

Dear Suzanne, Jack, Daniel, Ffion, & the Alice Ward team

RE: Virtual Visits October 2021

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

The time we spent with you all was greatly appreciated. We were particularly impressed how you cared for each other on the ward, recognising each other's pressures and working together to ensure everyone felt supported. It really stood out how as a team you apply flexibility and how you have implemented the current NHS philosophy around flexible working. With this in mind, we've asked some colleagues to get in contact so we are able to showcase what you are do within the Trust, in the hope that the positivity of your work will spread throughout the Trust. We'd love you to consider how we can get others to champion this work as you have done.

Having said that we also heard very clearly the impact of staffing constraints across the Trust on your ward, both the morale issues and the delivery of your services through your flexible working. Additionally, the future challenges for your team given the level of maternity leave you are about to experience and the limited workforce planning support in place.

You clearly articulated the current challenges and the level of uncertainty, together with the isolation the ward was feeling given recent changes and the impact this has had in operating as a Directorate and the connection and support of such within the Specialist Unit. Thank you for your professionalism in raising these issues and the openness with which you did this.

Since our visit there has already been discussion both at the Senior Leadership Group meeting and with the Unit management team regarding the challenges you raised with us, I'm hopeful that you will start to see a change in approach in the coming weeks. I'll be back in touch shortly to see if there has been any noticeable difference.

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

Yours sincerely

Kerry Robinson	Victor Pullicino	Hilary Pepler
Director of Performance	**CSU Clinical Chair**	**Board Advisor**

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Thursday 7th October 2021

Dear Dan, Shirley & your team

RE: Virtual Visits October 2021

To everyone in the catering team we just wanted to say thank you for the services you provide both our patients and staff. We know and recognise how much you care for everyone through the service you deliver which has not been easy to do in the last period. Having to adapt the way in which we deliver services together with some of the specific constraints in the country impacting catering has been significant for you and we see how hard you've all worked on this. The insight you gave us in our virtual visit, left all three of us with many thoughts and learning that we wanted to take a little time to digest before writing to you.

The time we spent with you all was greatly appreciated. We were particularly impressed how you cared for each other in the department, recognising each other's pressures and working together to ensure everyone felt supported. Hearing you describe the journey over the last 18 months with all the changes impacting service delivery was humbling.

You talked us through the following;

- Work pattern changes
- Allergen regulations
- Impact of Denbigh's for our staff
- Planning meal, numbers and content
- Moving to electronic menus
- Recruitment challenges
- Supplier delivery issues
- Providing support as a manager to your teams

Since we've met with you, we've connected you with our communications team so you can collectively work together on our Trust communications in regard to catering information. We've also ensured you are now included in the patient care activity planning information to enable better visibility of numbers for patient meals. Your HR business partner will be in touch shortly to gain insight to your experience as manager's for our renewal of our occupational health services.

We're reflecting on your feedback on support to staff and their wider family, together with the support we can provide managers in this endeavour and hope to provide further information in the weeks ahead.

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

Yours sincerely

Kerry Robinson	Victor Pullicino	Hilary Pepler
Director of Performance	**CSS Clinical Chair**	**Board Advisor**

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9th October 2021

Dear Pat

Re: Virtual Visit to Histopathology

Thank you for your time on Thursday 30th September where you took Shelley, Allen, Simon, and myself through all the good work you and your team are undertaking in Histology.

It was great to hear about the work you and your team carry out supporting the Trust and giving us an overview of the work that is carried out in the labs.

Thank you for highlighting the issues in relation to changes of contracts for the lab services and the impact that this will have. I am pleased that you have raised the issues in your area and have the support of your MD and Paul Cool. As stated, I will also assist in providing support and assistance and will arrange for the Chief Clinical Information Officer to be involved.

You stressed the importance of the links that you have created with the labs at RNOH, Stanmore and how this help support the innovative and world leading specialist care we provide.

Thank you all for taking the time to spend and share your good work, ideas, professionalism, and we will update you on our actions.

Following our meeting I will be your new "buddy" and look forward to meeting with you on a regular basis.

We thoroughly enjoyed the visit and took away a lot of key learnings to share with others as well as actions to deliver to you. Keep up the good work and lovely to see you all at your best.

Kind regards

Simon Adams

Digital Director

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Eric Hughes
Radiology Service Manager
RJAH

15 October 2021

Dear Eric

RE: Virtual Visit to Radiology

Firstly, may I thank you, Megan, Simran, Sophie, Grace and Connor for contributing to the virtual "Back to the Floor" session. Alison Tumilty (NED) and Russell Luckock (Governor) and I really valued our time with you.

Despite the limitations of a virtual format, the meeting proved to be extremely informative in giving an insight into the way in which your team responded to the challenges of dealing with Covid-19 and how you have changed working practices within the department. These are commended.

You all spoke proudly of the mutual aid that you have been offering to support Shrewsbury and Telford Hospital.

It was great to hear about the success with your international recruitment campaign, with recruitment being an area that had been challenging for some time.

My over-riding view is that the department worked as a united and committed team in order to help us respond to the demands and change required that Covid-19 has brought about.

We heard of your concerns, which included challenges with capacity and workforce within the department, the issues with IT in relation to home reporting, the new MRI installation, uncoupled appointments, and overarching communication to the department including perceived perception from other departments within the Trust. As a department and Unit, you were working hard on solutions to these challenges, and we offered assistance to enable you to unlock areas that you needed support with.

Thank you once again for your time. Please pass on our thanks to those involved. You should all be very proud of the work you do.

Yours sincerely

Stacey Keegan
Interim Chief Executive

Aspiring to deliver world class patient care

cc:

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Sammy Davies
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15 October 2021

Dear Sammy

RE: Virtual Visit to Outcomes

Firstly, may I thank you, Beth, Janet, and Clair for contributing to the virtual "Back to the Floor" session. Alison Tumilty (NED) and Russell Luckock (Governor) and I really valued our time with you.

Despite the limitations of a virtual format, the meeting proved to be extremely informative in giving an insight into the way in which your team responded to the challenges of dealing with Covid-19 and how you changed working practices to ensure patient outcomes were still being collected and reported.

My over-riding view is that the department worked as a united and committed team in order to help us respond to the demands and change required that Covid-19 has brought about.

Despite hearing a real want, we also heard of your anxieties regarding moving back to a more face to face service with patients, this is understandable and the Trust can help support that process.

The lack of digital solutions was raised as a challenge in enabling you to be even more efficient in your department; the Trust is working on an App solution that you are involved with.

I commended the excellent work your department has done in supporting the harms review process, something that doesn't routinely sit with your team. A huge thank you and well done on this work.

Thank you once again for your time. Please pass on our thanks to those involved. You should all be very proud of the work you do.

Yours sincerely

Stacey Keegan
Interim Chief Executive

cc:

Aspiring to deliver world class patient care

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Lee Osbourne
Transformation & Digital Lead
PMO
RJAH

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Friday 15th October 2021

Dear Lee and Team,

RE: Virtual Visit to the Project Management Office

Just a quick note to thank you and the team for your engagement as part of the recent virtual visit session to the PMO team.

We were impressed to hear how the team had adapted to the challenges of home working and introduced mechanisms to stay connected with one another despite the challenges posed by remote working. We were also pleased to observe the mutual support shown to one another from a wellbeing perspective during these challenging times.

It was useful to hear the appetite for a hybrid home/office model of working in the future; as a Trust we are looking to introduce an agile working approach for corporate services that aligns with this.

It was reassuring to hear that the number of projects being managed is at a more sustainable level than historically but we noted that there was still some challenges with prioritisation and unit responsiveness in achieving milestones and targets.

Finally, we would like to place on record the appreciation for all that you and the team do for RJAH and even though you might not routinely get the recognition of front line staff for the support you provide your value to the organisation is just as high.

Yours sincerely

C Macbeth

Craig Macbeth
Chief Finance & Planning Officer

CC:
Jo Banks – Managing Director of MSK
Colin Chapman – Governor

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4th October 2021

Dear Sarah and Allen

RE: Virtual Visit with Learning and Development Department

Firstly, we would like to thank you for taking the time to meet with us on 30th September 2021 for the virtual visit to the Learning and Development Department. We very much enjoyed the visit and the greater insight that you gave us into the Learning and department here at the Trust. The passion that you both clearly feel to continue to work with the teams to improve the processes and to build resilience into the teams absolutely shone through in the visit. You also advised us of the strategy that you have in place and the exciting opportunities that area available for the team.

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

- You stated that you were concerned about the fact that expensive courses are put on which staff members book onto but unfortunately staff then do not turn up for these courses and you gave an example of a few weeks prior when a course had been arranged and only one staff member turned up to do the course. Dawn Forrest stated that she would raise this at the Senior Leadership Group so that the managers can remind staff of the importance of attending the courses they have booked on. I can confirm to you that Dawn raised this at the SLG meeting on 5th October 2021. Dawn also suggested that maybe you could look at doing some training in the areas where staff were based, and you confirmed that you had already started to do some of this “train where you work”.

- Allen gave us an excellent update on the work he was doing with the apprenticeships and getting managers to understand how this can really enhance the workforce. He stated that it is his intention to put on some sessions for the managers to promote what is out there and to promote what we can do for our existing staff. Mr Ibrahim Roushdi agreed to send some contact names to Allen with regards the setting up of therapist apprenticeships and we understand that he has emailed you with the detail.

- Allen raised the issue of not having an office when he is on site and although there is always a hot desk available having to carry a box to and from the car with all his documents etc in is not ideal. Dawn explained that Alyson Jordon along with the estates team are currently undertaking a piece of work to look at how we can improve our hot desking and agile working facilities across the organisation.

We would once again like to thank you for all the hard work undertaken by the team and as we are all aware the work that is undertaken by the Learning and Development Team here at Robert Jones and Agnes Hunt will continue to support our workforce for years to come.

Kindest regards

Collette

Colette Gribble
Public Governor

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Phil Hulse
Therapies Service Manager
RJAH

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Friday 15th October 2021

Dear Phil & Team,

RE: Virtual Visits for Therapies Dept.

Just a quick note to thank you and the team for your engagement as part of the recent virtual visit session to the Therapies Department.

We heard your frustrations regarding the inability to achieve historical activity levels under the space constraints you are now working under and it was interesting to hear your suggestions as to how these may be resolved by organising the broader Estate differently. I have fed these back to Dawn Forrest along with a number of other issues that were discussed and I believe she is taking these forward with you.

To finish on a positive note, it was pleasing to hear how therapy services at RJAH continued during the height of the pandemic utilising non face to face contacts and how these innovative changes to practice have become embedded.

We would like to place on record the appreciation for all that you and the team do for RJAH and the consistent high standards of care you strive to provide for our patients. It was evident throughout our discussion just how hard you and the team are working and this really is valued.

Thanks again

Yours sincerely

C Macbeth

Craig Macbeth
Chief Finance & Planning Officer

CC:
Jo Banks – Managing Director of MSK
Colin Chapman – Governor

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4th October 2021

RE: Virtual Visit to Baschurch

Dear Lisa and Louise

Firstly, we would like to thank you for taking the time to meet with us on 30th September 2021 for the virtual visit to Baschurch. We very much enjoyed the visit and the greater insight that you gave us into the unit and the obvious pride that you have in the care that you deliver.

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

- You talked about the fact that the team were all really pleased that activity has now increased post covid and the unit is getting busy again. You explained that due to the unit footprint with the individual PODs and treatment/consultation rooms you are managing to socially distance our patients. Occasionally the waiting room does require some movement of patients to follow the social distancing rules but the staff undertake regular checks and move patients through in a timely manner.

- One of the issues that you raised is that it would be advantageous to manage staffing appropriately if the access team could advise you in advance of the days that are likely to be daycase "heavy". You gave an example of the previous Monday when you had 36 daycases on the unit. Dawn agreed to discuss with the Access Manager to establish if they could give you prior notice of the heavy/medium and light days so you can ensure that these days are staffed appropriately.

- We were extremely pleased to hear that your staff retention was very good and you also talked about the fact that your staff were very flexible and covered any sickness gaps etc if needed. This is clearly a sign of the excellent leadership on the unit and the fact that the staff are happy.

- You did however raise the issue of staff being moved onto other wards when they are short staffed and although you can understand the need to ensure that patients are safe across the entire organisation it does put pressure on your unit and the staff involved.

- We talked about the fact that there is an issue when there are all day lists and all of the patients arrive first thing in the morning. This does lead to complaints when the patients are not taken to theatre until late in the afternoon after sitting on the unit all day. You had suggested that maybe lists could be staggered with 70% of patients coming in first thing and then maybe the remaining 30% coming in at 10.30am. Mr Roushdi stated that he would discuss this with some of the clinical leads.

We would once again like to thank you for all the hard work undertaken by the team on Baschurch. I understand that Dawn had a walk round on the unit before the actual visit and she was extremely impressed with the unit which appeared to be extremely organised and the staff were very friendly and clearly proud of their unit.

Kindest regards

Collette

Colette Gribble
Public Governor

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Chair Assurance Report
Quality and Safety Committee – 18 November 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	25 November 2021
Director Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Quality and Safety Committee Agenda for the meeting of 18th November 2021. This will support the verbal report provided by the Non-Executive Chair of the Committee.

2. Executive Summary

2.1 Context

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

2.2 Summary

Due to the timing of the Committee, it is not possible for a written Chair's Report to be presented. The Non-Executive Director Chair of the Committee will provide a verbal report covering the discussion held at the meeting. A copy of the Committee agenda is shared for information.

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	18/11/21		14:00

Item	Owner	Time
1. Introduction		14:00
1.1. Apologies	All	
1.2. Minutes from the previous meeting	Chris Beacock	
1.3. Action Log / Matters Arising	Chris Beacock	
1.4. Declaration of Interests	All	
2. Caring for Patients		
2.1. Serious Incidents and Never Events	Sara Ellis Anderson	14:05
2.2. Harms Review Presentation	Dawn Forrest	14:10
2.3. Infection Control Q2 Report	Sue Sayles	14:15
2.4. Legal Claims	Shelley Ramtuhul	14:25
3. Governance		
3.1. Committee Self Assessment and Annual Report	Shelley Ramtuhul	14:30
3.2. Duty of Candour Report	Shelley Ramtuhul	14:35
3.3. Support Services Unit Quality Report	Alyson Jordan	14:40
3.4. Patient Safety Walkabouts	Sara Ellis Anderson	14:50
3.5. Performance Report (to follow)	Sara Ellis Anderson	14:55
3.6. CQC Action Plan	Shelley Ramtuhul	15:05
4. Annual Reports		
4.1. PAM Audit Report	Hannah Howells	15:15

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	18/11/21		14:00

Item	Owner	Time
5. Policy/Strategy		
5.1. Management of Medical Devices Policy	Phil Davies	15:25
5.2. Major Incident Policy	Nicki Bellinger	15:30
5.3. Discharge or Delayed Discharge Policy	Alison Lamb	15:35
6. Items to Note:		
6.1. Performance Report (Month 6)	Sara Ellis Anderson	15:40
6.2. Chair Report		15:45
6.2.1. Patient Safety Committee	Sara Ellis Anderson	
6.2.2. Research Committee	Dawn Forrest	
6.2.3. Trust Performance and Improvement Board	Stacey Keegan	
6.2.4. Infection Control Committee	Sara Ellis Anderson	
6.2.5. Health and Safety Committee	Sara Ellis Anderson	
6.2.6. Medical Devices Committee	Ruth Longfellow	
6.3. Ethnicity and Health Inequalities	Sara Ellis Anderson	15:50
6.4. Mortuary and Body Store Assurance	Stacey Keegan	15:55
6.5. Review of the Work Plan	Shelley Ramuthul	16:00
6.5.1. Attendance Matrix		
7. Any Other Business		
7.1. Next Meeting: Thursday 20th January 2022		

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Nicki Bellinger, Assistant Chief Nurse	Paper date:	25 November 2021
Senior Leader Sponsor:	Sara Ellis Anderson, Interim Chief Nurse and Patient Safety Officer	Paper Category:	Strategy
Paper Reviewed by:	Quality and Safety Committee – 14.10.2021	Paper Type:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Patient Experience Strategy is presented to the Trust Board for consideration and approval.

The Quality and Safety received the strategy for consideration on 14th October 2021 ahead of presentation at the Trust Board.

2. Executive Summary

2.1. Context

The importance of patient and public engagement in the NHS has been emphasised by findings from several key reviews relating to failures of care in the NHS, including Berwick (2013), Francis (2013) and Keogh (2013). The Berwick review into patient safety recommended that patients and their carers should be 'present, powerful, and involved at all levels of healthcare organisations from wards to boards and be listened to and involved in every organisational process at every step of their care. Berwick argues for a broad level of engagement of patients in the processes of design, regulation, and scrutiny of the system, not just in the individual clinician/patient relationship.

2.2. Summary

The Patient Experience Strategy (2021-2024) which builds upon the strategy from 2017-2020, setting out our ambitions for the next three years and will support all staff to continue to put patient experience at the heart of three we do.

Since the development of our original strategy NHS Improvement developed an Improvement Framework for Patient Experience (2018). This tool can be used for all levels within Trust to assess themselves against key principles and develop plans for continuous improvement to ensure that all staff recognise:

'Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.'

2.3. Conclusion

The Board is asked to consider the strategy and approve.

PATIENT EXPERIENCE STRATEGY

2021-2024

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6.	QUALITY ACCOUNT PRIORITIES 2021-2022	14
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Foreword from Sara Ellis- Anderson, Acting Chief Nurse and Patient Safety Officer

I am delighted to introduce the Patient Experience Strategy (2021-2024) which builds upon the strategy from 2017-2020, setting out our ambitions for the next three years and will support all staff to continue to put patient experience at the heart of everything we do.

Since the development of our original strategy NHS Improvement developed an Improvement Framework for Patient Experience (2018). This tool can be used for all levels within Trust to assess themselves against key principles and develop plans for continuous improvement to ensure that all staff recognise:

> *'Good experience of care, treatment and support is increasingly seen as an essential part of an excellent health and social care service, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.'*

We have embraced the guidance within our new strategy to ensure that we focus on a number of areas to achieve excellence in patient experience. These include:

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

We will work with all patient groups to strengthen our performance together and achieve the Trusts vision to provide patients with world class care.

SECTION 1: **INTRODUCTION**

The success of the Robert Jones and Agnes Hunt Foundation Trust as an organisation is how we act and work in a collaborative partnership with our patients, carers, their relatives and the community and the wider system.

Providing patients with world class care means the ability to enable the best experience of care possible at each phase of their pathways and interaction with our staff.

The Health and Social Care Act (2012) section 2422, places a legal duty on Trusts to consult and involve the people we serve. We must demonstrate that we are involving people and communities appropriately and proportionately. It is formally documented in the NHS Constitution in England 2012 and is used as a benchmark of Trust performance nationally. A patient's experience needs to be positive in order for them to engage fully with their care to enable positive outcomes.

Ensuring patients have communication in a manner that is accessible and to a standard that is appropriate for their needs is essential to enable active engagement with care delivery and to facilitate patients to make decisions regarding their care. The Patient Experience Strategy outlines the Trust's intention to ensure world class care and patient experience e for patients, carers, their relatives, and the wider community.

As we progress through the recovery phase of the pandemic, there will be undoubtedly difficult decisions to be made which may affect the Trust as a whole or on individual services. Where this is the case, the Trust will consult with the service users to seek their views and input.

SECTION 2: REVIEW OF THE PREVIOUS STRATEGY

The 2017-2020 Patient Experience Strategy set out three aims, as detailed below:

Always Event 1: Improve the patient Journey.
We will improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care.

Always Event 2: Improve communication.
We will improve the information we provide to enhance communication between our staff, patients and carers.

Always Event 3: Meet care needs.
We will meet our patients' physical, emotional, and spiritual needs while they are using our services, recognising that every patient is unique

There have been a number of successes during the three-year period covered by the Patient Experience Strategy. We now plan to take those successes: build and embed them even further to put this strategy at the heart of the organisation. We fully commit to a culture of continuous improvement within our Trust. This will establish us as a leader in delivering outstanding patient experience.

Key successes include:

Always Event 1: Improve the patient Journey We will improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care.

- *Provide clear information and directions on how to get to our hospitals public transport and alternatives. Clear information provided in a timely manner with maps and details of how to get to the hospital with all appointments. Also available on the Trust Web Site*
- *Further develop and maintain the information on the Trust website about the services provided along with contact details for wards and departments. Details updated on the website with easy access to all contact details*
- *Work closely with health and social care teams to ensure safe and co-ordinated discharge from hospital with all the necessary support in place. This may include the patient seeing a doctor, physiotherapist, or social worker before leaving hospital and ensuring medication to take home is ready in a timely manner. Ensure that family carers are fully involved in the discharge process and can provide care and support for their relative at home. Engagement sessions/workshops held with the local authority to enhance the process and increased the contact with social care to enable more collaborative working*
- *Engage with patients and carers when developing and reviewing services to ensure that their needs are taken into consideration. Development of the veteran service and accessible care standards group.*
- *Review and continually monitor hospital signage to ensure patients and visitors are directed to the right ward/department in a clear and easy way. Share patient feedback relating to*

signage and car parking with partner organisations where appropriate. Wayfinding system has been changed to a number system that is also dementia friendly.

- *Continue to improve the patients stay by working with the community encouraging individuals and groups to participate in a programme of activities which benefit both the community and the hospital, e.g., gardening groups, student beauticians/hairdressers providing free treatments to patients, singers/musicians entertaining patients, Pets as Therapy dogs visiting patients etc. Gardening group in place. Poetry reading group; pet therapy; singers and musicians and increased activities for spinal patients including the opening of Horacio's Garden*
- *Ensure our staff and volunteer helpers provide a friendly and efficient welcome to patients, carers and visitors. All volunteers now at the main entrance and have volunteers on the wards who act as dining champions*
- *Ensure our patients receive high quality care at the end of their life in line with the Trust's End of Life Care Strategic Plan. Wherever possible we will follow the patient wishes as set out in the Advanced Care Plan, Advance Decision to Refuse Treatment and/or Do Not Attempt Cardiopulmonary Resuscitation form. End of Life care is in line with the strategic plan, e-learning available and swan boxes on all wards.*

Always Event 2: Improve communication. We will improve the information we provide to enhance communication between our staff, patients, and carers.

- *Actively promote the #hello my name is…. campaign ensuring all staff are aware of the importance of introducing themselves to patients and asking how each patient would like to be addressed. Ensuring that all patients know the name of the healthcare professional looking after them.*
- *Ensure that patients are provided with well-written information leaflets on their care and treatment to enable them to prepare for their outpatient appointment or inpatient stay. Advise patients where they might find reliable high-quality information and support from sources such as national and local support groups, networks, and information services.*
- *Support wards to provide an information booklet to all inpatients including information about the ward routines, mealtimes, visiting hours, staff etc. New booklet developed and booking system for visitors*
- *Ensure that patients and carers are given the opportunity to complete a 'This is Me' booklet (dementia) or 'Purple Folder' (learning disabilities) to share important information about the patient with staff. These are used*
- *Ensure that staff can access interpreter and other services for patients who require information in alternative formats. Language line used or interpreter booked*

- *Provide information for carers on our Trust website with useful information about the Trust's services, carer's rights and links to local and national support and information for carers.*
- *Encourage patients to talk to staff if they have any questions or concerns and support patients to seek advice from the Patient Advice and Liaison Service (PALS) or to make a complaint. Increase in PALs contacts noted for sign posting and waiting times*

Always Event 3: Meet care needs. We will meet our patients' physical, emotional, and spiritual needs while they are using our services, recognising that every patient is unique.

- *Be kind, courteous and help patients, carers and visitors making them feel welcome in our hospital. In patient survey feedback shows that all staff have worked hard to ensure they provide kind and courteous care (99-100%)*
- *Provide care and treatment for patients which minimises the risk of harm and respects their privacy and dignity. 99-100*
- *Provide a clean, safe and comfortable environment, accessible to patients with a disability.99-100*
- *Ensure that our staff have access to the equipment they need to meet patient needs.*
- *Ensure that regular checks are made on all inpatients. Intentional rounding undertaken and documented*
- *Experiencing any pain or need help with food/drink or to use the bathroom. Staff will ask each patient whether there is anything else they need and check the call bell is within easy reach.*
- *Display information on our wards about staffing levels, numbers of infections, falls, pressure ulcers, cleanliness scores so you know 'How we're doing'.*
- *Ensure our patients and carers have access to all the practical, emotional, and spiritual support they need and provide contact information for organisations and support groups. Make sure that patients and carers have an opportunity to speak to a doctor, nurse, member of the chaplaincy team or other healthcare professional if they wish to. Evidence available that this occurs form in patient survey*
- *Ensure that all patients are treated as individuals and their cultural and/or religious needs, values and preferences respected.*
- *Develop an understanding of the patient as an individual considering factors such as physical or learning disabilities, speech or hearing problems and difficulties with understanding English. Ensure that any reasonable adjustments are made to meet the patients' needs.*
- *Accessible care standards group who review patients with additional needs, hearing loops, large print braille and foreign language translation Agreement to implement changing places*

SECTION 3: 2021-2024 STRATEGY

Our three year strategy has been developed with our patients experience at the heart of what we aim to deliver. The Strategy has utilised information gathered through stories, complaints and concerns, compliments, national and local surveys, and patient forums, social media, and feedback from Healthwatch.

Enabling our patients to be actively engaged in their voicing their individual patient experience and those of the wider community is crucial to the success of the Trust. We collectively need to actively listen to our patients and their loved ones to drive for the programme of continual improvement for patient experience. A positive patient experience will enhance the patient journey through phases of their pathway. We can do this by actively listening to our patients to their own needs and anxieties this will foster trust and improve a collaborative working relationship with those who are involved in their care.

Understanding what our patients perceive to be their priority of patient experience particularly as we transition through the pandemic and those associated restriction will enable us to make the necessary changes to care delivery. This in turn will assist in maintenance and improvement the patient's experience of our services by adopting the 'Getting it right first time' (GIRFT) principles.

The Trust has a well-established and loyal team of volunteers, during Covid 19 there has been a reduction in their ability to contribute to a positive patient experience and care. The aim is to safely bring back our volunteers which will undoubtedly result in an enhanced patient experience.

The Patient Experience Strategy is one of the ways in which we intend to achieve the Trusts vision of 'world-class healthcare'. The Trust will continue to build upon the principle of using Always Events®, making sure we find out what matters to people about their care and trying our best to deliver it. We will ensure a structured approach to implementation, learning from our experience before rolling out each improvement, involving patients at every step.

Our commitments are:

1. We will work in partnership with our patients and actively involve them in decisions about their care.
2. We will communicate to our patients in a manner that is accessible and appropriate to their own individual needs whilst listening to our patients about their priority of care and what matters most to them.
3. We will involve our patients and services users and the public generally in decisions regarding the way we deliver services and any future developments.
4. We will engage with our patients to facilitate patients to manage their own health conditions and get the best out of their wellbeing.
5. We will further develop the role of volunteers to ensure we maximise their input to enhance patient experience

COMMITMENT ONE: WE WILL WORK IN PARTNERSHIP WITH OUR PATIENTS AND ACTIVELY INVOLVE THEM IN DECISIONS ABOUT THEIR CARE.

- Encouraging patients to take a more active role in managing their health through a range of self-management initiatives, working with partner organisations in the local healthcare system, on a joined-up approach
- Increasing the number, representation, and engagement of our Trust members
- Involving patients from the start in the design of new improvement initiatives
- Increasing the scope of the Patient Panel, including membership of committees, supporting staff induction, safety walkabouts, interview panels
- Increasing the number of volunteers and widening the range of activities they support.

COMMITMENT TWO: WE WILL COMMUNICATE TO OUR PATIENTS IN A MANNER THAT IS ACCESSIBLE AND APPROPRIATE TO THEIR OWN INDIVIDUAL NEEDS WHILST LISTENING TO OUR PATIENTS ABOUT THEIR PRIORITY OF CARE AND WHAT MATTERS MOST TO THEM.

- Asking patients what matters to them
- Using patient stories, targeted surveys, or workshops to explore specific topics
- Asking people how we can reduce waste
- Making sure every specialty and department encourages feedback from all their patients
- Ensuring the Patient Advice and Liaison Service (PALS) has a more visible presence,
- Responding promptly to issues raised by PALS and complaints and spreading the lessons learned
- Recognising and spreading good practice
- Routinely contacting people during and after they have experienced our services to hear directly from them how it went.
- Providing information to patients about their own conditions making sure that they understand and can ask questions
- Meeting the Accessible Information Standard, making sure patients have access to information they can understand and any communication support they may need
- Ensuring that the Carers Strategy and the End-of-Life Care Strategy are understood by staff and implemented throughout the Trust, including the use of the RESPECT form.

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

- Providing better guidance about how to stay as well as possible, especially while living with a long-term condition
- Making sure that relevant information about patients is shared among those who need to know, across health and social care, so that people don't have to keep repeating their story
- Providing more information about plans to change services and about the future of our hospital.

COMMITMENT THREE: WE WILL INVOLVE OUR PATIENTS AND SERVICES USERS AND THE PUBLIC GENERALLY IN DECISIONS REGARDING THE WAY WE DELIVER SERVICES AND ANY FUTURE DEVELOPMENTS.

Transforming waiting

Patients and carers' time is valuable and should be treated as such. Patients tell us that waiting to be seen in our outpatient departments, or for their care to progress is sometimes frustrating. Some aspects of waiting that we are determined to improve are:

- The system in outpatients for flagging that a patient has a carer (or is a carer) and may require additional support
- The punctuality with which clinics start
- The comfort of outpatient waiting areas
- The system for the outpatient staff calling the next patient, so that mistakes or misunderstandings are less likely

We will do our best to improve the patient experience by:

  - Better communications in waiting room areas
  - Improved clinic appointment systems
  - Focus on reducing waiting times in clinics
  - Provision of reliable fast guest WIFI in waiting areas and on the wards
  - Hearing from our patients what would work best and how we can streamline our processes.

Moving care closer to home

People tell us they would prefer to have their care at home unless their condition absolutely requires them to be treated in hospital: We will:

- Increase the support available to people at home, for example through supported discharge, 'Discharge coordinators', and specialist support to primary care.

COMMITMENT FOUR: WE WILL ENGAGE WITH OUR PATIENTS TO FACILITATE PATIENTS TO MANAGE THEIR OWN HEALTH CONDITIONS AND GET THE BEST OUT OF THEIR WELLBEING.

Children and Young People

- The Trust will review the implementation of the Ready, Steady, Go project to help clinicians work with young adults to prepare them to transition to adult care and take responsibility for their own long-term condition or health care. We start 'Ready' from age 11 to 13 years, 'Steady' from 13 to 16/18 years and 18 years is 'Go'.
- In 2021-22 we aim to ensure that all children with chronic conditions aged 11-13 years have a discussion with their consultant about their condition and receive the 'Ready' leaflet.
- In a 2022 we want to see those children turning 13 years of age receiving the 'Steady' leaflet and feeling confident about their condition.
- A second project involves improving the transition of care for Children and Young People moving from paediatrics to adult care. The Trust will develop a business case to appoint a transition nurse to support children, young people and parents will help bridge the gap between children and adult services. This nurse's role will be to support children with complex needs in transitioning from children's to adults' services. This role will provide support, advice, expert knowledge and guidance for adult nursing and medical colleagues and the young person and family to make this transition as smooth as possible.

Self-management

- People tell us they would like to take more control of their own health but sometimes lack the expertise and confidence to do so: We will work with colleagues in the community to encourage improved self -management through:
- Encourage the use of Apps that support self-management, such as My Recovery
- Encourage clinicians to take up training in Coaching for Health
- Embed social prescribing as an intervention used whenever appropriate.

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COMMITMENT FIVE: DEVELOPING VOLUNTEERS

We are very grateful to our existing volunteers. We know many more people would like to help and we would like to increase the opportunities for volunteering. We will do this by:

- Identifying a wider range of volunteer roles
- Providing training for the roles
- Publicising the opportunities
- Providing volunteer support for inpatient activities such as befriending, games, breakfast club

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

SECTION 4: DELIVERING THE STRATEGY

A detailed delivery plan has been developed (Appendix 1) to achieve our commitments on a yearly basis outlining key success criteria. Quality priorities will be added each year in line with the annual quality account; 2021-22 priorities are outlined in section 6. The delivery plan will be monitored through the Trust Governance Systems as detailed below:

- The patient panel is a group of patients and carers who use the services of the Trust and are prepared to commit significant time to supporting the Trust as critical friends.
- The lead of Patient Experience and Engagement group is responsible for making sure that patient feedback is being sought in a range of ways, including reaching out to those less often heard, and that the results are analysed and regularly presented to the Experience and Engagement Group with escalation as required to the Quality and Safety Committee and to the Board. The lead of Patient Experience and Engagement also supports the Patient panel patient engagement activities.
- The patient experience committee, with the patient panel responds to all aspects of patient experience making recommendations and monitoring actions to improve the patient experience.
- The Quality and Safety Committee oversees the delivery of the Trust's Quality Improvement Strategy, which includes Patient Experience and will monitor the delivery of the plan.
- The Trust Board is responsible for providing visible leadership and strategic direction to improve the experience of patients. It receives regular reports from the Quality and Safety Committee and will receive an exception report of delivery of the plan.

The groups and committees will be supported by:

- PLACE visits are carried out by patients, governors and staff and are patient led, which have the opportunity to 'see' the changes and implementation of the delivery plan.
- Safety Walkabouts are carried out by Non-Executive Directors, Executives or senior managers, patients, and governors.

SECTION 5: LINKS TO OTHER TRUST STRATEGIES/POLICY

The Patient Experience Strategy is linked to other Trust strategies and policy identified below:

- Patient Safety Strategy
- Workforce Strategy
- Equality & Diversity Policy
- People Plan
- End of Life Care Strategy
- Food & Drink Strategy
- Patient Experience Dementia Strategy
- Carers' Strategy
- Annual Quality Account

SECTION 6: Quality Account Priorities (2021/22):

1 Improve communications to patients accessing outpatient services (Commitment two)

Objective: To ensure that patients have access to information regarding their treatment pathway in an appropriate format and at the appropriate time.

Rationale: During Covid-19 services have either been temporarily paused for periods or scaled back to ensure that infection prevention and control measures are taken. This has unfortunately resulted in patients waiting longer than usual for their appointments and increased communication regarding this will help to ensure patients remain appropriately informed whilst they are waiting.

2. Reduction in delayed discharges and improved patient communication (Commitment three)

Objective: Establish a zero tolerance of delayed discharges by completing a review of the discharge and resettlement leadership and further review and improve patient communications to ensure that all patients can access the information they need when they need it.

Rationale: Covid-19 has impacted on all clinical pathways and discharges from hospital are complex and can be a source of anxiety for patients

SECTION 6: STRATEGY DISSEMINATION

The strategy will be disseminated to:

- Staff, via the Trust's Intranet
- Patients, Public, Governors and members, via The Pulse newsletter and the public website.

APPENDIX 1: DELIVERY PLAN FOR THE PATIENT EXPERIENCE STRATEGY

Success Criteria	Year 1 2021-22	Year 2 2022-23	Year 3 2023-24
COMMITMENT ONE: WE WILL WORK IN OARTNERSHIPWITH OUR PATIENTS AND ACTIVELY INVOLVE THEM IN DECISIONS ABOUT THEIR CARE			
Monitor the participation of patient from the Trust in self-management initiatives, working with system partners, on a joined-up approach and plan a year-on-year improvement		⚐	
Monitor and review the number, representation and engagement of our Trust members ad develop annual strategies to tackle any inequalities or gaps • *The number of lay partners in the Patient Panel is maintained at around 15 and they feel valued and supported in their role*	⚐		
Establish one patient forum per unit, involving patients from the start in the design of new improvement initiatives and publicise feedback through 'You Said, We Did' noticeboards		⚐	
Ensure at least one member of the patient Panel, becomes a member of key committees, support staff induction, safety walkabouts and attend interview panels			⚐
Annual increase in each unit of the number of volunteers and widening the range of activities they support			⚐
95% of patients recommend our Trust to family and friends in all surveys.	⚐	⚐	⚐
Patient comments are reported via the Friends and family test are reviewed under the headings of patient experience; poor, good or very good and are regularly reviewed by the patient panel and patient experience committee.	⚐	⚐	⚐

Success Criteria	Year 1 2021-22	Year 2 2022-23	Year 3 2023-24
Through equality monitoring of patient feedback, the Trust will provide evidence that no discrimination is taking place and that all groups are receiving the same level of service irrespective of background.		⚐	⚐
COMMITMENT TWO: WE WILL COMMUNICATE TO OUR PATIENTS IN A MANNER THAT IS ACCESSIBLE AND APPROPRIATE TO THEIR OWN INDIVIDUAL NEEDS WHILST LISTENING TO OUR PATIENTS ABOUT THEIR PRIORITY OF CARE AND WHAT MATTERS MOST TO THEM			
Ensure pro-active documentation in records that demonstrates we have asked patients what matters to them monitored via Matrons audits	⚐	⚐	⚐
Develop a programme of patient stories, targeted surveys, or workshops to explore specific topics		⚐	⚐
Utilise the' you said, we did boards' in every specialty and department to publicise feedback from all their patients	⚐	⚐	⚐
Review where the Patient Advice and Liaison Service (PALS) is based and how it can provide has a more visible presence across the Trust	⚐	⚐	⚐
100% of complaints in every unit are acknowledged in 3 working days	⚐	⚐	⚐
100% of complaints in every division are responded to within 25 working days or within a timescale agreed by the complainant. The Trust key performance indicator is a target of 8 complaints per month.	⚐	⚐	⚐
Themes in complaints are reported to the Experience and Engagement Group along with the improvement actions taken in response which are measured with a completed action plan.	⚐	⚐	⚐
Implement a programme of routinely contacting people during and after they have experienced our services to hear directly from them how it went and provide feedback to staff on positive aspects and areas for	⚐	⚐	⚐

Success Criteria	Year 1 2021-22	Year 2 2022-23	Year 3 2023-24
improvement			
Through documentation audits monitor the provision of information to patients about their own conditions and evidence that they have had an opportunity to ask questions		⚐	
Develop a system to monitor the ability to meet the Accessible Information Standard	⚐	⚐	⚐
Implement a training programme to ensure that the Carers Strategy and the End of Life Care Strategy are understood by staff and implemented throughout the Trust, including the use of the RESPECT form.	⚐		⚐
Regularly audit the use of the respect form and review at the Trust quality forum to implement any remedial action to improve percentage compliance	⚐	⚐	⚐
Providing better guidance about how to stay as well as possible, especially while living with a long-term condition	⚐		⚐
Ensure that relevant information about patients is shared among those who need to know, across health and social care, so that people don't have to keep repeating their story – through the use of EPR			⚐
Developcommunication briefing for patients and the local community about plans to change services and about the future of our hospital	⚐	⚐	⚐
Quality Account Priority: Improve communications to patients accessing outpatient services			
Development of a KPI for ongoing monitoring	⚐	⚐	⚐
Reduction in number of negative comments relating to outpatient waits		⚐	⚐

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

Success Criteria	Year 1 2021-22	Year 2 2022-23	Year 3 2023-24
COMMITMENT THREE: WE WILL INVOLVE OUR PATIENTS AND SERVICES USERS AND THE PUBLIC GENERALLY IN DECISIONS REGARDING THE WAY WE DELIVER SERVICES AND ANY FUTURE DEVELOPMENTS.			
Transforming waiting			
The system in outpatients for flagging that a patient has a carer (or is a carer) and requires additional support	⚐		
Routinely monitor the punctuality with which clinics start and take remedial action where gaps are evident	⚐	⚐	⚐
Review the patient environment in waiting areas to provide comfort ensuring access to drinks and wifi	⚐		
Review the system for the outpatient staff calling the next patient, so that mistakes or misunderstandings are less likely and monitor any changes implemented	⚐		
Moving care closer to home			
Increase the support available to people at home, for example through supported discharge, 'Discharge coordinators', and specialist support to primary care.	⚐		
Achieve the Trust KPI of less than 2.5% of all patients delayed	⚐	⚐	⚐
Patient feedback regarding communication and inclusion in the discharge process	⚐	⚐	⚐
Monitoring of complaints / incidents relating to discharges	⚐	⚐	⚐
COMMITMENT FOUR: WE WILL ENGAGE WITH OUR PATIENTS TO FACILITATE PATIENTS TO MANAGE THEIR OWN HEALTH CONDITIONS AND GET THE BEST OUT OF THEIR WELLBEING.			
Children and Young People			

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

Success Criteria	Year 1 2021-22	Year 2 2022-23	Year 3 2023-24
The Trust will review the implementation of the Ready, Steady, Go project to help clinicians work with young adults to prepare them to transition to adult care and take responsibility for their own long term condition or health care. We start ‘Ready’ from age 11 to 13 years, ‘Steady’ from 13 to 16/18 years and 18 years is ‘Go’	⚐		
In 2021-22 we aim to ensure that all children with chronic conditions aged 11-13 years have a discussion with their consultant about their condition and receive the ‘Ready’ leaflet.		⚐	⚐
In a 2022 we want to see those children turning 13 years of age receiving the ‘Steady’ leaflet and feeling confident about their condition.		⚐	⚐
Develop a business case to appoint a transition nurse to support children, young people and parents will help bridge the gap between children and adult services.		⚐	⚐
Self-management			
We will work with colleagues in the community to encourage improved self -management through: • Encourage the use of Apps that support self-management, such as My Recovery • Encourage clinicians to take up training in Coaching for Health • Embed social prescribing as an intervention used whenever appropriate	⚐	⚐	⚐
COMMITMENT FIVE: DEVELOPING VOLUNTEERS			
Identifying a wider range of volunteer roles in conjunction with Units, including volunteer support for inpatient activities	⚐		
Develop a training plan for new roles	⚐		

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

Success Criteria	Year 1 2021-22	Year 2 2022-23	Year 3 2023-24
Publicise the opportunities of new roles and recruit	⚐	⚐	
Monitor the success of the new roles implemented			⚐

Learning From Deaths

0. Reference Information

Author:	Dr James Neil, Trust Lead	Paper date:	25 November 2021
Executive Sponsor:	Dr Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee – 14.10.2021	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report to be presented at the Trust Board.

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

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

The report is also discussed at the Multi-disciplinary Clinical Audit Meeting.

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

MSG report discussed at Patient Safety committee.

The Quality and Safety Committee considered and noted the report on 14th October 2021.

2. Executive Summary

2.1. Context

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

2.2. Summary

See Numbers Below.

2.3. Conclusion

No Concerns or specific learning identified.

Learning From Deaths

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes/Family feedback.	Actions
June 2021	0	0	0	0	No theme/Feedback	None required
July 2021	1	1	0	0	Positive feedback from family re EOL care.	None required
August 2021	0	0	0	0	No theme/Feedback	None required
September 2021	0	0	0	0	No theme/Feedback	None required

3.3. Associated Risks

None

3.4. Next Steps

Discussions in progress with SATH concerning a link with their Medical Examiner and Bereavement system. DPIA awaited from SATH but process progressing.

LFD lead at RJAH now attends Mortality steering group at SATH.

Shropshire LFD group having first meeting next week.

Incorporate family feedback into report.

(Requires setting up of a co-ordination office as part of the process to join with SATH bereavement).

3.5. Conclusion

No concerns or specific learning identified.

Appendix 1: Acronyms

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Infection Prevention & Control & Cleanliness Quarter 2 Report 2021/22

0.0 Reference Information

Author(s):	Anna Morris Sian Langford	Paper date:	25 November 2021
Executive Sponsor:	Sara Ellis-Anderson	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality& Safety Committee – 18.11.2021	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1.0 Purpose of Paper

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

The Board are asked to note the progress report against the annual plan for Infection Prevention and Control and Cleanliness Report.
The report has been presented to the Infection Control Committee and Quality and Safety Committee prior to Board.

2.0 Executive Summary

2.1. Context

Through the monthly Board performance report, the Board are briefed on the mandatory bacteraemia and any key issues emerging from those results. Over and above the mandatory reporting, the Board receive a report at least four times per year from the Director of Infection Prevention and Control (DIPC) (Chief Nurse). This report includes a high-level summary of the key issues in Infection Prevention and Control as well as cleanliness.

2.2. Summary

	MRSA Bacteraemia RJAH Acquired	MSSA Bacteraemia RJAH Acquired	E.coli/Pseudomonas/Klebsiella Bacteraemia RJAH Acquired	C.*Difficile*
Month	**No. of Cases**	**No. of Cases**	**No. of Cases**	**No. of Cases**
Jul	0	0	0	0
Aug	0	1	0	0
Sept	0	0	1	0
Quarter	**0**	**1**	**1**	**0**

2.3 Conclusion

The Board of Directors will have seen through the Board performance papers that there have been no cases of reportable MRSA bacteraemia since 2006.

The summary in the main report shows current performance in cleanliness and infection control against the work plan.

Infection Prevention & Control & Cleanliness Quarter 2 Report 2021/22

3.0 The Main Report

3.1.1 Introduction

This report provides an update on progress made within Quarter 2, 2021/22 to the Board of Directors, to ensure that the Board are briefed at a high-level on any trends or issues that identify best practice or any gaps in assurance from which further work or actions are required.

3.1.2 Infection Prevention & Control Committee (IPCC)

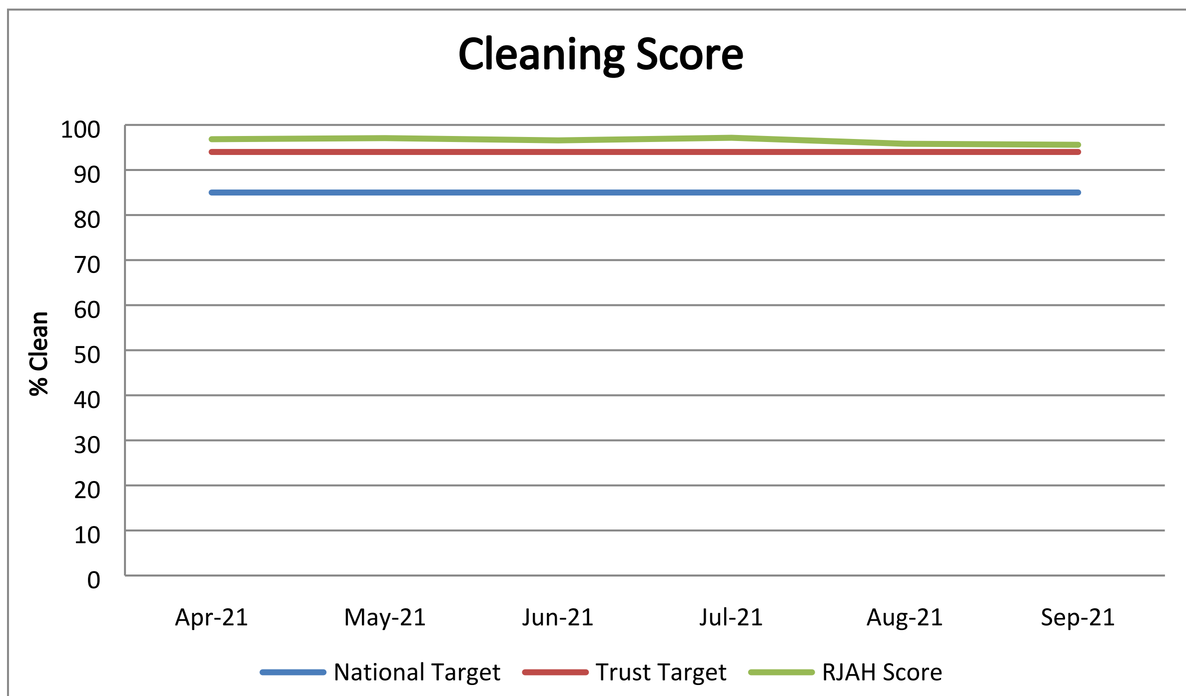
The IPC Programme of Work (POW) 2021-2022 which is based on the 10 criterions set out in the Health & Social Care Act 2008 has been developed by the IPC team and was presented at IPCC in July 2021. The IPC POW has been added to the Quality Management System and will continue to be reviewed at IPC Committee.

3.2. Cleanliness

Measured cleanliness has been maintained above the National calculated target (85.0%) and Trust target (94.0%) over the most recent quarter, achieving an overall average for the quarter of 96.19% which is lower than recent reporting periods, this report will further detail reasons for this.

3.2.1. Cleanliness – Detail

6 functional areas did not meet their National Specification for Cleanliness target audit across the quarter – 4 recorded in Very High Risk areas (Theatres and TSSU), 2 recorded in High Risk areas (MCSI OPD and Wrekin)



Over the quarter there were 16 instances reported where an individual area didn't meet its risk-based target for the month. Of these, 10 were in Very High-Risk Areas. Actions identified through this process continue to be raised via action sheets to the relevant team, which includes meeting with ward/department managers to discuss potential strategies to avoid repeated fails.

An external investigation into the July/August outbreak of MRSA in MCSI noted cleanliness as a contributing factor. Audits undertaken by NHSE/I and a peer review from SaTH noted unacceptable cleaning standards for items that are the responsibility of cleaning and clinical staff.

Further investigation found key themes identified on MCSI, could also be found across other areas of the Trust, including:

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- Surface and touch point cleaning was generally good, however deep cleaning was cause for concern – this included inside beds and under sides of clinical and non-clinical equipment
- Standards of cleanliness were being impacted by the tidiness of the environment, clutter, ineffective use of storage or inadequate storage facilities.
- Awareness of cleaning responsibilities – whilst recorded in the Trust approved policy, it was noted that staff were not aware of their responsibilities.

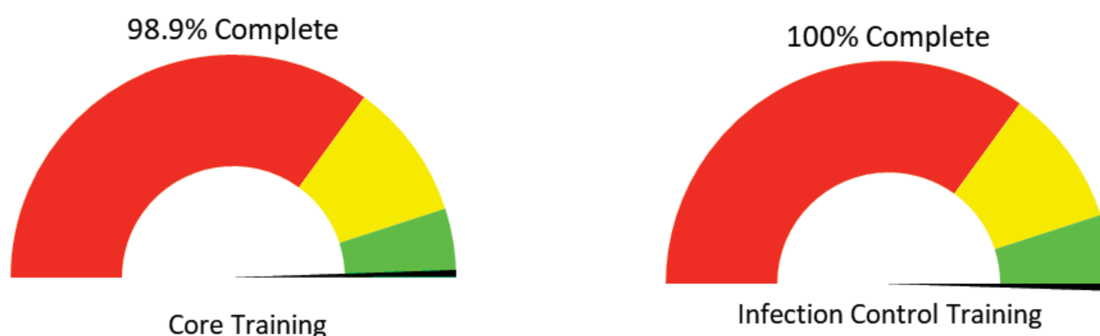
Actions relating to the outbreak have been managed by the Outbreak Control team, who met twice weekly to ensure actions were completed in a timely manner and advocated a multi-disciplinary approach when considering improvements.

Over the quarter, the primary focus of Estates & Facilities teams has been to improve environmental and equipment cleanliness, challenge ourselves on the cleanliness audit process in line with the finding of the external audits and to rectify environmental wear and tear or damage, both of which were monitored through escalated cleanliness audits undertaken by the management team and reported at outbreak meetings. This specific response has included contracting external deep cleaning specialists, who have been deployed across the Trust targeting wheeled items and equipment to bring all items up to the required standard.

Going forward, consideration is being taken to understand a sustainable option to maintain standards. Any service changes will be discussed and reported through the infection control committee governance structure.

3.2.2. Cleanliness – Staff Competency

Training has a very high compliance for the rolling 12-month period, demonstrating our commitment to the highest level of staff competency. The rolling year position at end of September 2021 is shown.

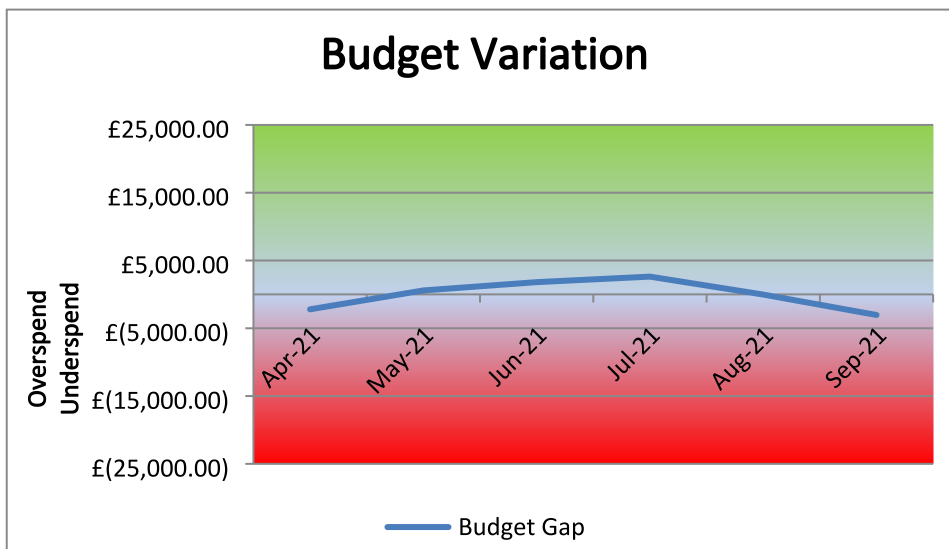


Staff across the Trust have also been required to complete NHS Midlands 'Cleaning for Confidence' programme, which reinforces the basic processes of cleaning and good cleanliness practice for staff in both clinical and non-clinical roles. Compliance at end of September 2021 is demonstrated below.

Staff Group	Compliance %
Add Prof Scientific and Technic	85.71%
Additional Clinical Services	91.39%
Administrative and Clerical	77.37%
Allied Health Professionals	87.43%
Estates and Ancillary	93.29%
Healthcare Scientists	85.71%
Medical and Dental	87.50%
Nursing and Midwifery Registered	89.92%
TOTAL	**86.23%**

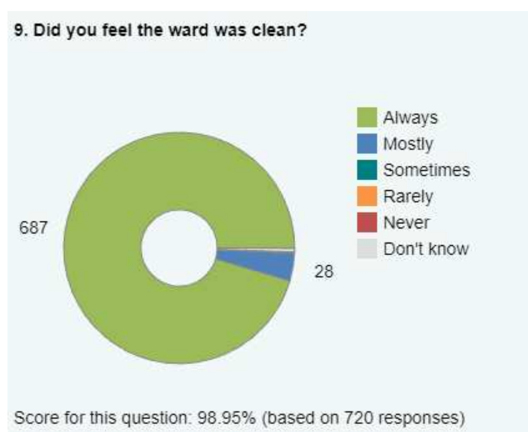
3.2.3. Cleanliness – Spend on Cleanliness

The below chart demonstrates the position at end of September 2021. This data has been skewed by the National push model for delivery of many stock items, including general purpose detergent and Tristel, during the pandemic. Costs directly attributed to the Trusts COVID response (such as increased touch point cleaning) not being reflected here.



3.2.4. Cleanliness – Patient Satisfaction

As part of feedback questionnaires, patients are routinely asked if their ward or department felt clean. Comments are regularly fed back to operational teams.



There were no comments, or detail relating to this specific question recorded, however feedback from the patient experience module included:

- “More nurses, more HCA’s and more cleaners needed in order to relive staff from cleaning duties and attend to patient care” *(Gladstone Ward, August 2021)*
- “All the staff were excellent. I felt very well looked after. The wards were clean, uncluttered and modern. Food and beverage frequency, options and quality were excellent. The provision of socks and hot blankets was fantastic and helped me feel more comfortable.” *(Kenyon Ward, September 2021)*
- “Friendly staff, quick, appointment running on time, very little waiting time, hospital was clean and very covid secure, well signposted” *(Outpatients, July 2021)*

- “Very clean, even cafe and restaurant staff very polite and quick to clean tables and seats once customers leave and all medical staff polite and helpful.” *(Montgomery Unit, September 2021)*
- “The whole experience was very calm and positive, the environment made me feel like a private patient and the staff were all amazing! They couldn’t do enough, were friendly, professional and helped put my nerves at ease. As a mum of two boys this was actually the most relaxing Saturday I’ve had in ages!” *(Baschurch Unit, September 2021)*
- “Room and facilities very tired and could do with investment to upgrade decor, quality of furnishing/en-suite facilities etc. One example is the overhead bed light was not working. However the treatment and care I received from all the staff I came in contact with (medical staff, nursing staff, ancillary staff, volunteers etc was exemplary. The reason I decided to self fund my operation was because of its excellent reputation and specialist standing as a centre of excellence in the local and wider community” *(Ludlow Ward, August 2021)*

3.2.5. Specific Cleaning & Cleanliness Improvements

HPV Decontamination
The facilities team continues to provide HPV fogging decontamination in response to the Trusts needs via Dewpoint solutions. A summary of usage over the quarter is shown below. Following the update of the infection control isolation policy, room cleaning requirements are designated as:

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

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

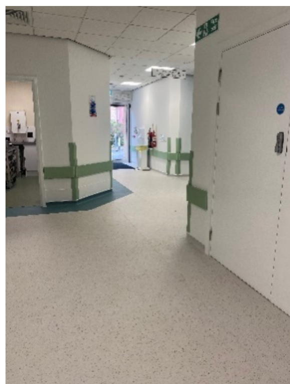
HPV fogging undertaken on site this quarter is summarised below:

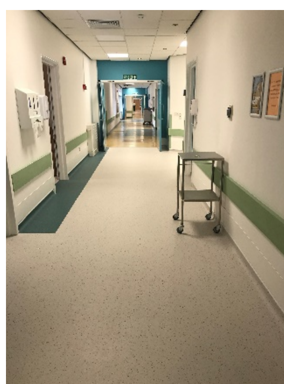
Date	Ward/Department	Area	Rationale
28/07/2021	Wrekin Ward	Double Room 1	Red Clean - MRSA
10/08/2021	Wrekin Ward	Double Room 1	Red Clean – MRSA
15/08/2021	Gladstone Ward	Bay F	Red Clean – MRSA
15/08/2021	HDU	Side room 6	Red Clean – MRSA

Collaborative Working
Through the IPC working group, the Estates & Facilities team continue to advocate a multi-disciplinary approach to environmental improvements across the Trust. This quarter, MCSI was prioritised, with significant support from the ward to maximise access, both teams were able to complete tasks at pace, which has included reorganisation and deep clean of multiple storage rooms, an ongoing programme of redecoration, as well as individual improvement projects shown below:

Renovation of clinical storeroom, which previously had open, wooden shelving to create a more efficient storage solution at the centre of the unit.

Edge protection on door frames – resolving chipped frames previously failing cleanliness audits and preventing further damage.





Replacement of areas of flooring throughout the unit – with addition of raised protective edging to prevent further damage.

3.2.6. Compliance Update - Facilities

National Standards of Healthcare Cleanliness

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

The standards are mandatory, with acute Trusts given implementation guidance and a deadline for completion of May 2022.

Implementation of the New Standards is being managed through the Infection Control Working Group, key milestones are detailed below. At each stage, relevant stakeholders (including the Senior Nursing Infection Control, Operational Cleaning and Ward/Department teams) are consulted. Facilities

colleagues are linking in with counterparts across SaTH and Shropcom to ensure a comparable approach is taken across the region.

Through the implementation process, discussion was held regarding ownership responsibilities of cleaning elements, the multi-disciplinary group reflected on the current board approved responsibilities, and where we would ideally wish the responsibilities to lie. This falls in line with the previously noted concerns escalated through external IPC audit.

Facilities are following the implementation plan set out by NHS England, to ensure the governance around the new standards meets expectations of future assessments.

The frequency gap analysis has highlighted the need for a review of cleaning service model, to ensure that cleaning input hours reflect the new functional risk rating requirements - particularly where areas previously designated as 'Significant Risk' (85% target score) now fall into 'FR 2' category (95% target score), reflecting the interventional procedures taking place in these areas.

A multi-disciplinary review of cleaning responsibilities, considering findings of externally led audits and subsequent deep clean regime, revealed resource shortcomings, meaning that sign off of this document has not yet been possible. At the Extraordinary Infection Control Committee held in September 2021, a delay to implementation of these standards was approved, with full implementation now due in Q4 so that additional cleaning resource and clear competencies can be defined prior to roll out.

Linen

Whilst under current restrictions, the Trust has been unable to complete its annual site audit of the linen contractor; assurance has been gained through monthly compliance reports – in line with their ISO accreditation and BS EN 14065 (Laundry Processed Textiles Biocontamination Control System) these include:

- Swatch testing (Machine Performance)
- Swab Testing (Personnel Hands)
- Swab Testing (Environment)
- Bioburden Testing (Final Products)
- Rinse Water

Contract review meetings continue quarterly.

PLACE

In September, the Trust received confirmation that National PLACE assessments would not take place again in 2021. As with 2020, Trusts are encouraged to undertake internal assessments, using the PLACE lite tool. The tool and associated guidance have been updated, with additional questions in the mood data collection focusing on key recommendations of the National Food Review, and Buildings and Facilities data collection including reference to the National Standards for Cleanliness, Commitment to Cleanliness Charter and visible star ratings.

A programme of audits has been developed, covering all wards and departments usually assessed by the National model, with representation from Estates, Facilities and Clinical teams undertaking the assessments.

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

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Ward/Dept Name	Audit Date	Cleanliness	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	Movement from Previous Audit
Radiology	23/07/2021	99.21%	90.48%	97.92%	73.91%	76.47%	↓ (6%)

Immediate feedback is shared with the ward/department team, accompanied by a copy of the full assessment report & associated comments.

Themes identified through the audit in radiology included:

- Handrails are not present in all areas (affecting both Dementia & Disability scores)
- Standardised patient facing signage required
- Improvements required to ensure equipment is stored appropriately

Actions and themes identified through this audit programme will be monitored by the Infection Control Working Group. Where areas of good practice are found, the group will look to share this across the Trust, encouraging a consistent approach which will improve overall scores once the National programme is reinstated.

COVID-19 Response

As previously reported, Estates & Facilities continues to support the wider Trusts COVID response, with the focus now on maintaining compliance with National guidance and safety measures whilst restoring services:

- Use of National Standard Operating Procedures for cleaning, including additional touch point cleaning and enhanced service, additional cleaning in staff only and office areas and documentation through additional sign off sheets has continued.
- Escalating any waste management issues to NHS England, and maintaining links with professional stakeholder groups to ensure any limitations in terms of clinical waste disposal nationally are considered in a timely manner.
- PPE Management including stock control, top up delivery and liaison with regional partners and NHS England to ensure continued supply.
- Management of fit testing for FFP3 masks, with operational support for testing provided by NHS England, including this quarter a focus on ensuring staff are fitted to more than one model of mask.
- Management of the Trusts COVID screening desk, based at the main entrance.
- In order to support restoration, services are being brought back with consideration to all infection control guidance via the Estates Plan meeting – with representation from the Senior Leadership Team and Estates & Facilities. Challenges arising here are focused on keeping staff and patients safe.
- Ongoing support for the Trust vaccination hub including management of consumables and PPE for this service.
- Ongoing capital projects supporting the IPC agenda including further installation of wall cladding/protection, replacement of handwash basins and consideration of 'Air Scrubber' units.

3.2.7. Compliance Update – Estates

It is noted that both decontamination group and water management group will be reviewing their terms of reference and reporting in Q3. Moving forward, chair's reports will be produced and sent to IPC for assurance or escalation, replacing minutes previously circulated.

Decontamination and Ventilation Equipment Updates

Audit

Estates support the business continuity of the Trust sterile services by maintaining the on-site decontamination equipment on a scheduled periodic basis. These periodic tests challenge the processes carried out by the decontamination equipment in 'worst case scenarios' to validate the machines for safe use. All periodic testing due this quarter has been carried out; 150 weekly tests, 9 quarterly tests and 6 yearly tests. As is standard practice all out of parameter results are followed up and resolved (note that no decontamination equipment is returned to service until it passes its periodic test).

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All periodic testing is audited by the Trust appointed Authorising Engineer (Decontamination).

Settle plate testing is carried out in some areas for further assurance, or as mitigation for those systems installed prior to HTM 03-01. This gives Decontamination Group a good grasp of the air-contaminate levels in these areas, providing further assurance.

For Q2, 52 settle plate tests were carried out; there was one plate that breached the limits set by Decontamination Group, but only at an 'investigate' level (4cfu), in TSSU B. Facilities investigated for root cause; cleanliness did not seem to be an issue, however there was items stored in the area that may be making cleaning difficult. It is noted that Estates have installed wall protection to some high-traffic areas which would add further infection control.

Reverification of the Critical Air Plant across site is a requirement of HTM 03-01 and is completed annually for each piece of equipment. Where remedial works cannot be completed, this is escalated through Decontamination Group. All reverifications due in Q2 have been completed. It is noted that there are ongoing issues with the John Charnley Laboratory clean air cabinets, which are in the process of receiving a replacement fan. The Committee can be assured that no tissues are being processed during this period, and that the clean room and equipment will receive full reverification once the works are complete.

Water Hygiene Updates
Audit

In line with HTM 04-01 and HSE Legionella Approved Code of Practice document, L8, the Trust conducts routine maintenance on the domestic water infrastructure across site on a planned and reactive basis. This quarter, the following water quality samples were taken:

Type	06/04/2021→ 27/07/2021
Legionella	19
Pseudomonas	83
Hydropool water quality	16
Z Bacteria	None required this quarter

There were no results that breached HSE/HTM guidelines for reporting to IPC in Quarter 2. As is standard practice all out of parameter results are followed up and resolved.

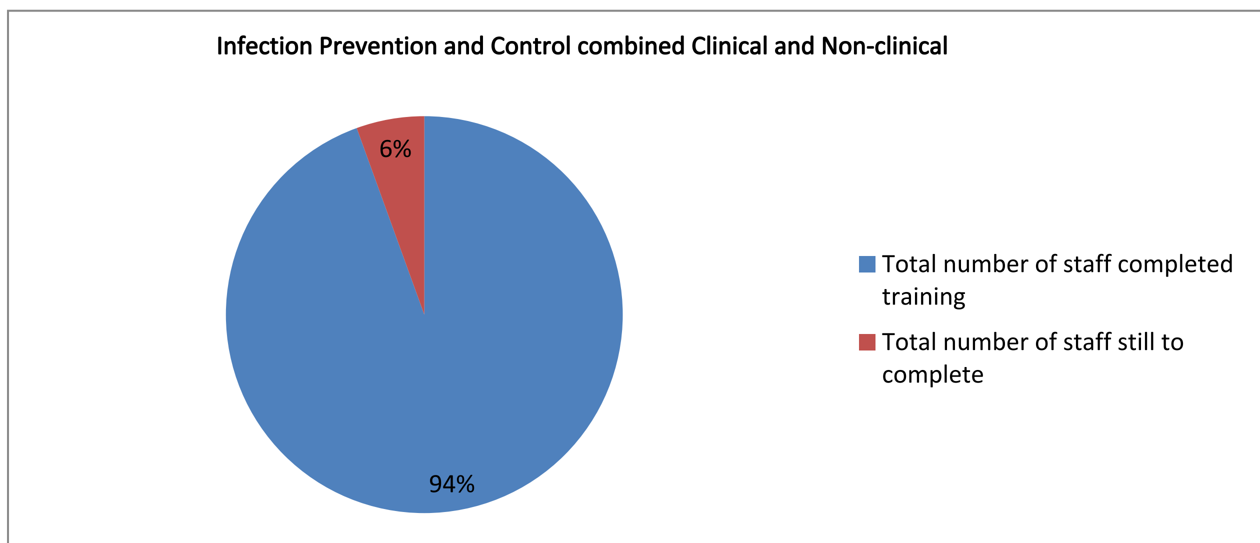
3.3. Infection Prevention & Control

3.3.1. Training

The graphs below show a break down in the infection prevention and control training figures for clinical and non-clinical staff by unit which is accessed via e-learning. Ward/departmental managers are responsible for ensuring that staff are up to date with infection prevention and control training as part of the appraisal process. Interactive infection control training is delivered to all staff on induction including volunteers and work experience to the Trust. Practical ward training is delivered on request

Infection Control Training Data as at 30 September 2021 - Unit Summary

	Completed "in date" Infection Prevention and Control (Clinical Staff)			Completed "in date" Infection Prevention and Control (Non-Clinical Staff)			Completed "in date" Infection Prevention and Control (Combined Clinical and Non-clinical)		
	Annual			3 Yearly			Annual/3 yearly depending on job role		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Assurance & Standards Team	2	2	100.0%	51	50	98.0%	53	52	98.1%
Clinical Services Unit	208	192	92.3%	96	96	100.0%	304	288	94.7%
MSK Delivery Unit	419	381	90.9%	55	52	94.5%	474	433	91.4%
Office of the CEO	0	0		10	9	90.0%	10	9	90.0%
Specialist Delivery Unit	262	251	95.8%	58	57	98.3%	320	308	96.3%
Support Services Unit	10	9	90.0%	336	334	99.4%	346	343	99.1%
Covid-19 Vaccination Centre	1	0	0.0%	1	1	100.0%	2	1	50.0%
TRUST WIDE TOTAL(including Medical Staff)	**902**	**835**	**92.6%**	**607**	**599**	**98.7%**	**1509**	**1434**	**95.0%**
Bank Staff	97	84	86.6%	38	35	92.1%	135	119	88.1%
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**999**	**919**	**92.0%**	**645**	**634**	**98.3%**	**1644**	**1553**	**94.5%**

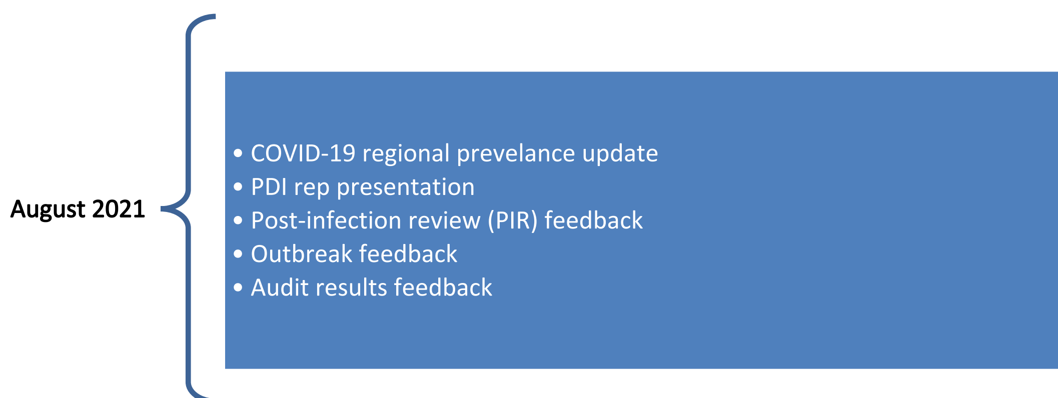


Legionella training

In collaboration with Estates and Facilities, the team secured Legionella Awareness training for link staff, in order for staff to understand the dangers of legionella and the practical steps that can be taken to avoid risks to patients. Link staff have received access to the training module and progress will be monitored through Infection Prevention and control Link Staff meetings.

3.3.2. Infection Control Link Meetings

Link meetings are held bi-monthly. Link staff are required to disseminate infection prevention and control updates/information to their work colleagues, as set out in the Link Staff Roles & Responsibilities document. Link Staff meeting attendance as been poor in recent months due to staff finding it difficult to access MS Teams in their work areas. This concern has been raised to ward managers at SNAHP; the IPC team are working towards to reintroduction of face-to-face link staff meetings providing mitigations are in place, to improve attendance.



3.3.3. Audit

All clinical areas with designated QR codes submit IPC audits via the perfect Ward System.

Montgomery Unit, Orthotics, ORLAU and Therapies will be added to the Perfect Ward system in the second phase of its roll out. These areas continue to complete audits via the paper system and manually analysed by the IPC Data Analyst in the interim.

All audit scores are fed into the local IPC Quality Management System (QMS) introduced in June 21. The system was designed to centrally collect data and form a statistical relationship between all IPC data streams.

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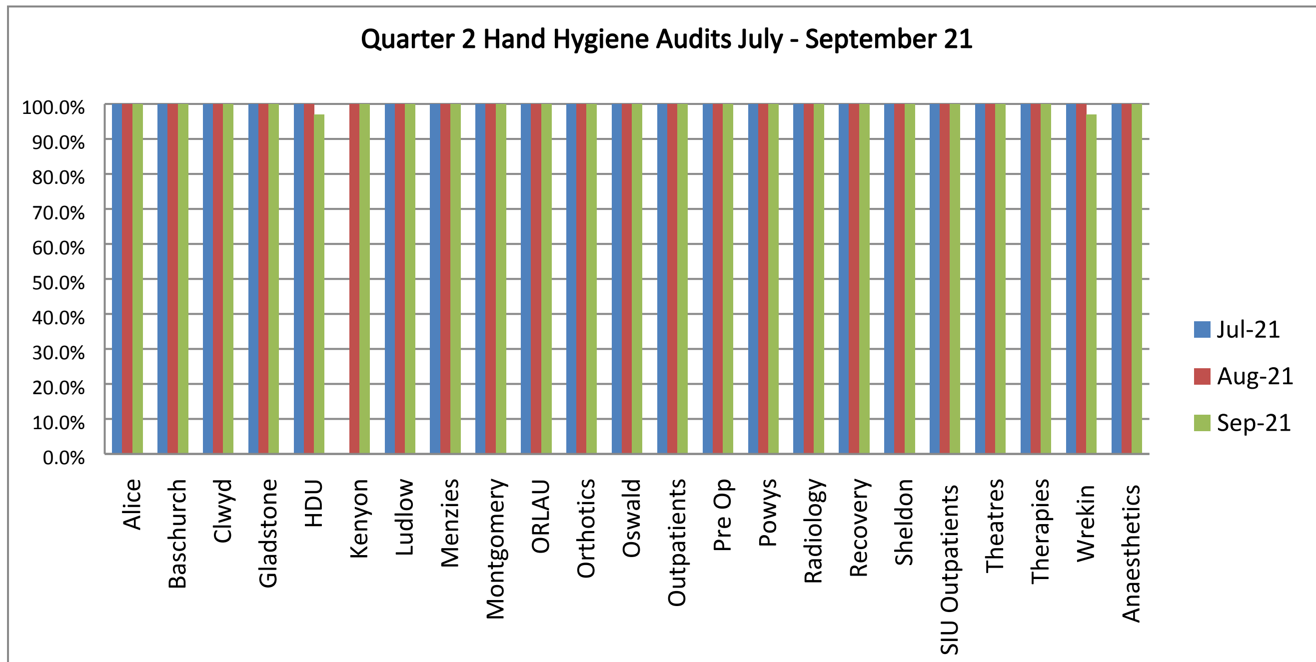
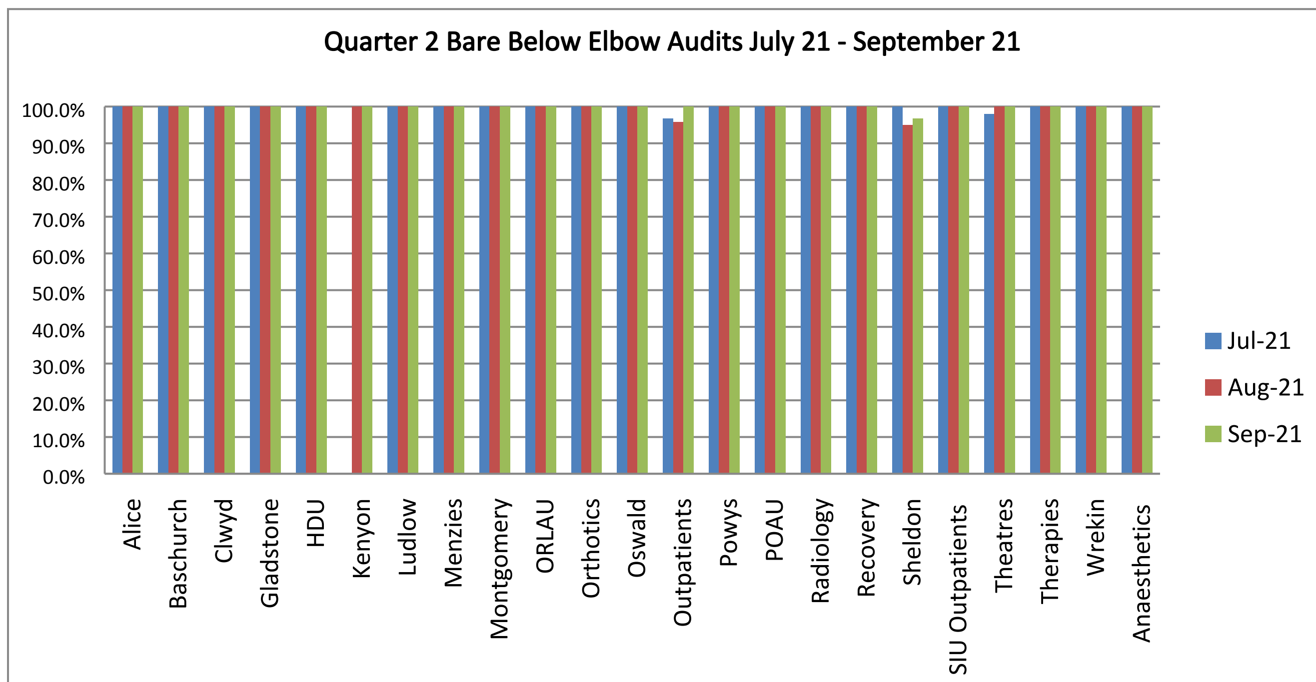
3.3.3.1. Hand Hygiene



3.3.3.2. Bare Below the Elbow (BBE)

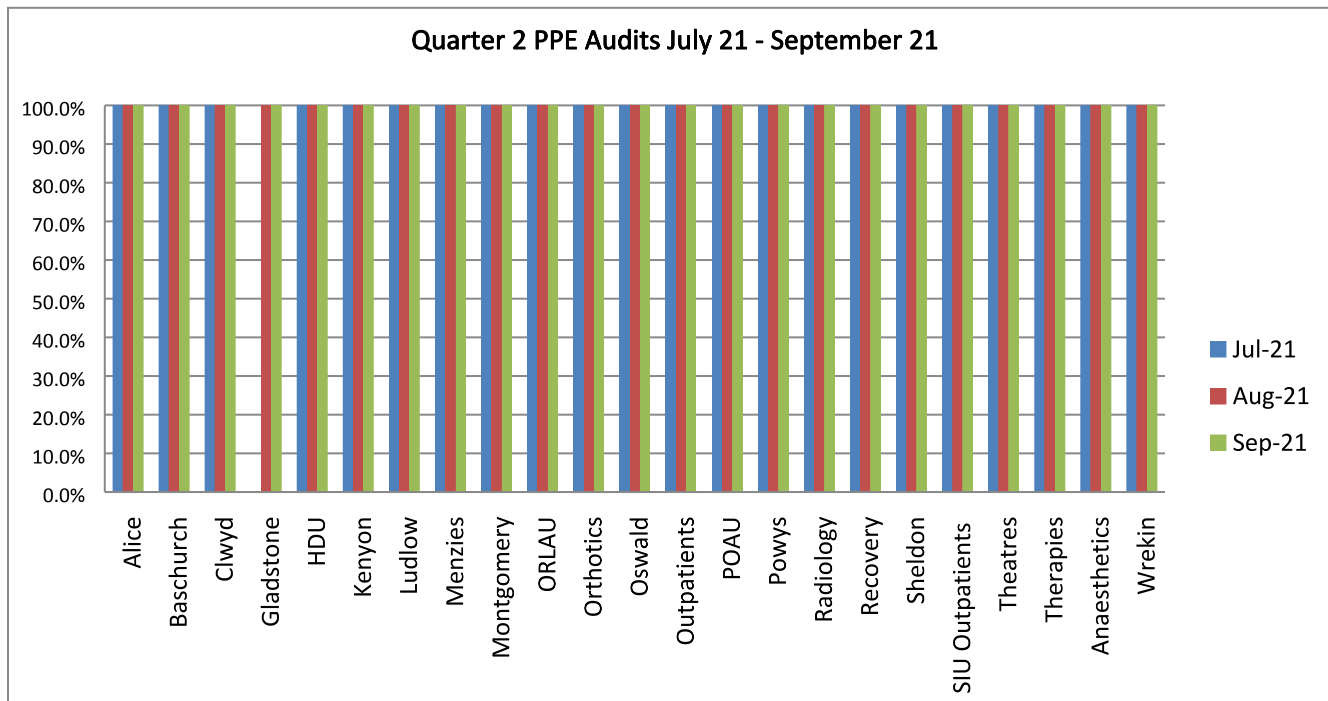


The above graphs demonstrate 99.7% compliance in Hand Hygiene and 99.9% compliance in Bare Below the Elbow.

Feedback collected from the audit forms and extracted from Perfect Ward identified issues relating to staff wearing watches and 5 moments of hand hygiene not being observed.

The QMS implemented continues to collect and feed all audit data into the redesigned IPC Unit reports.

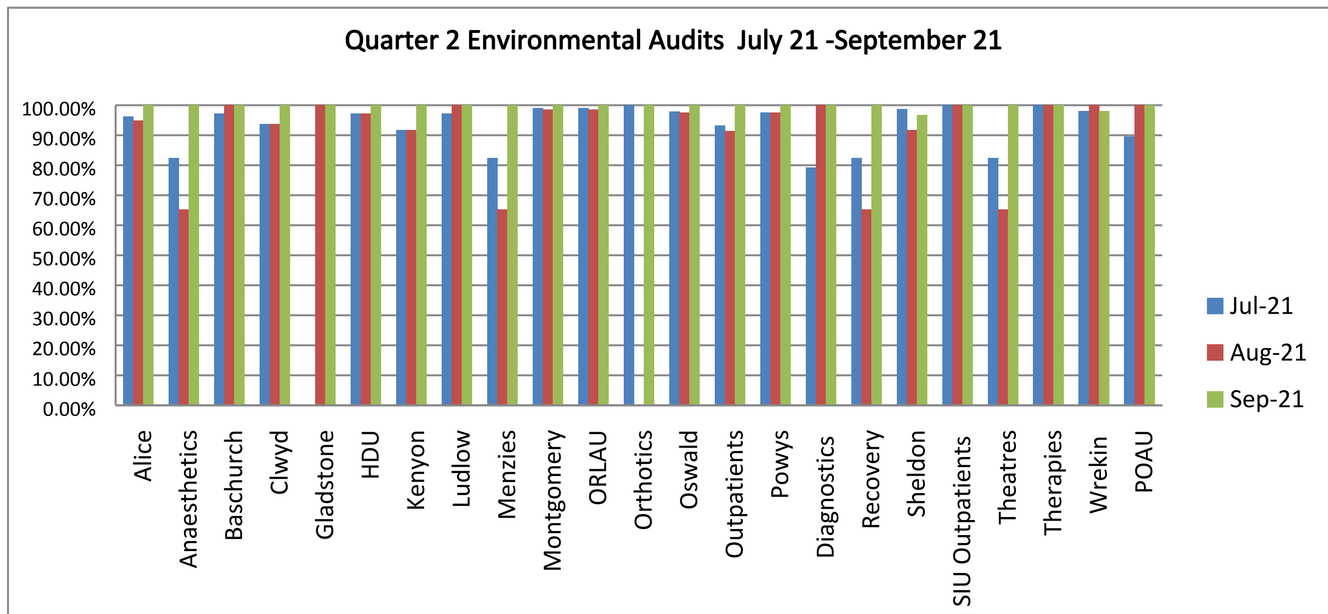
3.3.3.3. Personal Protective Equipment Audits (PPE)



Due to implementation of Perfect Ward System, the PPE audit has been amalgamated with the COVID-19 checklist. Scores are graphically separated to show compliance to both areas. The graph above shows that scores improved significantly with all areas demonstrating a 100% compliance throughout the quarter to PPE requirements.

The volume of IPC audits increased for this quarter in response to outbreaks detailed in the Outbreak section of the report.

3.3.3.4. Environmental Audits



Environmental audits are now captured via Perfect Ward. Observations extracted from the system show the following areas of noncompliance. In-depth detail surrounding areas of non-compliance will be summarised with actions undertaken in the quarterly IPC Unit Reports: and submitted to IPCC.

Location	Issue
Sheldon	❖ Sluice is overstocked. ❖ No Macerator checks in sluice for September 21. ❖ BBE posted not displayed on ward entrance ❖ Temporary closure mechanisms are not in use
Wrekin	❖ BP cuffs non disposable

3.3.3.5 COVID-19 Personal Protective Equipment Checklist Observational Tool

As stated above, PPE and COVID-19 checklist audits been amalgamated on the Perfect Ward system. However, scores are manually separated on the QMS to show individual compliance.

Audits for the quarter demonstrate all areas were 99.4% compliant to COVID-19 precautions with only one main theme of noncompliance identified:

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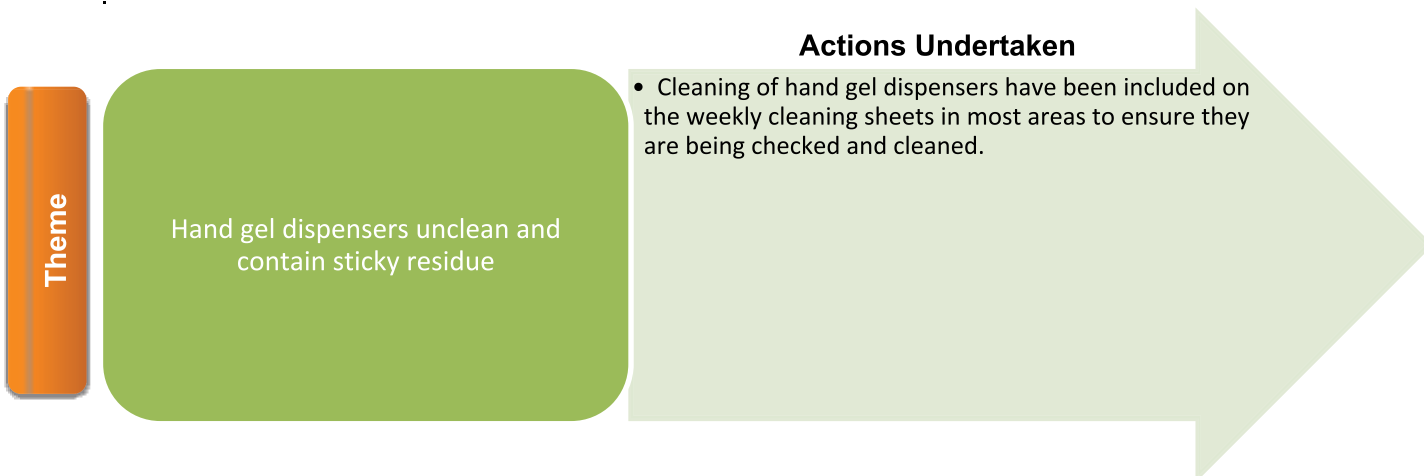

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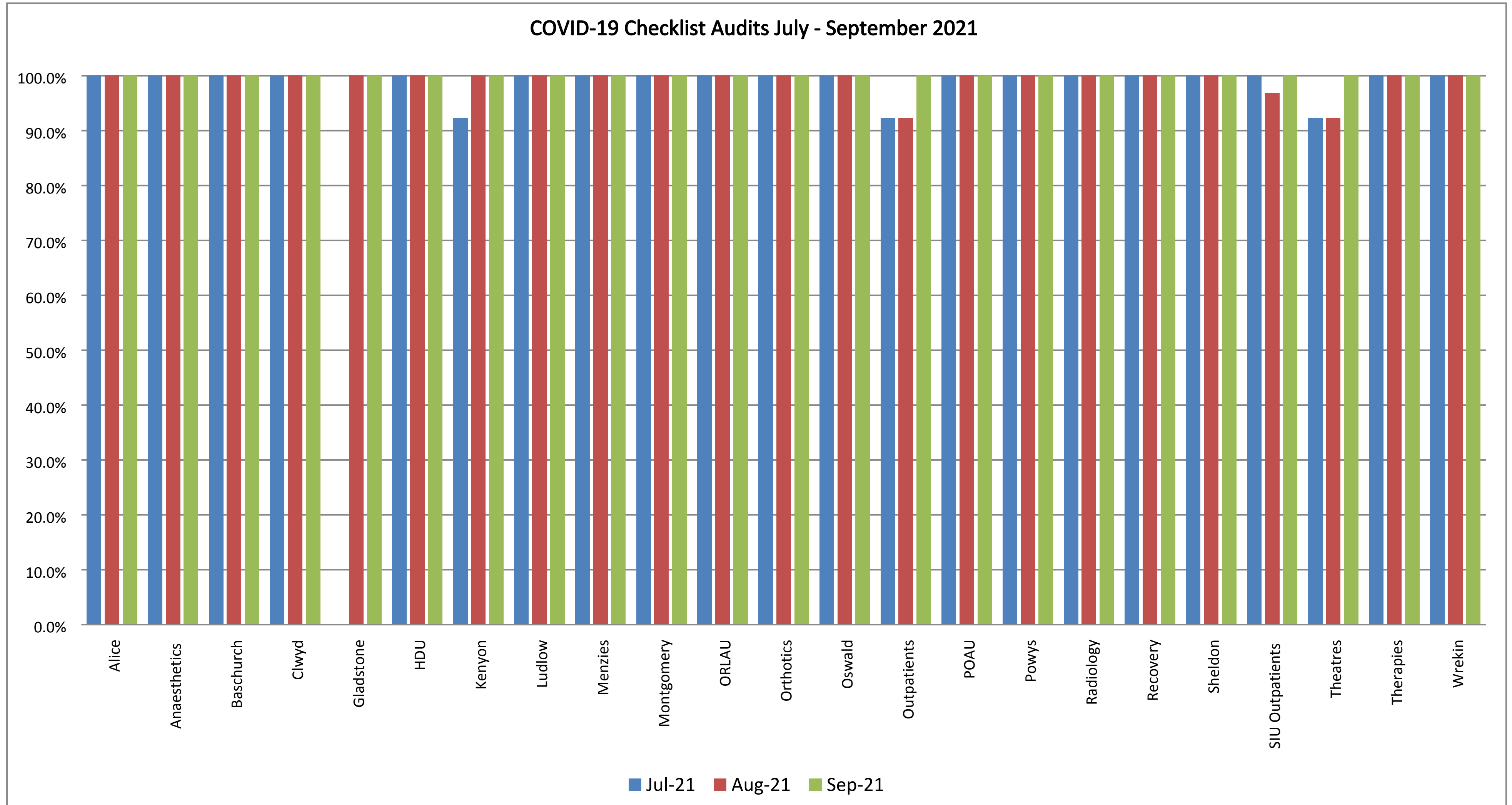

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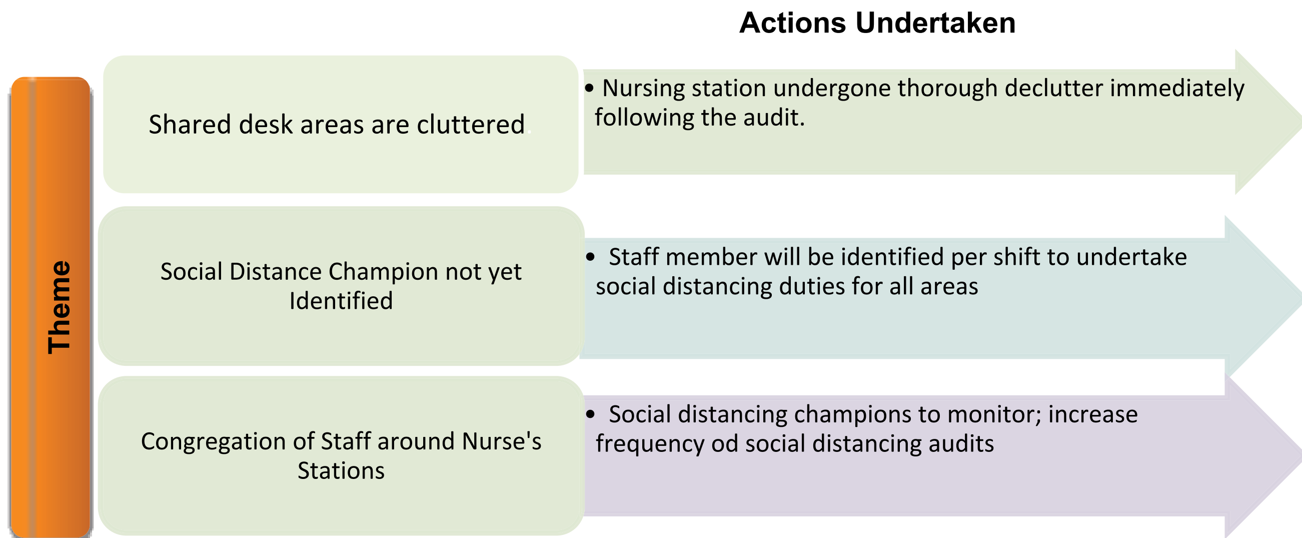
3.3.3.6 Social Distance Checklist Observation Tool

To avoid duplication of data, the audit dashboard has now been ceased for all areas undertaking audits via the Perfect Ward System. The system shows live data and therefore scores are easily obtained via the app for all areas. The Trust demonstrated a 99% compliance to social distancing requirements for this quarter. The following themes of non-compliance were extracted from the Perfect Ward system:



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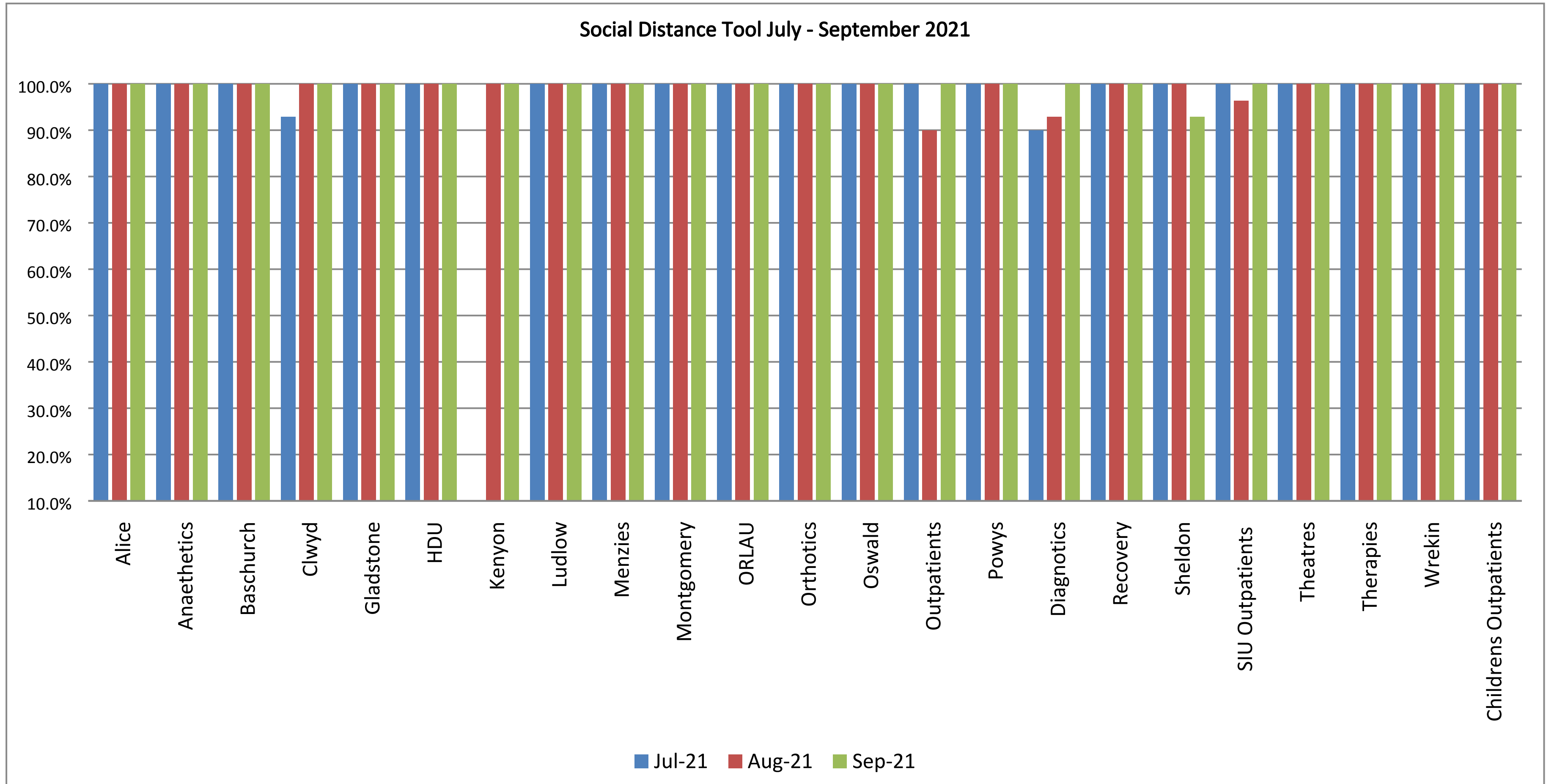

No data was submitted for Kenyon Ward in July due to ward closure

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

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IPC Quality Assurance Audits

During Q2, the IPC team reviewed the team audit process and developed a programme of inspection that adopted a tool which enables each ward to be provided with a score and RAG rating. Wards/depts are provided feedback by the IPC team along with a score showing their RAG rating. Action plans are created by ward/dept and a copy is sent to the IPC team for assurance purposes. Individual actions are addressed at ward level, and progress is shared to the IPC team. Progress on actions is monitored through the QMS and a position of all action plans is provided to the monthly IPCC. A process of escalation has been presented to IPC&C working group and approved through IPCC.

During the MRSA outbreak, Wrekin and Gladstone ward were audited using the accredited tookit from the Infection Prevention Society (IPS), as advised from NHSE/I. Theatres were audited using a tool also provided by the IPS. Moving forward into Q3, the IPC team will adapt and develop audit tools that are suitable for use in outpatient areas and Theatres in order to ensure that these areas are assessed to the same standard each time.

Ward	Planned date of assurance walk	Date completed	Score
Alice	13/08/2021	13/08/2021	82%
Sheldon	16/08/2021	16/08/2021	91%
Kenyon (Closed)	16/08/2021		
Gladstone	17/08/2021	18/08/2021	92%
Wrekin	18/08/2021	15/09/2021	97.50%
Clwyd	17/08/2021	19/08/2021	91%
Powys	17/08/2021	17/08/2021	86%
Recovery	17/08/2021	17/08/2021	82%
HDU	19/08/2021	16/08/2021	81%
Oswald	16/08/2021	16/08/2021	90%
Ludlow	19/08/2021	18/08/2021	81%
Dept			
Outpatients			**feedback provided**
Physiotherapy			**feedback provided**
Theatres	31/08/2021	31/08/2021	81%
Radiology			**feedback provided**

Compliant: Green >90% Partial Compliance: Amber 81-89% Non-compliance: Red <80%

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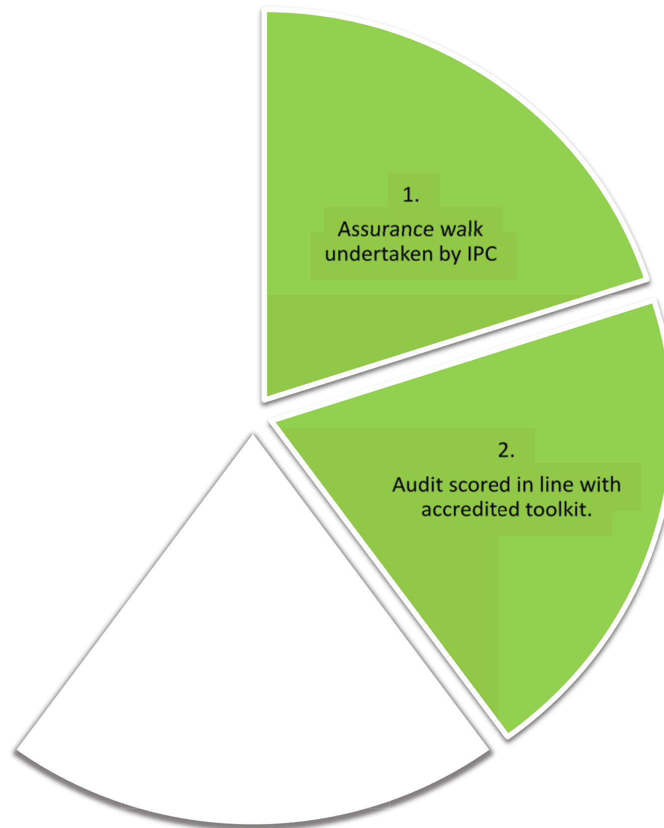
An IPC assurance walk governance process has been created to provided below to support the new system and is displayed below:



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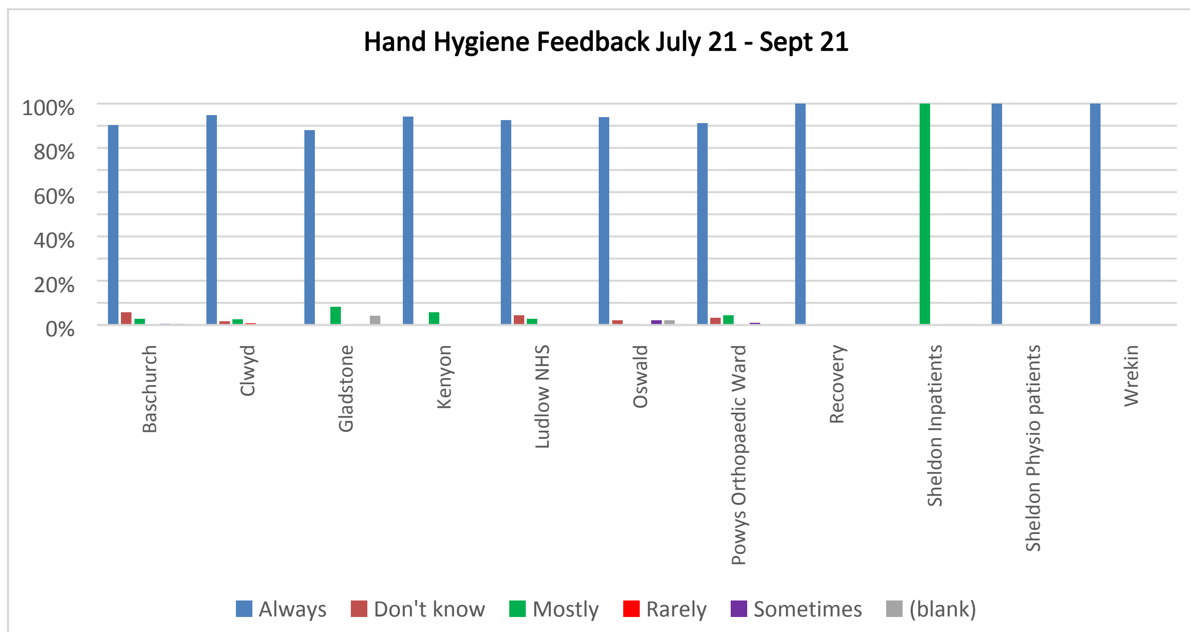
Hand Hygiene – Patient Feedback



The graph above shows the positive responses received in relation to hand hygiene practices observed during their stay.

3.3.4. Surgical Site Surveillance

Providing data to the national SSI process enables the Trust to benchmark on a national basis with other Trusts and promote the low infection rates within the Trust. The process uses nationally agreed criteria from which the definition of a Surgical Site Infection is formed. Understanding surgical site infection rates enables the Trust to estimate the size of SSI risk in patients undergoing specific operations.

The Trust submits the maximum of all data, which is above the national requirement for one quarter of surveillance in one category of surgery per year. Year-round surveillance is performed for total hip, total knee and spinal surgeries.

The Trust submits surgical site infection data to the PHE database on a quarterly basis; reports are always one quarter behind to allow a window of time for any infections to present.

The data below shows the SSI rates for April, May and June 2021. The Trust report a total of 8 surgical site infections for Quarter 2.

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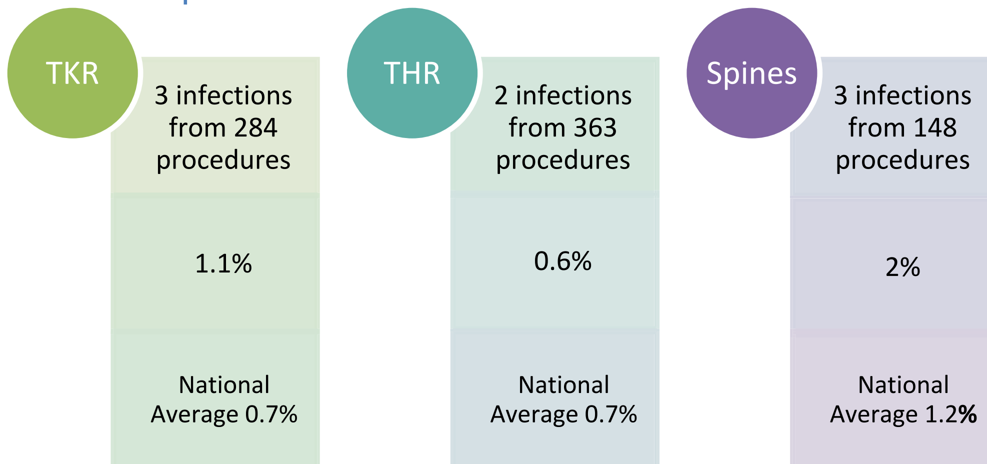
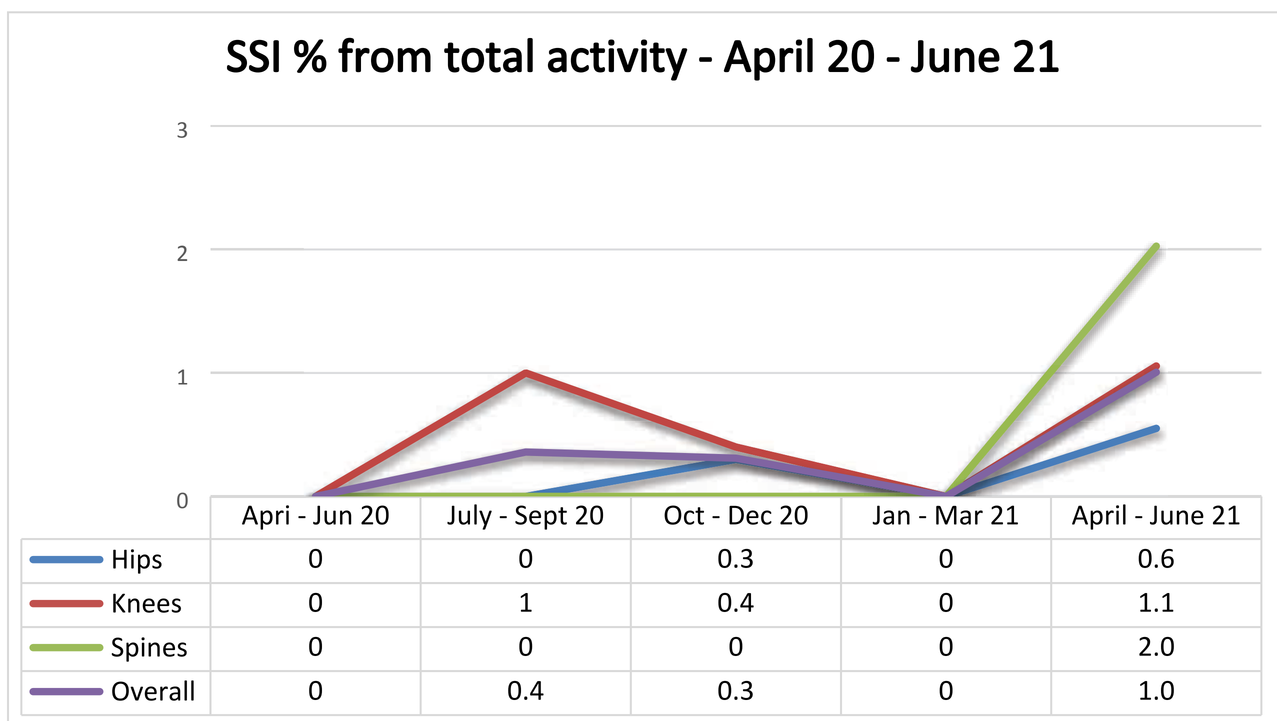


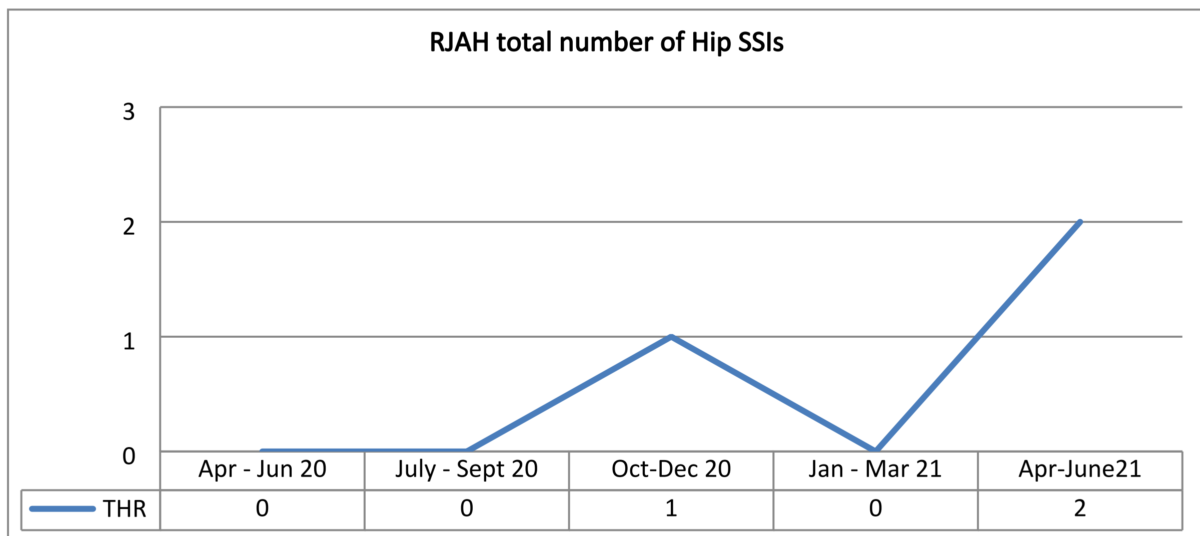
The Surgical Site Surveillance Nurse liaises with the consultants concerning wound infections. The data for April, May and June 2021 has been verified and the results have been submitted to PHE and published on their web site. All of these infections were discussed and confirmed at the Infection Multi-Disciplinary Team meeting (IMDT).



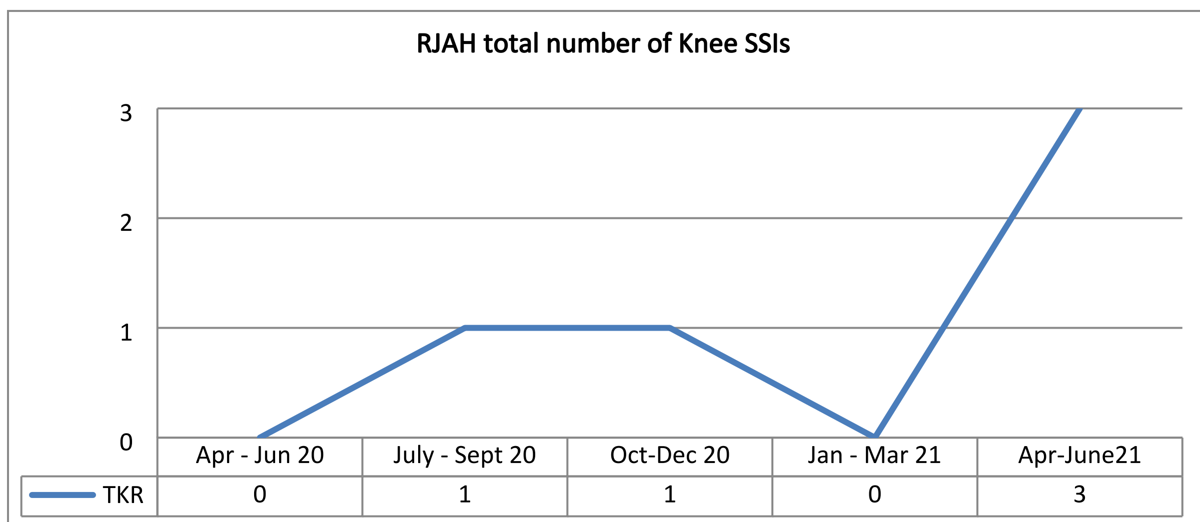
	Apri - Jun 20	July - Sept 20	Oct - Dec 20	Jan - Mar 21	April - June 21
Hips	0	0	0.3	0	0.6
Knees	0	1	0.4	0	1.1
Spines	0	0	0	0	2.0
Overall	0	0.4	0.3	0	1.0

The graph above shows RJAH Infection rates for the last 12 months. Rates for Hips (THR), knees (TKR)

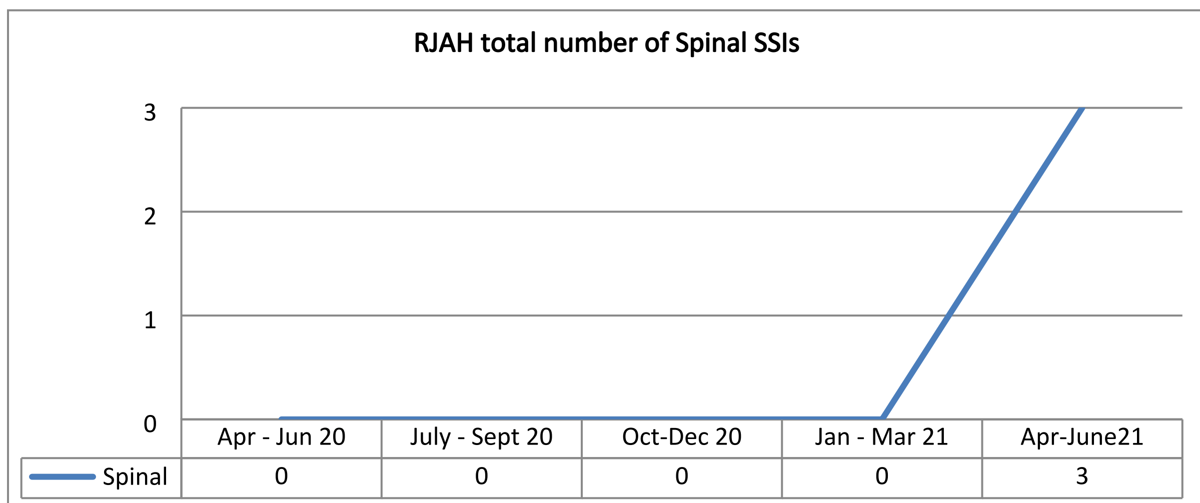
The Trust reported a total of 8 SSI infections for April – June; the graphs below show the break for each speciality:



	Apr - Jun 20	July - Sept 20	Oct-Dec 20	Jan - Mar 21	Apr-June21
THR	0	0	1	0	2



	Apr - Jun 20	July - Sept 20	Oct-Dec 20	Jan - Mar 21	Apr-June21
TKR	0	1	1	0	3



	Apr - Jun 20	July - Sept 20	Oct-Dec 20	Jan - Mar 21	Apr-June21
Spinal	0	0	0	0	3

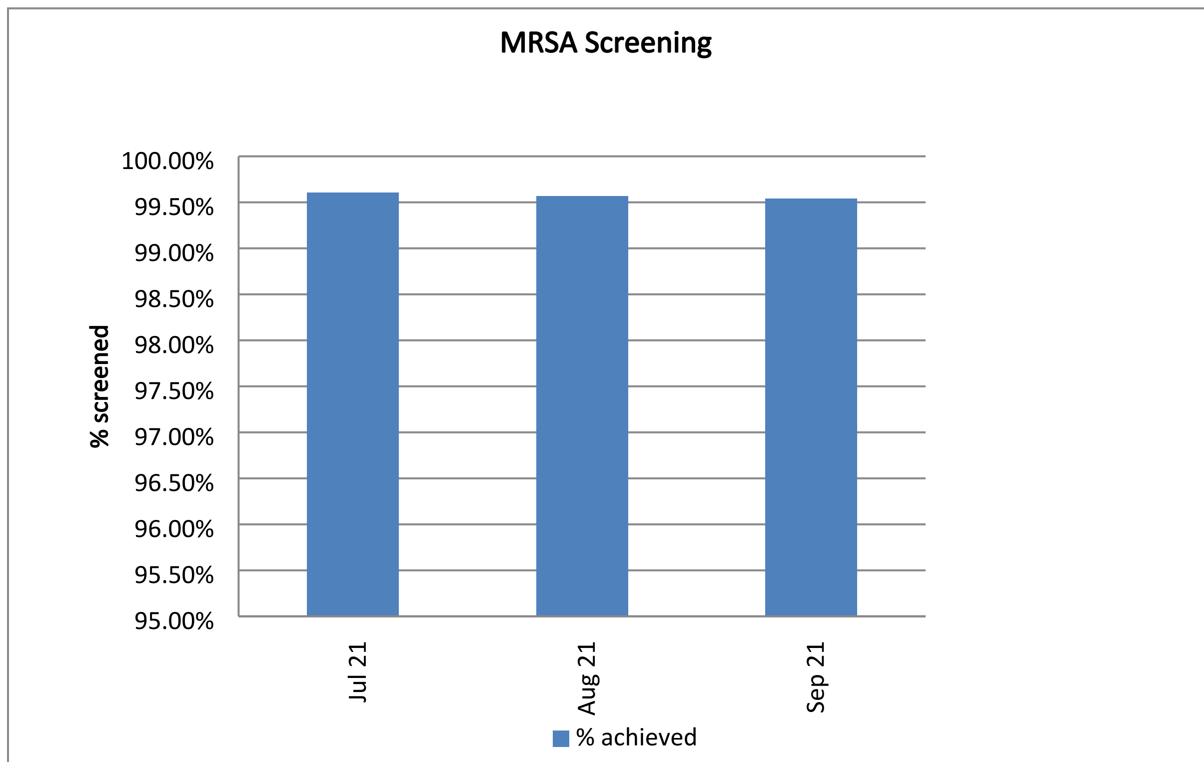
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

An investigation has been undertaken and on full analysis taking into account data from 2015, this number of SSIs is in line with periodic trends; however, a review of the process for investigating SSIs is being undertaken by the IPC team and will be reported through IPCC.

3.3.5. MRSA Swabbing and New Isolates

MRSA swabbing for all admissions continues and is monitored internally to ensure that the Trust remains compliant to the national requirement for reducing preventable Hospital Acquired Infections.

	July 21	Aug 21	Sept 21
Eligible patients	763	697	868
Screened for MRSA	760	694	864
% achieved	99.61%	99.57%	99.54%
Target	100%	100%	100%



MRSA screening compliance remains high and above the target set by the commissioners. MRSA swabs that have not been undertaken are alerted to the relevant line managers for investigation.

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

3.3.6. Alert Organisms

3.3.6.1. C.*Difficle*

There have been 0 cases of C.*Difficle* to report during Quarter 2.

3.3.6.2. MSSA bacteraemia

The Trust report one case of MSSA bacteraemia in Quarter 2. A post-infection review (PIR) was undertaken which identified a surgical site infection as the source. Themes were identified in relation to poor documentation around catheter insertion and blood cultures. An action plan has been created to include to following recommendations:

- VIP score to be added to the VitalPac system
- Catheter audit to be completed in Theatres
- Identify the Sepsis lead for the Trust
- To investigate the management of the diabetic patient post-surgery
- The Trust to provide blood culture training to medical and nursing staff
- For Registrars to receive Sepsis management training
- PIR recurrent themes to be reflected in the Matron's Unit Reports and presented at IPCC

Progress from the PIR action plan will be monitored through the Quality Management System reported to IPCC.

PIR feedback was shared at the latest SNAHP meeting and will be shared at the next IPC link staff meeting.

3.3.6.3. E.*coli*/Klebsiella/Pseudomonas bacteraemia

There was one case of E.coli bacteraemia in Quarter 2. A post-infection review was booked for 12/10/21 but was postponed due to poor attendance. A review of the process for future PIRs will be discussed at the next IPCC in October 2021.

3.3.6.4 COVID-19 Coronavirus

During Quarter 2 the Trust continued to react and implement changes in response to COVID-19.

The Trust Coronavirus policy is regularly monitored and updated in accordance with the latest national guidance.

3.3.6.5 CQC Assessment/ Board Assurance Framework

As the understanding of COVID-19 has developed, NHS England, PHE and related guidance on required infection prevention and control measures has been published, updated, and refined to reflect learning.

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

There are ten overarching key lines of enquiry. The Trust is compliant with the majority of these standards. An action plan has been produced to capture any areas of improvement. Monitoring of this action plan is captured through the IPC QMS and a position on the progress will be reported to IPCC.

Infection Prevention & Control & Cleanliness Quarter 2 Report 2021/22

10 Key Lines of Enquiry

- Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
- Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide or secure adequate isolation facilities
- Secure adequate access to laboratory support as appropriate
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

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

Infection Prevention & Control & Cleanliness Quarter 2 Report 2021/22

Outbreaks

A total of 2 outbreaks were reported during Quarter 2 which are summarised below:

1. **MRSA outbreak – Wrekin Ward**

An outbreak of MRSA on Wrekin ward was declared on 20th July which involved a total of 10 patients, 8 of which acquired MRSA during their admission. Twice-weekly outbreak meetings were held that included CCG, PHE and NHSE/I. Audits were undertaken by the IPC team using an accredited toolkit from the Infection Prevention Society. Findings showed issues relating to cleanliness, estates, clutter, and usage of PPE; and an initial audit showed a score of 79% compliance. External audits were undertaken by NHSE/I and a peer review by SaTH which showed similar findings. Over a period of two months, compliance scores improved to 98.5% which reflects the hard work and collaboration between the teams to improve standards (some examples can be found in 3.2.5).

Two patients were infected with MRSA and received systemic antibiotics in accordance with antibiotic guidelines.

Seven out of eight patients who acquired MRSA were successfully decolonised. One patient remained MRSA positive after two attempts at decolonisation, in accordance with the Trust's MRSA policy and discussion with the Consultant Microbiologist who advised it was not appropriate for further decolonisation treatment at this point.

As a specialist centre for spinal injuries, several patients at referring trusts were affected during the outbreak due to the closure of the ward. These patients were supported by the MCSI team and harm reviews were completed.

Lessons learned were identified and are summarised below:

- The importance of maintaining a clutter free environment
- Doors to isolation rooms should remain closed unless risk assessment is in place i.e compromised patient safety issue from keeping doors closed
- Importance of hand hygiene in between each patient interaction
- Training of patient screening requirements for staff required
- Staff need more awareness of decolonisation regimes
- Training required for cleaning responsibilities between clinical and facilities staff

Recommendations were made which included:

- Review Trust MRSA policy
- Clear cleaning responsibilities between clinical and domestic to be defined
- Introduce groin swabbing as part of all patients medical/surgical pathways
- Immediate identification and resolution of all environmental and estates repairs
- Regular peer and external departmental audits of compliance with IPC
- IPC quality walkabout audits undertaken using the RAG rating system to determine frequency of audits dependant on the overall score
- Develop avenues to check on understanding of IPC guidance and consider different ways of disseminating information.
- Audit of MRSA decolonisation regimes
- Shared learning from outbreaks cascaded through clinical leads and ACNs.

More details around these recommendations will be captured in the SI RCA paper.

There are a number of platforms where the lessons learned have been shared, including SNAHP, ward meetings, IPCC and Unit governance meetings and ward teaching sessions.

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

Moving forward the focus for MCSI is on the maintenance and sustainability of the standards that have been achieved since the outbreak. The ward will continue to follow their standard auditing process; along with a programme of IPC quality assurance walks that will include collaboration with the Facilities team.

The outbreak was declared a serious incident and a serious incident investigation following the Trust's Serious Incident Policy is ongoing.

2. **COVID-19 outbreak**
An outbreak of COVID-19 involving 3 members of staff was reported in September 2021. The transmission of infection was identified as a social gathering outside of the workplace. Outbreak meetings were held that included CCG and PHE. There was no further transmission to staff or patients. An RCA was completed, and lessons learned were identified and will be shared at the next SNAHP meeting on 19th October 2021.

3.4 Serious Incidents

There has been 1 serious incident declared during Quarter 2 in relation to the MRSA outbreak (see 3.4) on Wrekin Ward declared on 20th July 2021.

3.5 Conclusion

The Trust reports positive outcomes against national set targets for HCAI:

All orthopaedic surgery is being monitored closely and cases of suspected/confirmed infections are discussed at the Consultant led weekly Infection MDT meetings.

The Trust continues to follow national guidance in order to prevent and control the transmission of infections.

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

Appendix 1: Acronyms

BAF	Board Assurance Framework
C.*diff*	Clostridium *difficile*
E.coli	Escherichia. Coli
FFP3	Filtering Face Piece
IPC(N)	Infection Prevention & Control (Nurse)
HCAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
MCSI	Midlands Centre for Spinal Injuries
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
TKR	Total Knee Replacement
THR	Total Hip Replacement
OPD	Out Patients Department
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessments of the Care Environment
PPE	Personal Protective Equipment
QMS	Quality Management System
SSI	Surgical Site Infection
SaTH	Shrewsbury and Telford Hospitals
SNAHP	Senior Nurse and Allied Health Professional
TSSU	Theatre Sterile Services Unit
UTI	Urinary Tract Infection

Glossary

Bacteraemia: The presence of bacteria in the blood without clinical signs or symptoms of infection

C.*Difficile*: or C.*Diff* is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.

E coli: is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.

HCAI: Health Care Associated Infection. An infection acquired because of receiving treatment in a health care setting.

MRSA: or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria, Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.

MSSA: or Meticillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise because of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

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

Chair's Assurance Report
People Committee – 4th November 2021

0. Reference Information

Author:	Mary Bardsley Assistant Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Paul Kingston, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the People Committee on 4th November 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the People Committee. This Committee is responsible for seeking assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended and noted as quorate
- The members of the meeting considered and noted People Plan deep dive.
- An update was received on the impact on activity in relation to annual leave and out of job plan.
- The Committee received a presentation from the Trusts Freedom to Speak Up Guardian.
- The Committee received the standard agenda items, Performance Report and Board Assurance Framework for consideration and approval before onward presentation at the Board.
- Assurance Chair Reports were provided.

2.3. Conclusion

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

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

Chair's Assurance Report
People Committee – 4th November 2021

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 4th November 2021. The meeting was quorate with 2 Non-Executive Director and 3 Senior Leaders in attendance. The full list of attendees is listed below:

Attendance:	
Paul Kingston	Non-Executive Director (Chair)
Harry Turner	Non-Executive Director
Chris Beacock	Non-Executive Director
Hilary Pepler	Trust Board Advisor
Stacey-Lea Keegan	Interim CEO
Kerry Robinson	Chief Performance Improvement and OD Officer
Ruth Longfellow	Chief Medical Officer
Sara Ellis Anderson	Chief Nurse and Patient Safety Officer
Shelley Ramtuhul	Trust Secretary
Sarah Thomas	Learning & Development Manager
Liz Hammond	Freedom to Speak Up Guardian
Alex Yashchik	Consultant Anaesthetist and Wellbeing Guardian
Donna St John	MSK Unit Matron
Jo Banks	MSK Unit Managing Director
Rob Freeman	Consultant Orthopaedic Surgeon
Sue Pryce	Head of People Services
Amber Scott	Minute Secretary
Apologies:	
Craig Macbeth, Sarah Sheppard and David Low.	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declarations of Interest		
None to note	N/A	
Performance Report (month 6)		
The Committee noted the Performance Report. Further verbal assurance was provided on the sickness absence metric. Although normal variation is noted, the metric has exceeded target for four consecutive months, currently c.1% above target. People Service Business Partners are working with the managers of those staff who are on long term sick. A deep dive will be presented to the Committee if a significant change is recorded.	Yes	
People Plan/Action Plan		

Chair's Assurance Report
People Committee – 4th November 2021

The Committee noted the paper. The action plan has undergone a full review since the previous meeting. The People Service Business Partners will provide a deep dive report into the priority areas on a monthly basis.	Yes	
People Plan Deep Dive		
The Committee noted the paper. The three areas of focus included: rest breaks/annual leave, wellbeing conversations and risk assessments.	Yes	
Board Assurance Framework		
The Committee approved the framework. There have been no new risks added to the framework but the current risks have undergone a full review. Further strengthening the risk around turnover of Senior Management and Loss of Corporate memory was agreed.	Yes	
Impact on Activity – Annual Leave and Out of Job Plan		
The Committee received an update on the impact annual leave and out of job plan has on activity and what mitigations the Trust has implemented to support. Concerns were raised regarding the possibility of consultants scheduling OJP whilst on annual leave. It was noted that although this is discouraged by the Trust, the organisation is unable to ban OJP in Consultants personal time. There are firmer controls in place to monitor the booking and ensure wellbeing of the Consultant body. It was recommended by the Committee that 'buy back of annual leave' would only be approved in exceptional circumstances to which the Trust agreed. It was agreed that a regular report on OJP planned within annual leave would be presented to the Committee for oversight.	Partial	Risks of wellbeing were noted and discussed by the group.
Freedom to Speak Up Report		
A presentation was shared with the Committee. Following discussions, it was agreed that F2SU cases were to be recorded by units going forward. It was suggested that the Trust highlights which Guardian is on site to encourage face to face discussions. The Committee requested that benchmarking was completed against organisations of a similar size to RJAH. A further review on bullying and harassment was requested.	Yes	Further work to be embedded the process and accessibility to the Guardians. The Trust confirmed the policy is undergoing a review.
Training MCSI Progress Report		
The action plan summary was presented to the Committee. A total of 18/22 actions have been completed with no overdue actions recorded. Detailed discussions took place regarding the outbreak and Trust wide training. The Committee encouraged staff to maintain a positive culture to promote all departments to complete the training and ensure this is audited for continued high standards.	Yes	No issues were raised in relation to the process of the training however the Committee asked for the detailed training progress action plan to be circulated to Committee members only.
Chair Reports		

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

Staff Experience Committee The report was noted by the Committee – no concerns were raised.	Yes	
Trust Performance and Organisation Improvement Board The report was noted by the Committee – no concerns were raised.	Yes	
Learning and Development Group Concerns were raised regarding the lack of attendance to Mental Capacity Act training. It was confirmed that the issue is being monitored by the Safeguarding Committee and noted a trajectory will be set by the Committee, similar to the one set for Safeguarding Level 3 training.	Yes	The People Committee acknowledged that the training will be monitored through the Safeguarding Committee.
Learning and Development Group Terms of Reference		
The terms of reference were considered and approved following suggestions made at the previous meeting.	Yes	
Policy Tracker		
The tracker was reviewed and noted by the Committee.	Yes	
Committee Workplan		
The Committee agreed for the Committee terms of reference to be presented at each meeting as a reminder of individual objectives. A review will be completed in line with the implementation of the ICS structure. The AHP recruitment will be incorporated into the workplan to provide assurance and oversight. The Committee approved the workplan.	Yes	
Wellbeing Conversations		
The Committee noted the paper which was circulated for information only.	N/A	
Midlands International Retention Innovation Bid		
The Committee noted the paper which was circulated for information only.	N/A	
Any Other Business		
There were no further items of business discussed.	N/A	

3.4 Approvals

Approval Sought	Outcome
None to note.	

3.5 Risks to be Escalated

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

3.6 Conclusion

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

ED&I Workforce report and annual report

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

0. Reference Information

Author:	Sarah Sheppard, Chief People Officer	Paper date:	25 November 2021
Executive Sponsor:	Sarah Sheppard, Chief People Officer	Paper Category:	Strategy / Governance and Quality / Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

This paper includes two documents for the consideration of the Trust Board relating to important Equality and Diversity and Inclusion (EDI) requirements for NHS organisations.

2. Executive Summary

Context

There are a number of documents that the Trust is required to produce and publish on the organisation's public website. These two documents meet the requirements as set out below. Ongoing monitoring will take place via the People Committee and an action plan will be developed for this purpose for internal monitoring once agreed with clear accountabilities and timeframes.

We are also developing our 5 year EDI Strategy and this will build on these reports and be developed in early 2022 for approval and implementation. The EDI committee will be involved in this work and the Trust Board will have the opportunity to input into this using our strategy sessions.

Summary

Document 1: Workforce Report
The annual Workforce Equality Data and Analysis Report provides a detailed analysis of our workforce by the protected characteristics and includes the following:

- Workforce Race Equality Standard report and action plan
- Workforce Disability Equality Standard report and action plan
- Gender Pay Gap report

The reports included within this wider workforce report fulfils the trusts legal obligation to the Equality Act 2010 by completing these NHSE mandated standards.

Document 2: EDI Annual Report
The EDI Annual report updates the Board on EDI activity for 2020/21.

3.Conclusion

The Trust Board is invited to approve both reports and support the publication on our public website.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHS ROBERT JONES AND AGNES HUNT TRUST

WORKFORCE REPORT

2021

Produced by the Equality and Inclusion Team and Midlands and Lancashire Commissioning Support Unit (MLCSU)

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Workforce Disability Equality Standard report and action plan....17

Gender Pay Gap Report....27

Executive Summary

This annual Workforce Equality Data and Analysis Report has been produced to provide a detailed analysis of our workforce by the protected characteristics of age, gender, disability, race, religion or belief, sexual orientation and marital status.

This report will include:

- Workforce Race Equality Standard report and action plan
- Workforce Disability Equality Standard report and action plan
- Gender Pay Gap report

The reports included within this wider workforce report fulfils the trusts legal obligation to the Equality Act 2010 by completing these NHSE mandated standards.

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

Workforce Race Equality Standard (WRES)

Introduction

This section of the workforce report describes the Trust's approach to and performance against the Workforce Race Equality Standard (WRES) in 2021.

WRES was mandated by the NHS from April 2015 and was included within the NHS Standard Contract from 2015-16. WRES baseline data has been provided and published on a yearly basis by the NHS since July 2015.

The main purpose of the WRES is to help local and national NHS organisations review their data across nine WRES indicators and to produce an action plan to improve workplace experiences of Black, Asian and Minority Ethnic (BAME) staff. The WRES places an obligation on NHS organisations to improve BAME representation at board and senior level.

The WRES is applicable to providers and commissioners alike.

The Trust has two roles in relation to the WRES – as a provider of NHS services and as an employer. In both roles, our work is shaped by key statutory requirements and policy drivers including those arising from:

- The NHS Constitution
- The Equality Act and Public Sector Equality Duty
- The NHS Standard Contract
- The NHS Oversight Framework (this has replaced the CCG Improvement and Assessment Framework).

The NHS Standard Contract and NHS Oversight Framework both require CCGs to give assurance to the NHS England and Improvement (NHSE/I) WRES Team that their providers are implementing and using the WRES.

The Trust has monitoring arrangements in place to provide the above assurance through contract monitoring work, equality audits and performance reporting.

The Nine WRES Indicators

Workforce indicators
For each of these four workforce indicators, compare the data for White and BAME staff

1	Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce. Note: Organisations should undertake this calculation separately for non-clinical and clinical staff.
2	Relative likelihood of staff being appointed from shortlisting across all posts.
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to that of white staff. *Note: This indicator will be based on data from a two-year rolling average of the current and previous year.*
4	Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD).

National NHS Staff Survey indicators (or equivalent)
For each of the four staff survey indicators, compare the outcomes of the responses for White and BAME staff.

5	Key Finding (KF) 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that the CCG provides equal opportunities for career progression or promotion
	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

Board representation indicator
For this indicator, compare the difference for White and BAME staff.

9

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:
- By voting membership of the Board
- By executive membership of the Board

Note: This is an amended version of the previous definition of Indicator 9.

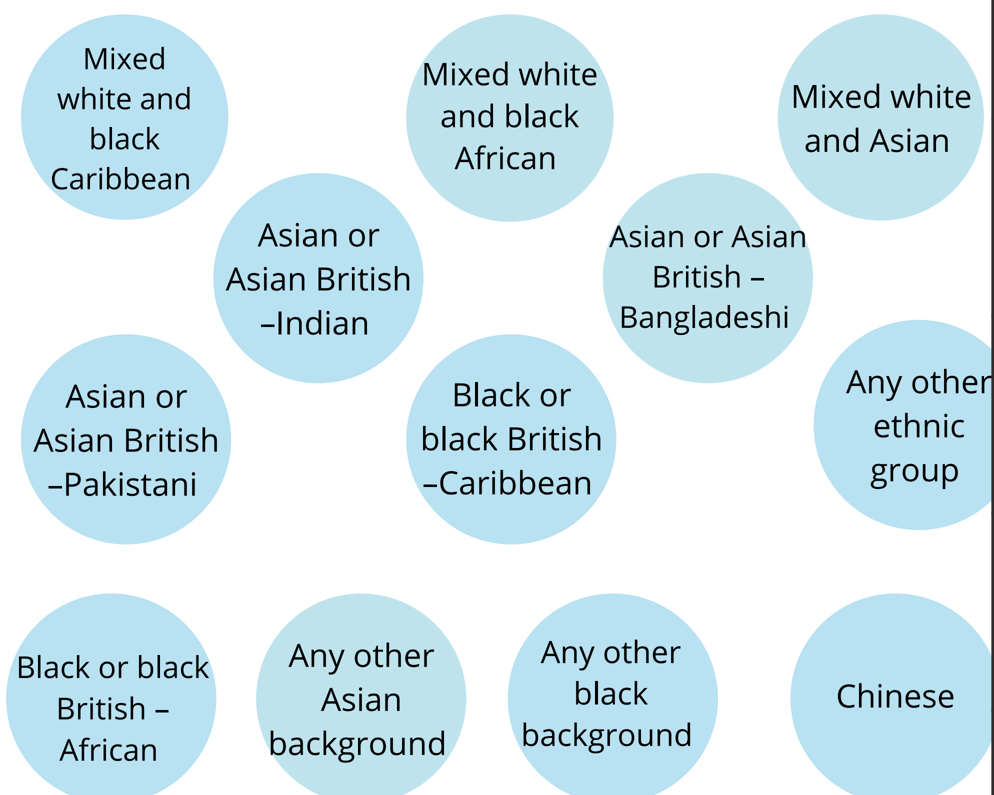
Definitions of ethnicity – people covered by the WRES:

Within the WRES, BAME refers to Black, Asian and Minority Ethnic groups. WRES publications often cite the term 'BME' which refers to Black and Minority Ethnic groups.

Data regarding BAME within the WRES relates to staff in the following groups which are categorised by the Office of National Statistics and cited within the WRES technical guidance:

White includes:

BAME includes:



Implementation of the WRES, Trusts should:

- Collect data on the workforce and submit through the Strategic Data Collection Service between 6 July and 31 August 2021.
- WRES – about data protection
- Publish its WRES report and action plan.

The Trust's reporting information and data has been collated from its staff Electronic Staff Records (ESR) and internal data sets.

WRES technical guidance is available which notes that certain 'white groups' such as Gypsies and Travellers and Eastern European staff may be a significant minority group within an organisation and experience discrimination. Where this is the case, organisations should explore tackling such discrimination using workforce data, surveys and employing the principles of the WRES.

Our WRES data sets

The following tables show WRES reporting from the last 2 reporting periods for each of the indicators. The following data has been collated from the WRES submission templates for Robert Jones and Agnes Hunt Orthoepic Hospital NHS Foundation Trust - which are in excel format.

Table showing summary workforce data – relating to indicator 1 and 9:

Relating to indicators:

- Percentage of staff in each of the AfC Bands 1-9 and Very Senior Manager (VSM) (including executive Board members) compared with the percentage of staff in the overall workforce

- Percentage difference between the organisations' Board voting membership and its overall workforce disaggregated: By voting membership of the Board and executive membership of the Board

  Note: This is an amended version of the previous definition of Indicator 9

These indicators link to Goals 3 and 4 of the Equality Delivery System.

The Robert and Jones Agnes Hunt Trust	2020	2021
No. of staff employed within the organisation - headcount	1596	1626
Proportion of BAME staff %	5.7%	5.7%
Proportion of BAME staff in VSM %	0%	0%
Total Board Members headcount and %	0 from 11 0%	0 from 11 0%
Proportion of BAME Executive Board members headcount and %	0 from 4 0%	0 from 4 0%
Proportion of staff self-reporting their ethnicity %	94.7%	95.1%

About this data:
The data sets shows a slight increase in staffing since last year, though BAME representation has stayed static at 5.7% of staff.

Context – local BAME population:
According to the JSNA, the local BAME population of Telford and Wrekin is 10.5%. The local BAME population of Shropshire is 4.6%.
(Source: https://www.telford.gov.uk/download/downloads/id/10502/chapter_2_population_and_household_characteristics.pdf
https://www.shropshire.gov.uk/media/3415/2011-census-digest-ethnicity.pdf)

Very Senior Managers (VSM):
The proportion of BAME staff in VSM across the Trust has stayed stagnant at 0%. The proportion of BAME staff in VSM is below the local BAME population. This can affect the confidence levels BAME staff as they do not see representation at the senior levels.

Board Members:
Across the overall Trust data, the number of Board members has remained fairly static with an increase of one new member since 2020 reporting, totalling 12in 2021. Of these, the proportion of BAME is currently 0% which is the same as the previous year.

Proportion of BAME executive Board members:
The number of executive Board members is relatively small – with a total of 4 people in 2021, the same as in 2020. For this period and previous reporting period, the BAME proportion remains at 0. BAME representation for executive Board members is lower than both local population and BAME overall staff representation.

Self-reporting of ethnicity:
The self-reporting of ethnicity on staff records is consistently high with overall reporting at 95.1%

Table showing Recruitment data relating to indicator 2:

Related indicators:

- The relative likelihood of staff being appointed from shortlisting across all posts

These indicators link to Goals 3 and 4 for the Equality Delivery System.

The Robert and Jones Agnes Hunt Trust	2020	2021
Number of short-listed applicants (headcount)	1228	779
BAME short listed applicants – headcount and %	139 11.3%	51 6.5%
Number appointed from shortlisting	688	190
BAME appointed from shortlisting – headcount and % from total appointed	21 3%	5 2.6%
Relative likelihood of likelihood of appointment from shortlisting for: a) White staff b) BAME staff c) Unknown	 30.05% 15.11% 7.14%	 24.14% 9.8% 53.13%

The above data shows:

The number of appointments has decreased from 668 in the last reporting period to 190 in 2021.

The number of BAME people shortlisted is relatively small and the appointed number from BAME is only 5 people from a total of 51 in 2021. This affects the confidence levels in the likelihood data of appointments across white, BAME and unknown backgrounds

Table showing Disciplinary data relating to indicator 3

Related indicators:

- Relative likelihood of BAME staff entering the formal disciplinary process compared to that of white staff

These indicators link to Goals 3 and 4 for the Equality Delivery System.

The Robert and Jones Agnes Hunt Trust	2020	2021
Number of staff entering into formal disciplinary process	REDACTED	REDACTED
Number of staff from BAME entering into formal disciplinary process	0	0
Likelihood of staff entering the formal disciplinary process as a % a) White staff b) BAME staff c) Unknown	 00.07% 00.00% 00.00%	 00.07% 00.00% 00.00%

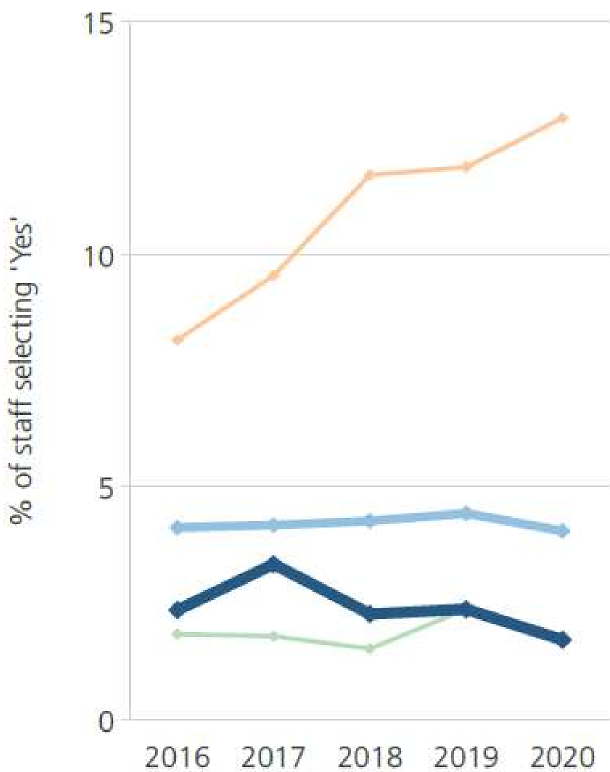
The above data shows:

This data set has been redacted within this report due to possible identifiable data.

Staff Survey – experience

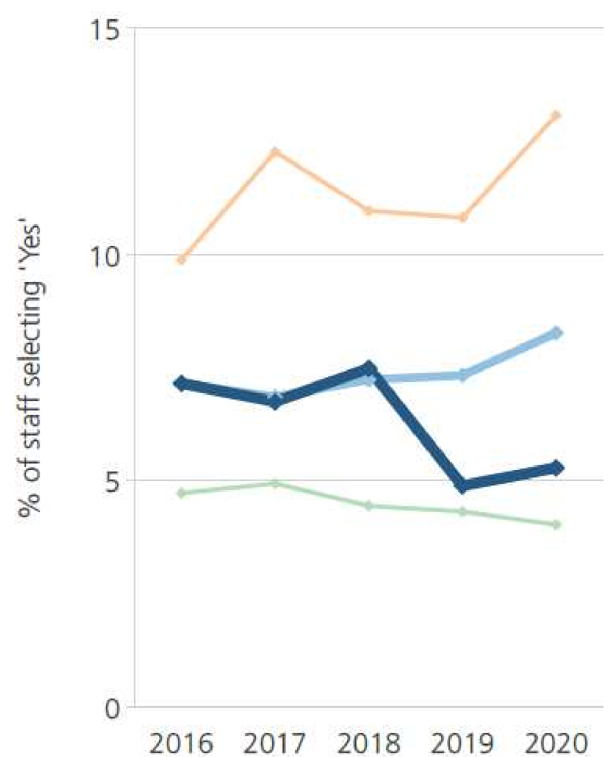
Related indicators:

In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



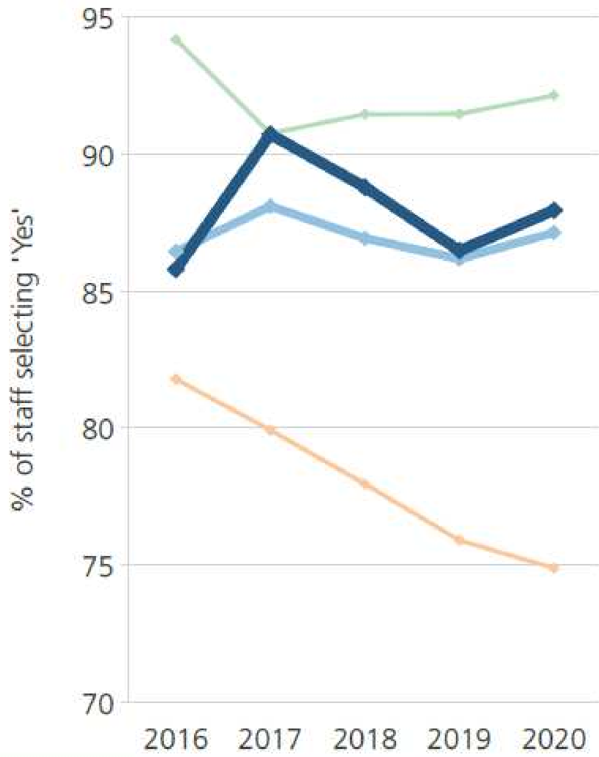
	2016	2017	2018	2019	2020
Worst	8.2%	9.5%	11.7%	11.9%	12.9%
Your org	2.4%	3.3%	2.3%	2.4%	1.7%
Average	4.1%	4.2%	4.3%	4.4%	4.1%
Best	1.8%	1.8%	1.5%	2.4%	1.7%

In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



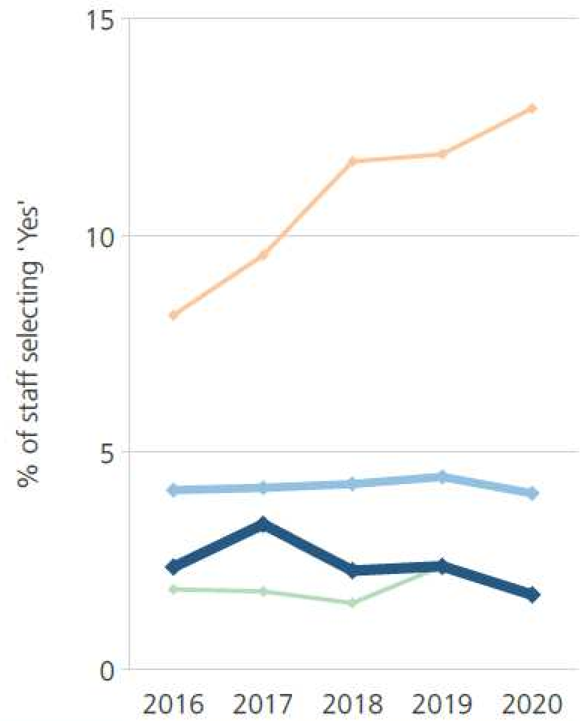
	2016	2017	2018	2019	2020
Worst	9.9%	12.3%	11.0%	10.8%	13.1%
Your org	7.1%	6.7%	7.5%	4.9%	5.3%
Average	7.1%	6.8%	7.2%	7.3%	8.3%
Best	4.7%	4.9%	4.4%	4.3%	4.0%

Does your organisation act fairly with regard to career progression /promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



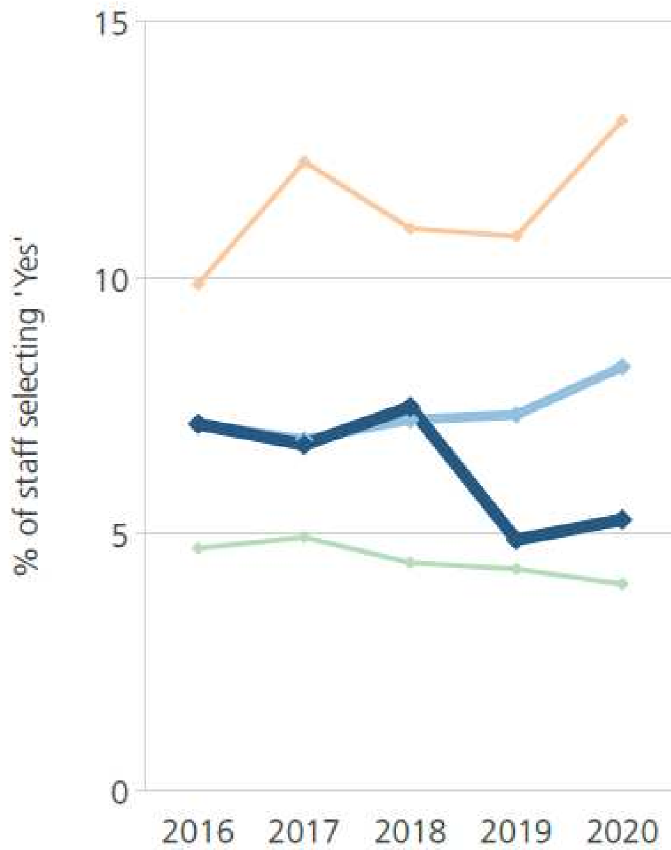
	2016	2017	2018	2019	2020
Best	94.2%	90.7%	91.4%	91.5%	92.1%
Your org	85.8%	90.7%	88.8%	86.5%	87.9%
Average	86.4%	88.1%	86.9%	86.2%	87.1%
Worst	81.8%	79.9%	78.0%	75.9%	74.9%

In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2016	2017	2018	2019	2020
Worst	8.2%	9.5%	11.7%	11.9%	12.9%
Your org	2.4%	3.3%	2.3%	2.4%	1.7%
Average	4.1%	4.2%	4.3%	4.4%	4.1%
Best	1.8%	1.8%	1.5%	2.4%	1.7%

In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2016	2017	2018	2019	2020
Worst	9.9%	12.3%	11.0%	10.8%	13.1%
Your org	7.1%	6.7%	7.5%	4.9%	5.3%
Average	7.1%	6.8%	7.2%	7.3%	8.3%
Best	4.7%	4.9%	4.4%	4.3%	4.0%

WRES Action Plan

Trusts are required to produce an action plan based on the WRES findings. We will produce a Trust WRES action plan which will be published on the Trusts website. This will outline the steps to be taken by the Trust to improve inclusion and ensure that support is in place to meet the needs of all staff including BAME staff that are at higher risk of experiencing discrimination at work.

The action plan also brings together a range of actions relating to the NHS Peoples Plan – published in July 2020 and the Model Employer Our WRES action plan will also incorporate the recently published reports - NHS Peoples Plan 2020-21 Action for us all and WRES Strategy report – A Model Employer. Our action plan will also make reference to the links to Equality Delivery System (EDS) goals.

EDS is an equality performance and evaluation tool to help improve equality performance across 4 goals –

1. Better health outcomes
2. Improve patient access and experience
3. A represented and supported workforce
4. Inclusive leadership

WRES relates directly to all goals but specifically directly to goal 3 and 4.

Our action plan and progress will be regularly reviewed throughout the year with oversight from our governance processes. This is documented separately to this report.

The Executive Management Team will have overall oversight for monitoring with Trust Board member Kerry Robinson who has responsibility for reducing inequalities to have responsibility at Board Level.

Progress will be reported and published within:

- 2021/22 Equality and Inclusion Annual Report
- 2022 WRES report

WRES Actions

Indicator	Suggested Action/ Date for completion	
1- Percentage of staff in each of the AFC Pay Bands compared with the percentage in the overall workforce 2 - Relative likelihood of staff entering the formal disciplinary investigation	Unconscious Bias training for all management and recruiting staff	May 2022
	Health and wellbeing conversations with staff/appraisal conversations	Ongoing
	BAME network promoting opportunities for learning with sharing of experiences with the wider Trust	Sept 2022
3- Relative likelihood of staff entering the formal disciplinary investigation 4 -Relative likelihood of staff accessing non-mandatory training and CPD compared to BAME staff 5 - Percentage of staff experiencing bullying and harassment	Maximise the use of the Cultural Ambassadors in the business of the Trust to ensure that EDI is championed throughout day to day activities	Ongoing
	Staff side access to training and training requests, including managers	Sept 2022
	Staff are made aware of Freedom to Speak up initiative through the induction process	Ongoing
	Use the Trust's buddy visit programme to provide the Board/senior members an opportunity to discuss EDI with staff to understand and explore staff experience	
	Ensuring the voice of the BAME network in decisions about both workforce and patient experience with a focus on EDI at Board Voice of Staff/ Patients	Ongoing
6 - Percentage believing that trust provides equal opportunities for career progression or promotion 7- In the last 12 months have you personally experienced discrimination at work from any of the following? B) manager/team leader or other colleague 8 - Percentage difference between the organisations Board voting membership and its overall workforce	Ensure line management and senior leaders are aware of opportunities that are available to staff	Sept 2022
	Longer term aims to increase board diversity. Board managers to champion EDI and 'Allyship' in line with system people plan delivery model	2024
	Make staff aware of Whistleblowing policies and work alongside Freedom to Speak Up teams to ensure staff feel supported and are able to raise any concerns without fear	Apr 2022

Indicator	Suggested Action/ Date for completion
6 - Percentage believing that trust provides equal opportunities for career progression or promotion 7- In the last 12 months have you personally experienced discrimination at work from any of the following? B) manager/team leader or other colleague 8 - Percentage difference between the organisations Board voting membership and its overall workforce	Develop an organisational culture of fairness and respect in line with system people plan delivery model Embed reverse/reciprocal mentoring for all senior managers using the regional and system expertise.

Workforce Disability Equality Standard (WDES)

Introduction

This report has been compiled following the 2021 submission of the Trust's data against the Workforce Disability Equality Standard.

This report therefore sets out The Robert Jones and Agnes Hunt Orthopaedic Hospital NHSFT's performance information against the mandatory WDES metrics and our actions.

The Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and applies to all NHS Trust and Foundation Trusts.

The WDES is a data-based standard that uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. Four of the indicators focus on the workforce data, four are based on data from the national NHS Staff survey questions and one indicator focuses on disability representation on Board.

The Nine WDES Indicators

Workforce indicators
The WDES is a data-based standard that uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. Four of the indicators focus on the workforce data, four are based on data from the national NHS Staff survey questions and one indicator focuses on disability representation on Board.

1. Percentage of staff in AFC paybands or medial groups and very senior managers (including Executive Board members) compared with the percentage of the overall workforce
2. Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts
3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
4. Percentage of disabled staff, compared to non-disabled staff experiencing harassment, bulling or abuse.
5. Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
8. Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work

9	The staff engagement score for disabled staff compared to non-disabled staff and whether the trust has taken action to facilitate the voices of disabled staff in your organisation to be heard
10	Percentage difference between the organisation's Board voting membership and the organisation's overall workforce

Metric 1 - Percentage of staff in AFC pay-bands or medical subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff overall

	Disabled Staff			Non-Disabled Staff		
	2020 %	2021 %	Difference %	2020 %	2021 %	Difference %
Bands 1 - 4	2.01	3.9	+1.89	64.66	62	-2.66
Bands 5 - 7	2.46	5.4	+2.94	61.17	72.3	+11.13
Bands 8a - 8b	2.7	0	-2.7	62.16	76.2	+14.04
Bands 8c - 9 &VSM	0	4.8	+4.8	33.33	52.4	+19.07
Medical Staff, Consultants)	0	0	0	47.31	47.96	+0.65
Medical Staff, non-career grades	0	0	0	66.67	69.57	+2.9
Medical staff trainee grades)	0	0	0	61.29	52.63	-8.66

Metric 2 - Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

	2020	2021
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	1.97	1.58

Metric 3 - Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process

	2020	2021
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability process.	0.00	0.00

Metric 4 - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

*Please note this metric will compare data from 2019 and 2020 as 2021 staff survey data is not collected in time for the WDES.

Staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other member of the public in the last 12 months					
Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
20.4%	21.7%	+1.3%	14.4%	13.7%	-0.7%

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Staff experiencing harassment, bullying or abuse from managers in the last 12 months

Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
18%	18.7%	+0.7%	11.0%	9.7%	-1.3%

Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months

Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
27.0%	34.1%	+7.1%	18.6%	34.1%	+15.5%

Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

Percentage of disabled staff compared non-disabled staff believing that the trust provides equal opportunities for career progression or promotion

Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
78.2%	81.5%	+3.3%	88.4%	90.1%	+1.7%

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

Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Percentage of disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite no feeling well enough to perform their duties					
Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
16.2%	35.2%	+19%	21.9%	13.5%	-8.4%

Metric 7 - Percentage of Disabled staff compared to Non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work

Percentage of Disabled staff compared to Non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work					
Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
39.3%	43.0%	+3.7%	55.4%	54.9%	-0.5%

Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work

	2019	2020
Percentage of Disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work	75.5%	79.2%

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

Metric 9 - The staff engagement score for Disabled staff, compared to Non-Disabled staff

The staff engagement score for Disabled staff, compared to Non-Disabled staff

Disabled Staff			Non-Disabled Staff		
2019	2020	Difference	2019	2020	Difference
7.2	7.2	0	7.6	7.6	0

Metric 10 - Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

	2020			2021		
	Disabled	Non - Disabled	Non known	Disabled	Non - Disabled	Non known
Executive	0	4	7	0	3	2
Non-Executive	0	0	7	0	3	4
Voting	0	4	0	0	6	5
Non-Voting	0	0	7	0	0	1

WDES Action Plan

Trusts are required to produce an action plan based on the WDES findings. We will produce a Trust WDES action plan which will be published on the Trusts website. This will outline the steps to be taken by the Trust to improve inclusion and ensure that support is in place to meet the needs of all staff including disabled staff that are at higher risk of experiencing discrimination at work.

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- Better health outcomes
- Improve patient access and experience
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- Inclusive leadership

WDES relates directly to all goals but specifically directly to goal 3 and 4.

Our action plan and progress will be regularly reviewed throughout the year with oversight from our governance processes. This is documented separately to this report.

The Executive Management Team will have overall oversight for monitoring with Trust Board member Kerry Robinson who has responsibility for reducing inequalities to have responsibility at Board Level.

Progress will be reported and published within:
• 2021/22 Equality and Inclusion Annual Report
• 2022 WDES report

WDES Actions

Indicator	Suggested Action/ Date for completion	
1- % of staff in Agenda for Change bands, medical subgroups and VSMs compared with the % of staff in the overall workforce 2 - Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts	Unconscious Bias training for all management and recruiting staff	May 2022
	121s are continued and consistent with all staff	Ongoing
	Establish a disability network – including hidden disabilities	Ongoing
	Ensure all communications within the trust and when recruiting are accessible	Apr 2022
	Progress disability confident accreditation	Apr 2022
	Develop an organisational culture of fairness and respect in line with system people plan delivery model	
3- Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process 4 -Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse. 5 - Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Staff side access to training and training requests, including managers	Sept 2022
	Staff are made aware of Freedom to Speak up initiative through the induction process	Sept 2022
	Ensure managing staff are aware of reasonable adjustments and how to implement them effectively	Apr 2022
	Patients are made aware of behaviour that is expected towards staff when visiting the trust	Ongoing
	Enhanced support for those becoming disabled during employment to ensure they are not advantaged by our processes (sickness and performance particularly)	Ongoing

Indicator	Suggested Action/ Date for completion	
6 - Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties 7- Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work 8 - Percentage of disabled staff saying their employment has made adjustments to enable them to carry out their work	Ensure line management and senior leaders are aware of opportunities that are available to staff	Sept 2022
	Longer term aims to increase board diversity. Board managers to champion EDI and 'Allyship' in line with system people plan delivery model	2024
	Make staff aware of Whistleblowing policies and work alongside Freedom to Speak Up teams to ensure staff feel supported and are able to raise any concerns without fear	Apr 2022
9 - The staff engagement score for disabled staff compared to non-disabled staff 10 - Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	Embed reverse/reciprocal mentoring for all senior managers using the regional and system expertise.	Apr 2022

Gender Pay Gap

Introduction

We can use the results of this Gender Pay Gap report to assess:

- the levels of gender equality in our workplace
- the balance of male and female employees at different levels
- how effectively talent is being maximised and rewarded

Through analysis of the report's findings the challenge in our organisation and across Great Britain is to eliminate any gender pay gap. However, the gender pay gap should not be confused with equal pay.

Equal pay deals with the pay differences between male and females who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of their gender. Robert Jones and Agnes Hunt Hospital Trust supports the fair treatment and reward of all staff irrespective of gender or any other protected characteristic.

In producing this report we recognise that we have more to do to reduce the gender pay gap and we remain committed to a workplace that respects and harnesses equality and diversity. We will work to improve the gender pay gap by undertaking the actions set out at the end of this report.

What is the Gender Pay Gap?

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

What is the difference between the gender pay gap and equal pay?

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value.

It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are. In some cases, the gender pay gap may include unlawful inequality in pay but this is not necessarily the case.

Gender Profile across the Robert Jones and Agnes Hunt Trust

The Trust is required by law to carry out Gender Pay reporting under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. This involves carrying out six calculations that show the difference between the average earnings of men and women in our organisation; it does not involve publishing individual employees' data.

Average & Median Hourly Rates

	Avg. Hourly Rate	Median Hourly Rate
Male	23.7003	16.7183
Female	15.1547	13.2697
Difference	8.5462	3.4486
Pay Gap %	36.0585	20.62777

Number of employees | Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
1	368.00	90.00	80.35	19.65
2	378.00	80.00	82.53	17.47
3	375.00	76.00	83.15	16.85
4	279.00	187.00	59.87	40.13

Bonus Pay Figures

	Avg. Pay	Median Pay
Male	10,222.90	9,048.00
Female	10,231.27	9,048.00
Difference	- 8.37	0.0
Pay Gap %	- 0.08	0.0

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	5.00	1505.00	0.33
Male	36.00	459.00	7.84

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

NHS ROBERT JONES AND AGNES HUNT TRUST

EQUALITY AND INCLUSION ANNUAL REPORT

2020 - 2021

Produced by the Equality and Inclusion Team and Midlands and Lancashire Commissioning Support Unit (MLCSU)

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Executive summary

RJAH has a national and international reputation for orthopaedic surgery and musculoskeletal medicine, including research into disorders of bone, joints and muscles. Services and research activities include spinal injuries, rheumatology, sports injuries, stem cell therapy, metabolic disorders and orthotics.

The Trust prides itself in achieving orthopaedic excellence and maintains a significant contribution to training orthopaedic surgeons. The hospital trains 10% of all orthopaedic surgeons within the UK through the post graduate training scheme. The Trust also contributes to the training of Pre Registration Healthcare professionals by providing clinical placements for nursing, physiotherapy, occupational therapy, operating department practitioners, orthotic and radiography students.

The Trusts purpose is to provide a high quality service to patients in an environment that fosters excellence in teaching and research in order to improve healthcare. The Trust has an excellent reputation with patients and professionals for care and clinical excellence.

When our patients are visiting RJAH they can expect:

- To have a clear explanation of their condition and the treatment options available
- To be asked for their written fully informed consent to any operation or procedure
- To see their patient records if they wish
- To be sure that the information in their records will remain confidential
- To be treated with respect and dignity at all times
- To be informed about different aspects of their treatment and what procedure(s) are being carried out
- To keep relatives or carers informed of progress, if they wish

Vision, values and aims

Doctors, nurses, allied health professionals, administrative staff and more, alongside the Senior Leadership Team, continue to work together to deliver the vision upon which the hospital was founded to provide outstanding patient care to every patient every day.

In order to support the quality agenda within the organisation, the expectations of staff are clear through the development of our Trust values. These values underpin the culture required to support staff to deliver high quality care and should provide a positive environment in which quality will flourish. The values provide a framework for staff to challenge behaviours at all levels and to define what working at the RJAH means to them.

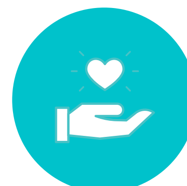
Our equality objectives:

The Trust has five core values that all staff should be aware of. These are:

Friendly

Caring

Professional


Respect

Excellence

COVID-19 response

The NHS in Shropshire, Telford and Wrekin and Public Health England (PHE) are well prepared for outbreaks of new infectious diseases. The NHS has put in place measures to ensure the safety of all patients, the community and NHS staff while ensuring as many services as possible are available to the public.

During the pandemic, infection prevention and control measures have helped to keep patients and staff safe. During this time, patients and visitors have had to wash their hands, wear face coverings and maintain a social distance of two metres.

Although the Government confirmed that as of Monday 19 July, it will no longer be a legal requirement to wear a face covering, keeping the Trusts patients safe remains a priority. For this reason, there will not be any changes to safety measures at the RJAH

These safety measures minimise the risk to vulnerable patients and staff and help people feel more confident about coming to our hospital to receive care.

Information around COVID-19 can be located on the RJAH website which includes:

- What to do if symptoms associated with Coronavirus are present
- Face coverings
- Testing advice
- Public health England advice

COVID-19 Vaccination programme

The coronavirus vaccination programme took a step forward in Shropshire, Telford & Wrekin at the beginning of January 2021, with the opening of the county's second hospital hub at RJAH. By early March 2021, the hospital hub transitioned into a vaccination centre, meaning more people are able to get vaccinated at the RJAH centre, as patients will be able to book their appointments through the national booking system.

Patients were prioritised according to the Joint Committee on Vaccination and Immunisation's recommendations.

The legal and NHS mandated duties for equality and inclusion

There are several legal duties and NHS standards which underpin our equality and inclusion work including:

The NHS Constitution

The NHS Constitution states that:

"The NHS provides a comprehensive service, available to all irrespective of **age**, **disability**, **sex** (gender), **race**, **sexual orientation**, **gender reassignment**, **religion**, **belief**, **pregnancy and maternity** or **civil partnership** status."

"The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to everyone that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population."

The Equality Act 2010

This places key duties on statutory organisations that provide public services. It protects people from unfavourable treatment and discrimination, and this refers particularly to people with the following protected characteristics:

- Age
- Disability
- Sex (gender)
- Sexual orientation
- Gender reassignment
- Race (including national identity and ethnicity)
- Religion or belief
- Pregnancy and maternity
- Marriage and civil partnership.

When making commissioning decisions, we also pay due regard to the needs of carers, homeless individuals, gypsies, travellers, military veterans and people with low incomes.

The Modern Slavery Act 2015

This requires any UK commercial organisation that supplies goods and services with an annual turnover of more than £36 million to produce a slavery and human-trafficking statement for each financial year showing intent, compliance with the legislation and a supporting action plan.

NHS mandated standards

WRES

The Workforce Race Equality Standard (**WRES**) is submitted to NHSE annually. The WRES outlines our monitoring of the recruitment, development and support of our staff from a Black, Asian and Minority Ethnic background (BAME). This helps us to address the professional development, satisfaction and experience of BAME staff. It is well evidenced that a representative, reflective workforce can best meet the needs of patients.

WDES

The Workforce Disability Equality Standard (**WDES**) helps us to monitor the extent to which we and our providers offer fair and equal treatment to employees with a disability. The WDES became a mandatory requirement for our providers in 2019.

AIS

The **Accessible Information Standard** applies to all health and social care providers including NHS trusts, foundation trusts and GP practices. It ensures that all our public information is accessible and that patient communication needs are recorded and considered when delivering health services.

EDS

The **Equality Delivery System** (EDS) is an assessment framework we use to measure our performance on equality and inclusion. It helps us to understand if people have fair and equal access to services and what we need to do to improve our workforce and leadership goals. The four EDS goals are:

Goal 1: Better health outcomes
Goal 2: Improved patient access and experience
Goal 3: Empowered, engaged and well supported staff
Goal 4: Inclusive leadership

Governance

As a Foundation Trust, it is RJAHs duty to provide care to patients that is safe, effective, caring and responsive to the needs of the population we serve.

RJAH have developed a structure of governance through committees and processes to ensure the quality of care is assured. Each year a rigorous review of our own performance is undertaken, and that of the committees which assure the quality of care provided through a self-assessment against Monitor's Quality Governance Framework to ensure the framework and systems of Governance are fit for purpose.

The Board Governance structure consists of four assurance committees chaired by Non-Executive Directors.

The Quality and Safety Committee reviews and monitors the systems and processes required to ensure the effectiveness of the care provided, workforce issues and the patient experience. Clear sign off of the annual Cost Improvement Programme by the Chief Nurse and Chief Medical Officer is essential to ensure quality of care to patients and the work environment for staff is not compromised where savings have been identified these are presented and monitored by the Quality and Safety Committee.

The Audit Committee supports the formal and transparent arrangements for considering how the Board applies the corporate reporting, risk management and internal control principles which are reported through the annual governance statement within the annual report. The Audit Committee is also responsible for maintaining working relationships with the Trust's internal and external auditors. All business cases are quality impact assessed and risks identified, monitored and mitigated to ensure quality is not affected.

The Risk Committee overseas risk and assurance processes and provides assurance to the Board in relation to the management of risk across the organisation.

The Finance Planning and Investment Committee provides assurance to the Board in relation to the operational performance and financial management structures and processes required for the delivery of the services.

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The Quality Forum

In order to support the quality agenda within the organisation, the Trust have been clear about what is expected from staff through the development of the Trust values. These values underpin the culture required to support staff to deliver high quality care and should provide a positive environment in which quality will flourish. The values provide a framework for staff to challenge behaviours at all levels and to define what working at the RJAH means to them.

In order for quality to be consistently achieved, there needs to be a culture across the organisation of commitment to collective quality improvement rather than individual departments focusing on their own projects. If the values of the organisation support an environment of team working then the aims and objectives of the organisation can be embraced by everyone which will lead to a cohesive approach to patient safety, engagement and quality improvement that is achievable and sustainable.

External reviews, Patient Advice and Liaison Service (PALS), concerns and complaints, incident reports, risk assessments, clinical audit and quality outcomes data are all 'free intelligence' and should be used that way. Engaging with patients and visitors as well as those delivering the services across the organisation will provide a wealth of knowledge that can only help to point in the right direction whether that is creating opportunities for innovative change or more of the same.

Supporting our Armed Forces

The Robert Jones and Agnes Hunt Orthopaedic Hospital is proud to be a Veteran Aware hospital aiming to provide the best care for veterans in the NHS.
Veteran Aware hospitals are leading the way in improving veterans' care within the NHS.
RJAH are part of the Veterans Covenant Hospital Alliance (VCHA) which means the Trust are sharing and driving best practice in NHS care for people who serve or have served in the UK Armed Forces in line with the Armed Forces Covenant.
The Trust support the health commitments of the Armed Forces Covenant and is committed to ensuring no disadvantage and giving special consideration where appropriate.

RJAH works in collaboration with Shropshire Council to provide **Armed Forces Outreach Support** for military personnel, veterans and their families.
Sarah Kerr, Armed Forces Outreach Support Coordinator at Shropshire Council, is based in the Main Entrance every Thursday afternoon offering signposting, support and advice.
She is also supported by a range of organisations and charities who can provide information on housing, healthcare, finance and benefits, education, wellbeing and employment.

Step into health

An initiative which supports service leavers, veterans and their families develop skills, RJAH supports Step into Health by offering service leavers, veterans and their families work experience placements.

Veterans' Gateway

There is a huge network of organisations who support the Armed Forces community and the Veterans' Gateway is the recommended first point of contact. Made up of a number of organisations and charities, connecting veterans and their families with the right support as soon as possible

Employer Recognition Scheme

Veteran Aware hospitals support the employment of veterans and reservists in the NHS workforce and RJAH is involved in the Employer Recognition Scheme.

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Freedom to speak up (FTSU)

30 concerns raised from March 2020 - December 2020

Anonymous concerns decreased by over 30%

Actions taken on concerns raised are fed back to those raising the concern in a timely manner

New logo launched to promote FTSU at RJAH

New logo for the National Guardian's Office

We have had our National Guardian logo since the office began in 2016. We wanted to build upon our trademark green, and have a logo which communicated the flourishing of Freedom to Speak Up and the network of guardians.

The term culture stems from the Latin 'cultivare' - to cultivate and grow, and we have chosen to use a tree to symbolise both our strong supportive network and the culture we're seeking to embed within health. A culture where learning, growing, sharing and reaching out is business as usual.

The symbol of the tree encapsulates the guardian values:

Courage: a tree stands strongly rooted in a storm

Impartiality: trees welcome all within their branches without judgment

Empathy: trees nurtures the lives which live within its branches

Learning: a 'growth' mindset.

We'll be gradually rolling out our new logo across our communications, but wanted guardians to be the first to see our new look

FTSU Champions gather monthly to identify themes in concerns raised

FTSU concerns acknowledged within 48 hours

"Thank you" poster produced to highlight some concerns raised, actions taken and lessons learnt

FTSU information included in induction package given to all new starters

Teaching package on FTSU provided. What FTSU is and how to raise a concern

New e-learning resources & induction film to help NHS staff when raising concerns produced by Health Education England

Managers training session/handbook is in development

NHS Rainbow badges

The NHS Rainbow Badge originated at Evelina London Children's Hospital to make a positive difference by promoting the message of inclusion and is now being launched by NHS organisations across the country.

The badge is a visual reminder that staff can be approached to talk about who you are and how you feel in a non-judgemental, inclusive and caring way.
RJAH staff are able to make a pledge in order to receive an NHS Rainbow Badge.

Rainbow windows

The windows in the main entrance of The Robert Jones and Agnes Hunt Orthopaedic Hospital were transformed to reflect the colours of the Pride rainbow flag and featured six powerful pledges made by staff as part of Pride month celebrations.

David Low, Improvement and Organisational Development Manager, said: “The pledges on the windows have also come from our very own staff at RJAH, and represent three key themes – equality and diversity, supporting patients and colleagues, and personal experiences. I’m really proud that RJAH is a visible ally to the LGBTQ+ community.”

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EDI Mandatory Training

The STW People Plan for 2021/22 sets out actions to support transformation of the workforce across the whole of the Trusts health and care system and focuses on how to continue to look after each other and foster a culture of inclusion and belonging.

This begins with equipping the workforce with the skills, knowledge and understanding they need in relation to equality, diversity and inclusion and continues with support for their ongoing needs and opportunities for them to share experiences and develop good practice.

The Trusts aim is to create a compassionate, inclusive and caring workforce that understands the differing needs of colleagues and the communities they serve through training and sharing lived experiences of those living and working in our local communities.

- Annual EDI Mandatory training
- Scenario based learning
- Local stories and case studies
- Faith / Religion
- Recommended to increase to 1 hour in length
- Interactive quiz
- Transition and gender
- Signposting to further EDI resources
- Sharing individuals lived experiences
- Neurodiversity
- Disability
- Race
- Allyship framework - recognising different personality types
- A patients perspective

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

Current Work

We are on a journey with our system in addressing health inequalities. This will involve local clinical teams being empowered to take ownership and drive forward plans to address inequalities to achieve demonstrable impact. As a Trust we will continue to work collaboratively with the system to gain a deeper understanding of how care needs to adapt to reduce inequalities.
We recognise that the lens for which we observe data can and will change as we look to further evolve and understand health inequalities. We are also analysing data to ensure we are restoring inclusively whilst also ensuring datasets are complete and timely. We continuously collect data on the following:

- Local health system population ethnicity data
- Waiting list profile data
- Local health system population deprivation data

The above data informs the actions of the trust moving forward. Future work includes:

- **Mitigating against digital exclusion** - we are aiming to increase virtual attendances during quarter 3 and quarter 4 of 2021/22. Can we be assured we are still offering face-to-face care to patients who cannot use remote services? This report will incorporate data collection to identify who is accessing face-to-face, telephone, or video consultations.
- **Equitable outcomes** - Our Trust collects and reports on patient reported outcomes measures (PROMs). Are we collecting outcome data equitably? What insight can the scores provide us on any variances in outcome for ethnicity and by IMD that may exist?
- **Ensuring datasets are complete and timely** - We have put in place processes that support in improvements in data capture for ethnicity. A review is recommended during 2021/22 to observe the improvements that have been made.

RJAH Learning Disabilities and Autism Improvement plan

Unwarranted variation in care and the poorer outcomes sometimes experienced by people with learning disabilities, autism or both mean trusts need to sustainably improve many of their services. The NHSI Learning Disability Standards for NHS Trusts provide a benchmark against which all trusts can measure their performance in delivering services to people with learning disabilities which in turn drives quality improvement.

The four standards are;

1. Respecting and protecting rights,
2. Inclusion and engagement,
3. Workforce,
4. Specialist Learning Disability Services

Compliance with these standards requires trusts to assure themselves that they have the necessary structures and processes, workforce and skills to deliver the outcomes that people with learning disabilities expect and deserve (NHSI, 2018).

A task and finish group has been set up within RJAH to monitor progress and set out improvements for patients with learning disabilities and autism accessing our services. The group includes a patient representative. Key milestones so far include the development of a ward introduction video for patients accessing our wards/departments to allay potential fears and anxieties, the continued promotion of the patient passport to identify individual needs enabling the staff to make reasonable adjustments and the development of tier 1 Learning Disability and Autism awareness training for all staff groups.

Conclusion

Throughout the last year there has been considerable pressure on the NHS and staff due to the COVID-19 pandemic. There have been changes for both patients and workforce, but equality and ensuring wellbeing have been at the core of decision making.

The RJAH Trust continue to demonstrate compliance to legal and mandated equalities duties and continue to embed equality considerations throughout the Trust, this includes commissioning decisions that impact our communities and also internal workforce changes which directly or indirectly impact on our workforce.

Whilst we perform well in meeting our equalities duties, we are aware that there is still further work to do and challenges to overcome. Moving forward, we will work hard to further promote the equality agenda and uphold human rights. We have met our legal equality duties as a provider and as an employer. We will continue to respond to the challenges ahead, working together with our partners across Shropshire, Telford and Wrekin to promote good practice and ensure that the work we do continues to promote the equality agenda.

Chairs Assurance Report
Finance, Planning and Digital Committee – 23 November 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	25 November 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Finance, Planning and Digital Committee was held on 23rd November 2021. A verbal update will be provided by the Non-Executive Chair of the Committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

Due to the timing of the Committee, it is not possible for a written Chair's Report to be provided. The Non-Executive Director Chair of the committee will provide a verbal update on the discussions held at the meeting. A copy of the agenda is shared with the Board for information.

2.3. Conclusion

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

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Agenda

Location	*Date*	*Owner*	*Time*
Microsoft Teams Meeting	23/11/21		14:00

1. Introduction		14:00
1.1. Apologies	Rachel Hopwood	
1.2. Minutes from the previous meeting/actions	Rachel Hopwood	
1.3. Matters arising	All	
1.4. Declaration of interests	All	
2. Digital		14:05
2.1. EPR Update (Presentation)	Simon Adams	
2.2. Cyber Secruity Update	Simon Adams	
2.3. Chair Report - Digital Steering Group	Simon Adams	
3. Performance		
3.1. Support Services Unit Efficiency Delivery Update	Alyson Jordan	14:15
3.2. Performance and Restoration Report	Kerry Robinson	14:25
3.3. Theatres Comparison Report	Kerry Robinson	14:35
3.4. RJAH and Midlands Comparisons	Kerry Robinson	14:40
3.5. RJAH Financial Performance Report	Mark Salisbury	14:45
3.6. System Financial Performance Report (to follow)	Craig Macbeth	14:50
4. Planning		
4.1. H2 Plan - Final Submisson	Kerry Robinson	14:55
4.2. H2 Financial Plan 2021/22	Mark Salisbury	15:05

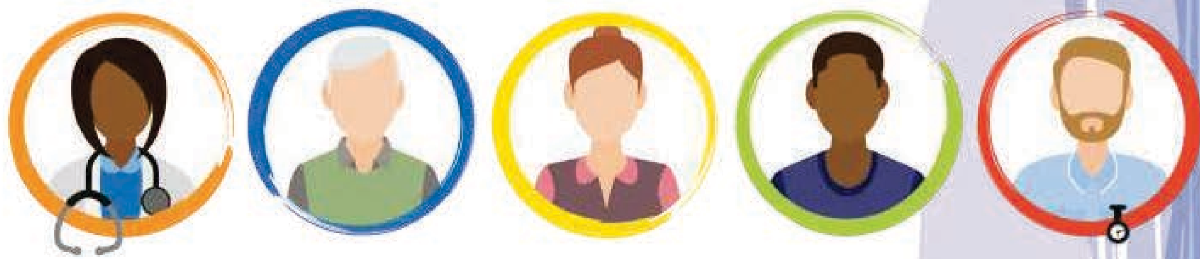
Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Microsoft Teams Meeting	23/11/21		14:00

Item	Owner	Time
5. Policy/Strategy		
5.1. Business Case and Investment Policy	Mark Salisbury	15:15
5.2. Agency Staffing Authorisation Policy	Mark Salisbury	15:20
6. Governance		
6.1. Board Assurance Framework & Corporate Objectives	Shelley Ramtuhul	15:25
6.2. Chair's Assurance Reports:		15:30
6.2.1. ICS Sustainability Committee	Craig Macbeth	
6.2.2. RJAH Sustainability Working Group	Craig Macbeth	
6.2.3. MSK Transformation Programme Board	Craig Macbeth	
6.2.4. Capital Management Group	Craig Macbeth	
6.3. For noting:		
6.3.1. Review of the Work Plan	Shelley Ramtuhul	15:45
6.3.1.1. Attendance Matrix	Shelley Ramtuhul	
7. Any Other Business	All	15:50
7.1. Next meeting: 25 January 2022		

Financial Plan H2 2021/22



The Robert Jones and Agnes Hunt Orthopaedic Hospital
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RJAH Financial Plan H2

Category	H1 Actual £k	H2 Plan £k	Movement £k	2021/22 Full Year £k
Clinical Income	50,026	48,975	-1,051	99,001
Top Up Funding	2,605	2,688	83	5,293
Covid Funding	1,452	1,370	-82	2,822
ERF Income	683	3,157	2,474	3,840
Non Clinical Income Support	878	675	-203	1,553
Non Clnical Income	6,288	5,614	-674	11,902
Pay	-34,955	-36,768	-1,813	-71,723
Non Pay	-23,428	-24,293	-865	-47,721
Control Total	3,549	1,418	-2,131	4,967

- Surplus of £1.4m planned for H2 – a reduction of £2.1m from H1
- Position assumes funding from ERF of £3.2m (subject to delivery of increased activity)
- The main drivers for the deterioration are :
  - Private patient income returning to normal levels (H1 benefitted from additional capacity due to LLP contract)
  - Recruitment to vacancies
  - Reduced benefit from ERF (H2 assumes pass through of additional costs only)

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Month 7 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	25/11/2021
Executive Sponsor:	Kerry Robinson	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

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

The committee is asked to note the overall performance as presented in the month 7 (October) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

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

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

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

2.2. Changes this month

Improvements have been made to the reporting of the WHO process. This has previously been reported in the IPR that goes to the Quality and Safety Committee. It is recommended that oversight should also be reported to eh Board of Directors. Therefore, the following two measures are added this month:

- WHO Quality Audit - % Compliance
    - *% Of audited sessions where whole/part WHO process was implemented as part of patient care*
- WHO Documentation Audit - % Compliance
    - *% Of sticker compliance for steps one to five of WHO documentation*

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Month 7 Integrated Performance Report

2.3. Overview

The Board through this IPR should note the following;

The impacts of covid continue to be seen in the delivery of our statutory targets and will continue not to be met due to pausing of elective services last year. Therefore, assurance cannot be given for meeting the targets, hence assurance should be through the processes in place to manage such impact. The Trust will be reviewing targets and trajectories in upcoming months aligning to H2 plans.

Patients continue to be booked in line with guidance regarding clinical priority as a primacy rather than date order, illustrated in the long wait patients impact.

Caring for Staff;

- Sickness Absence
  - Metric showing normal variation but now exceeded target for five consecutive months
  - Short term sickness showing special cause variation of concern and been above target for three consecutive months
  - Long term sickness above target for four consecutive months

Caring for Patients;

- WHO
  - Highlighting change in reporting and Documentation Audit below target
- Cancer 62 Days Standard
  - Performance reported below 85% target at 33.33%
- 18 Weeks RTT Open Pathways
  - Metric is showing special cause variation of an improving nature; although consistently failing the target as expected from covid impact which will continue for a significant time.
  - Whilst this metric remains affected from the covid impact, and will not be met NHSEI H2 planning guidance has set out the expectation that Trusts should stabilise waiting list numbers at the level seen at the end of September 2021 as the assurance around process rather than target.
- Patients Waiting Over 52 Weeks
  - Presentation includes combined number of patients, together with breakdown of English, Welsh & BCU Transfers.
  - Both English and Welsh showing special cause variation with increases reported this month.
  - BCU Transfers shows continuous improvement with reductions since November 20, with now 10 patients remaining.
  - NHSEI H2 planning guidance documents that as a Trust we should hold or where possible reduce the number of patients waiting over 52 weeks. For month 7 our English patients waiting over 52 weeks is 104 patients above our planned trajectory and Welsh patients 22 above our planned trajectory.
- 6 and 8 Week Wait for Diagnostics
  - Both metrics indicate common cause variation with variable achievement of Welsh target and consistently failing English
  - MRI capacity remains a constraint given the Trust is operating above its previous capacity levels.
  - CT mutual aid has been provided in this period to system partners impacting available capacity.

Caring for Finances;

- Bed Occupancy – All Wards – 2pm
  - Metric is consistently failing target
- Expenditure

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- Adverse in month

2.4. Conclusion

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

Integrated Performance Report October 2021 – Month 7

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

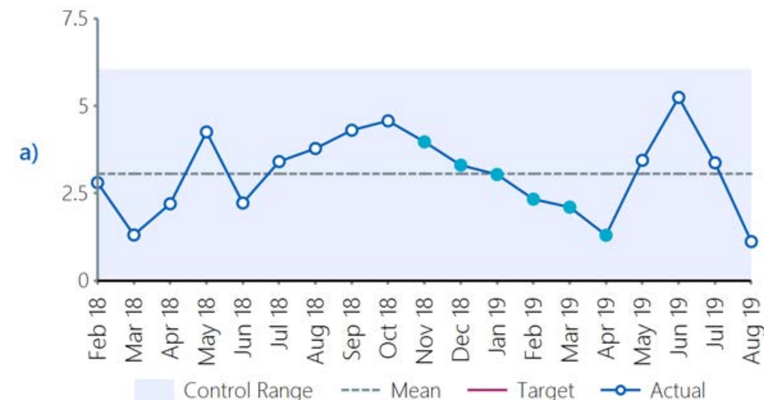
Different colours have been used to separate these trends of special cause variation; ● **blue points** have been used to show **areas of improvement** and ● **orange points** for **areas of concern.** It should be noted that SPC charts do not compare performance against targets; that is the purpose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

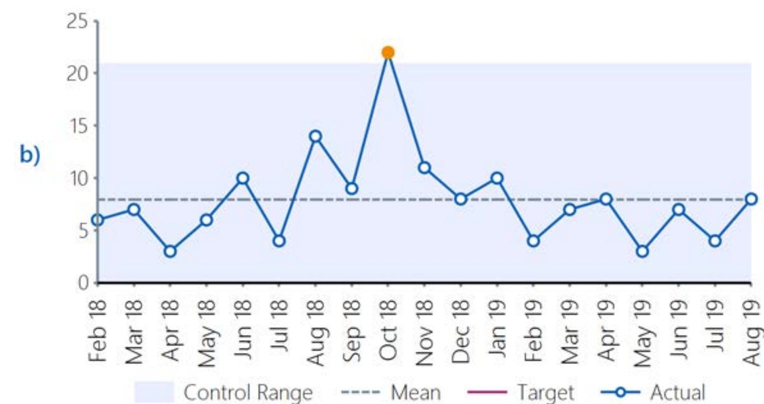
Some examples of these are shown in the images to the right:

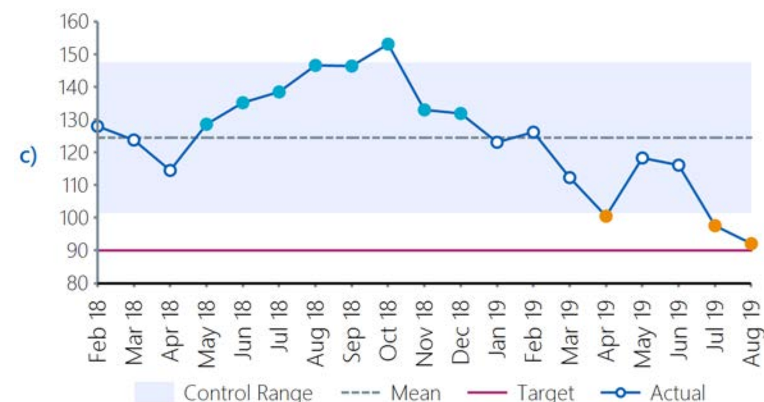
a) shows a run of improvement with 6 consecutive descending months.

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

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







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Summary Icons Reading Guide

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

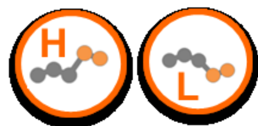
Exception Reporting

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

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

Variation Icons

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



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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

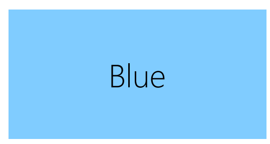
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Data Quality Rating Reading Guide

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

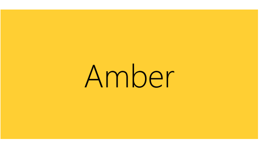
Colours

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

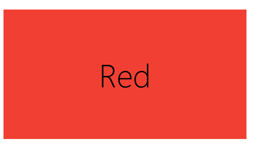


No improvement required to comply with the dimensions of data quality

Satisfactory - minor issues only



Requires improvement



Siginficant improvement required

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1 & H2)	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	4.80%				+	27/02/20
Voluntary Staff Turnover - Headcount	8.00%	7.98%					24/06/21

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1 & H2)	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	?		
Never Events	0	0		N/A to SPC	?		16/04/18
Number of Complaints	8	9			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	?		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Unexpected Deaths	0	0		N/A to SPC	P		16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P	+	

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1 & H2)	Variation	Assurance	Exception	DQ Rating
WHO Documentation Audit - % Compliance	100%	93%		N/A to SPC	F	+	
31 Days First Treatment (Tumour)*	96%	100%		H	?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85.00%	33.33%	100.00%		?	+	24/06/21
18 Weeks RTT Open Pathways	92.00%	55.99%		H	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,514	1,410	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	672	650	H	F	+	24/06/21
6 Week Wait for Diagnostics - English Patients	99.00%	85.42%			F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	89.28%			?	+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1 & H2)	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	1,069	917	903	N/A to SPC	Moving Target		24/06/21
Bed Occupancy – All Wards – 2pm	87.00%	78.37%			F	+	05/09/19
Total Outpatient Activity	15,248	12,894	12,312	N/A to SPC	Moving Target		24/06/21
H1 & H2 Plan Performance	-105	46		N/A to SPC	Moving Target		
Income	9,876	10,113		N/A to SPC	Moving Target		
Expenditure	10,026	10,113		N/A to SPC	Moving Target	+	
Efficiency Delivered	216	238		N/A to SPC	Moving Target		
Cash Balance	22,482	22,482		H	Moving Target		
Capital Expenditure	739	794		N/A to SPC	Moving Target		
Recurrent Financial Performance (Sustainability Plan)	-305	-132		N/A to SPC	Moving Target		

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

Sickness Absence

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

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
3.60%	4.80%		

Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

Although the sickness absence rate is displayed as normal variation in the SPC above, it has now steadily increased above target for four consecutive months. Unit level detail below for those areas that are above target:
* MSK Unit - overall sickness was 5.40% in October and has been above target for five consecutive months. The highest reason for sickness was Other musculoskeletal
* Specialist Unit - overall sickness was 6.18% in October and has been above target for five consecutive months. The highest reason for sickness was Anxiety/Stress/Depression (not recorded as work related)
* CSU - overall sickness was 5.36% in October and has been above target for six consecutive months. The highest reason for sickness was Anxiety/Stress/Depression

Actions

The Trust has rolled out information on the Staff psychological wellbeing assessment and support hub and is focussing on this at Unit meetings. Wellbeing conversations are also being rolled out and have a key role in addressing stress and anxiety issues. The People Services Business Partners are working with managers to signpost to Remploy's services for psychological support. Information has been circulated to managers on the additional services available to staff. All Units are actively monitoring and encouraging staff to take their leave entitlement.

Utilisation of the sickness absence policy continues with pro-active milestone management. The Specialist Unit have held a training session with Senior Nursing staff in supporting staff through sickness absence. A similar session is now planned within the MSK Unit and both units plan to role this out to areas other than nursing.

Within the MSK Unit to address musculoskeletal absence, managers are referring to Occupational Health where appropriate and manual handling assessments are being undertaken.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
3.60%	4.45%	4.42%	4.40%	3.43%	3.27%	2.77%	3.16%	3.97%	3.96%	4.36%	4.55%	4.80%

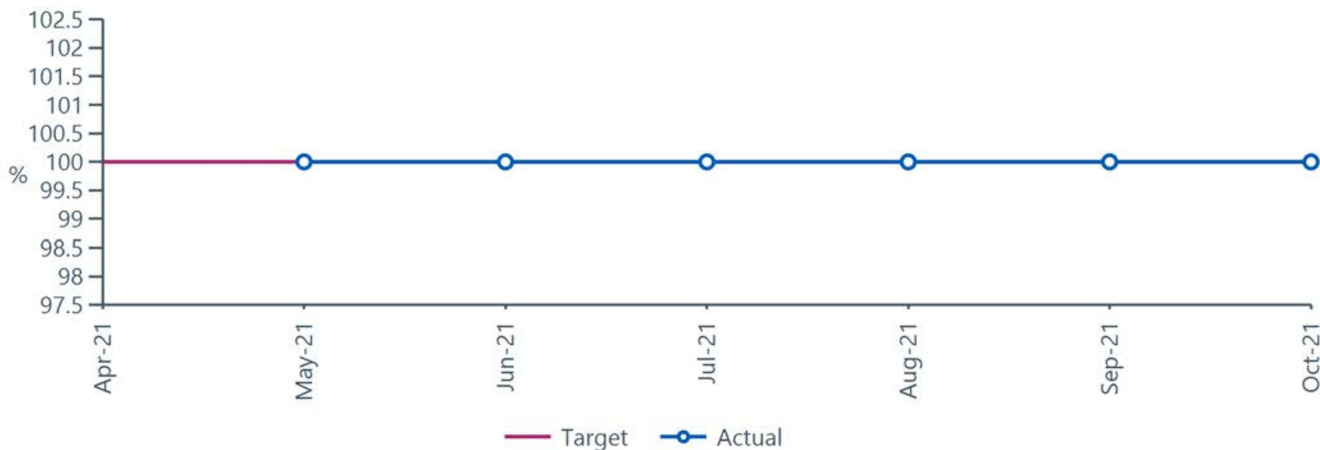
WHO Quality Audit - % Compliance

% of audited sessions where whole/part WHO process was implemented as part of patient care

Exec Lead:
Chief Medical Officer

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

Trajectory/Plan (H1&H2)



What these graphs are telling us

This measure does not have enough data points for robust reporting in SPC so is displayed as a line graph. The assurance is indicating the metric will consistently pass the target.

Narrative

Senior members of the Theatre team are undertaking ten complete Safety Checklist Audits per month by observing a random sample of theatre sessions, through a mix of specialties, cabins and surgeons, and across different days of the week. The aim of the audit is to understand how well Theatre staff are engaged in the WHO process, and how robustly each of the WHO steps are being followed. A full and complete record of the background evidence of the audit is retained by Theatres and the outcomes of the audit are being reviewed for common themes and, where appropriate, actions to improve. It is expected that once the process is fully embedded, reporting will move to the newly introduced Perfect Ward app. Data on this new KPI has been collated since May and year to date the Trust is reporting 100% compliance.

Actions

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
	100%	100%	100%	100%	100%	100%

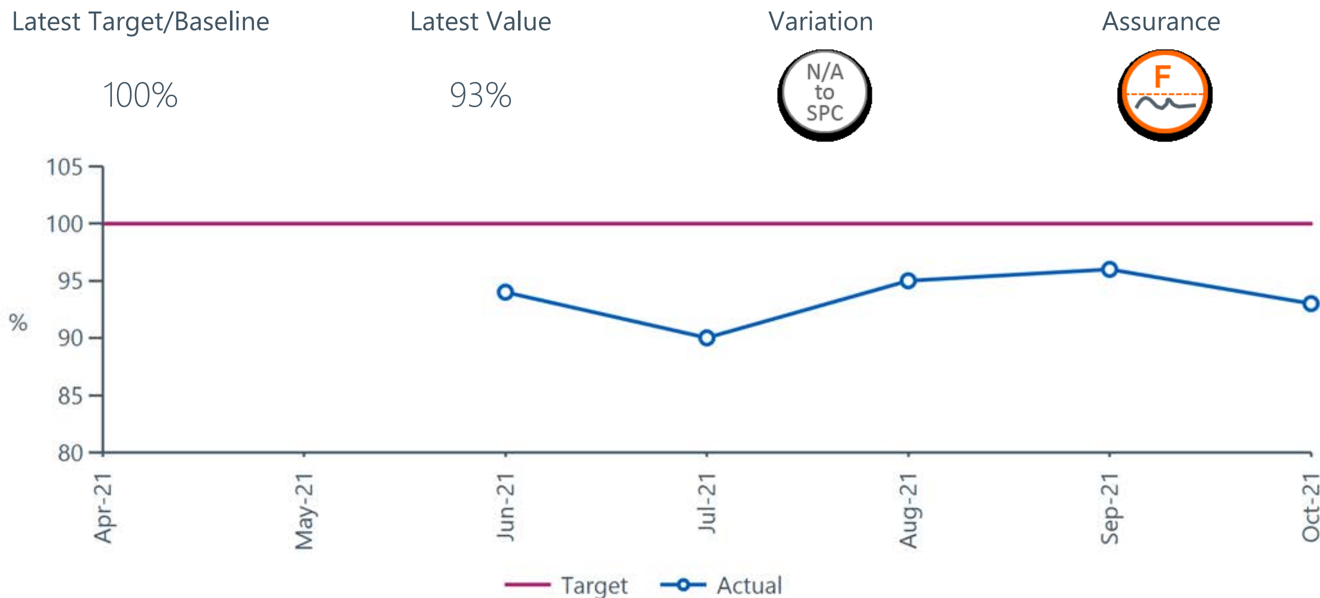
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

WHO Documentation Audit - % Compliance

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

Exec Lead:
Chief Medical Officer

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/Plan (H1&H2)
100%	93%			



What these graphs are telling us

This measure does not have enough data points for robust reporting in SPC so is displayed as a line graph. The assurance is indicating the metric will fail to consistently meet target without system changes.

Narrative

Senior members of the Theatres team are undertaking ten documentation audits per week by randomly sampling patient's paperwork for stickers evidencing adherence to each of the WHO five steps. The aim of the audit is to ascertain how well the team are recording compliance in patients notes. A full and complete record of the background evidence of the audit is retained by Theatres and the outcomes of the audit are being reviewed for common themes and, where appropriate, actions to improve. Once the process is fully embedded, the option to move reporting to the newly introduced Perfect Ward app will be explored. Data on this new KPI has been collated since June and in October the Trust is reporting 93% compliance.

Actions

Reporting against this measure is an improvement on what was in place, however it is acknowledged that there are still further improvements that can be made. Initial findings from the data collection to date will be reported and discussed through the MSK Board.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
		94%	90%	95%	96%	93%

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

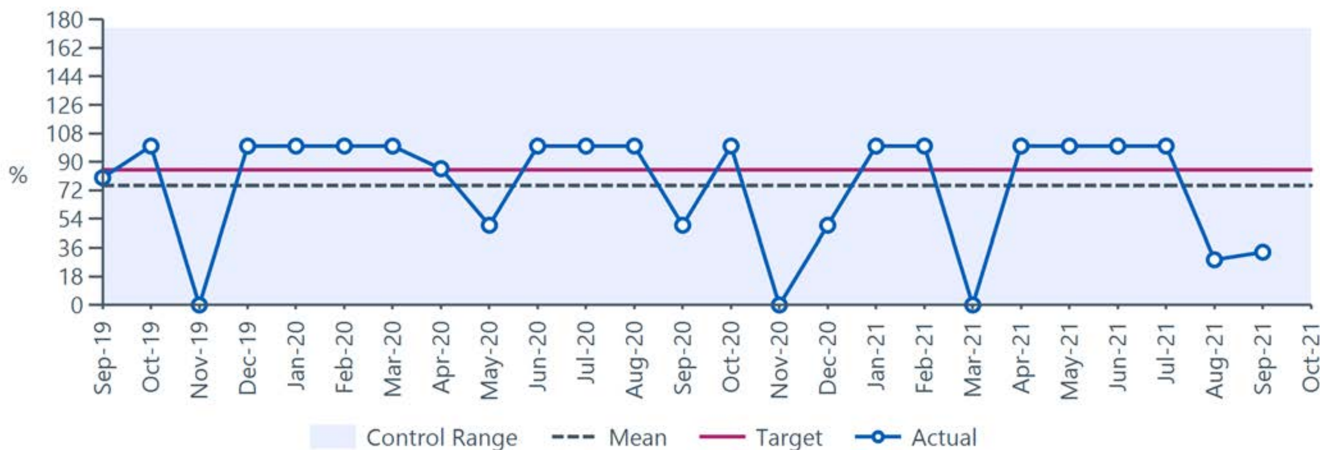
Cancer Plan 62 Days Standard (Tumour)*

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
85.00%	33.33%		

Trajectory/Plan (H1&H2)



What these graphs are telling us

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

Narrative

The Cancer 62 Day Standard is reported at 33.33% in September; this measure is reported in arrears. This equates to two patients whereby the first was a shared pathway that met the 62 day target and the second shared pathway was a breach that was fully accountable to RJAH. The pathway that did not meet the standard was complex where subsequent investigations where required to confirm the diagnosis.

It must also be noted, that the overall % for this indicator will always be impacted by low numbers.

Performance that will be reported for October is forecast to be 100.00%.

Actions

Discussions are ongoing between Radiology and Tumour teams around ringfenced availability.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
100%	0%	50%	100%	100%	0%	100%	100%	100%	100%	28%	33%	

18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	55.99%	H	F

Trajectory/Plan (H1&H2)

57.46 — 55.99

Actual — Trajectory

Control Range — Mean — Target — Actual

What these graphs are telling us

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

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

Narrative

Our October performance was 55.99% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows: MS1 - 7257 patients waiting of which 1895 are breaches, MS2 - 1189 patients waiting of which 759 are breaches, MS3 - 4474 patients waiting of which 3032 are breaches.

Actions

H2 planning guidance documents that as a Trust we should stabilise waiting lists around the level seen at the end of September 2021. We continue with the Trust's plans and actions to manage demand. These are inclusive of:
- Increasing available Theatre sessions
- Exploring options to increase Cases per Session (CPS): - CPS when compared with 2019/20 is being impacted by complexity of patients presenting as high priority.
- More clock stops in non-admitted pathways - Capacity in delivery area (i.e. Radiology or MOPD) is continually assessed.

Spinal Disorders continues to be a pressured area for the Trust which is a proportion of our overall waiting lists. Actions inclusive of mutual aid discussions and recruitment actions for this service are in progress.

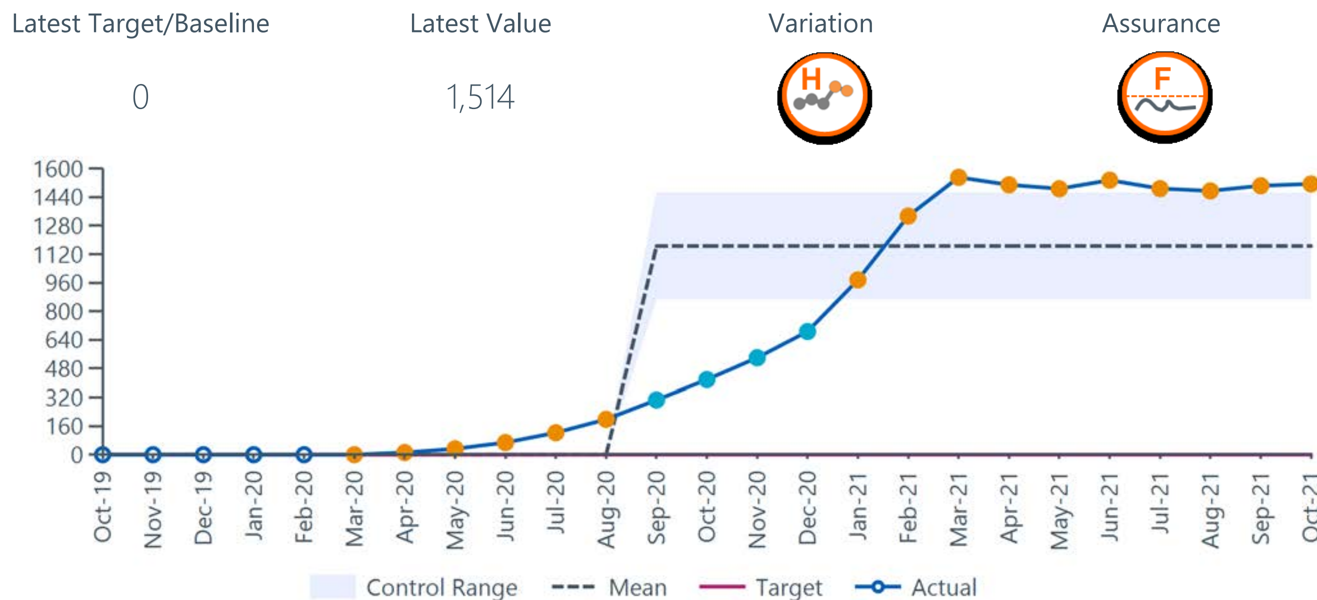
Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	56.68%	57.46%	58.10%	58.40%	57.02%	55.71%	55.99%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1,514	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

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

Narrative

At the end of October there were 1514 English patients waiting over 52 weeks; above our trajectory figure of 1410.

The patients are under the care of the following sub-specialities; Spinal Disorders (616), Knee & Sports Injuries (307), Arthroplasty (268), Upper Limb (157), Foot & Ankle (71), Spinal Injuries (69), Metabolic Medicine (10), Tumour (7), Paediatric Orthopaedics (4), Neurology (2), Rheumatology (2) and Geriatrics (1).

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1008 patients
- >78 to <=95 weeks - 360 patients
- >95 to <=104 weeks - 78 patients
- >104 weeks - 68 patients

Actions

H2 planning guidance documents that as a Trust we should hold, or where possible, reduce the number of patients waiting over 52 weeks. The submitted plans are reflected in the trajectory line above for future months.

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

For Spinal Disorders mutual aid discussions are on-going.
A number of workforce actions are being undertaken inclusive of a locum consultant being appointed and a registrar also being recruited to support. An additional Senior Fellow will also join the cohort in February for 6 months. Further workforce actions also being explored and progressed.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
418	540	687	976	1334	1551	1509	1487	1535	1488	1475	1504	1514

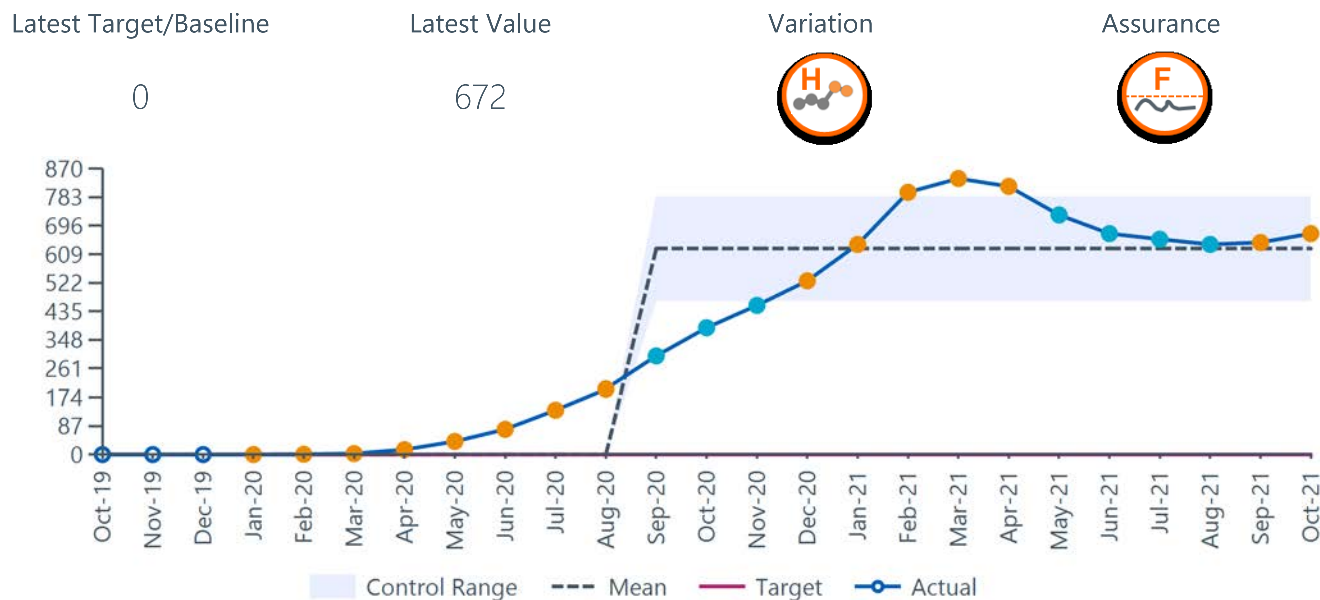
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

Patients Waiting Over 52 Weeks – Welsh

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	672	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

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

Narrative

At the end of October there were 672 Welsh patients waiting over 52 weeks; above our trajectory figure of 650 by 22. The patients are under the care of the following sub specialties; Spinal Disorders (397), Knee & Sports Injuries (88), Arthroplasty (84), Upper Limb (48), Foot & Ankle (21), Spinal Injuries (14), Paediatric Orthopaedics (6), Tumour (6), Metabolic Medicine (4), Neurology (3) and Rheumatology (1).

The patients are under the care of the following commissioners; BCU (xxx), Powys (xxx), Hywel Dda (xx), Aneurin Bevan (x) and Cardiff & Vale (x).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks -391 patients
- >78 to <=95 weeks - 158 patients
- >95 to <=104 weeks - 60 patients
- >104 weeks - 63 patients

Actions

H2 planning guidance documents that as a Trust we should hold, or where possible, reduce the number of patients waiting over 52 weeks. Although the H2 requirements only relate to English patients we have still made plans for all our patients and this is reflected in the trajectory line above for future months.

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

For Spinal Disorders mutual aid discussions are on-going.
A number of workforce actions are being undertaken inclusive of a locum consultant being appointed and a registrar also being recruited to support. An additional Senior Fellow will also join the cohort in February for 6 months. Further workforce actions also being explored and progressed.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
385	453	528	639	798	840	816	729	672	655	639	645	672

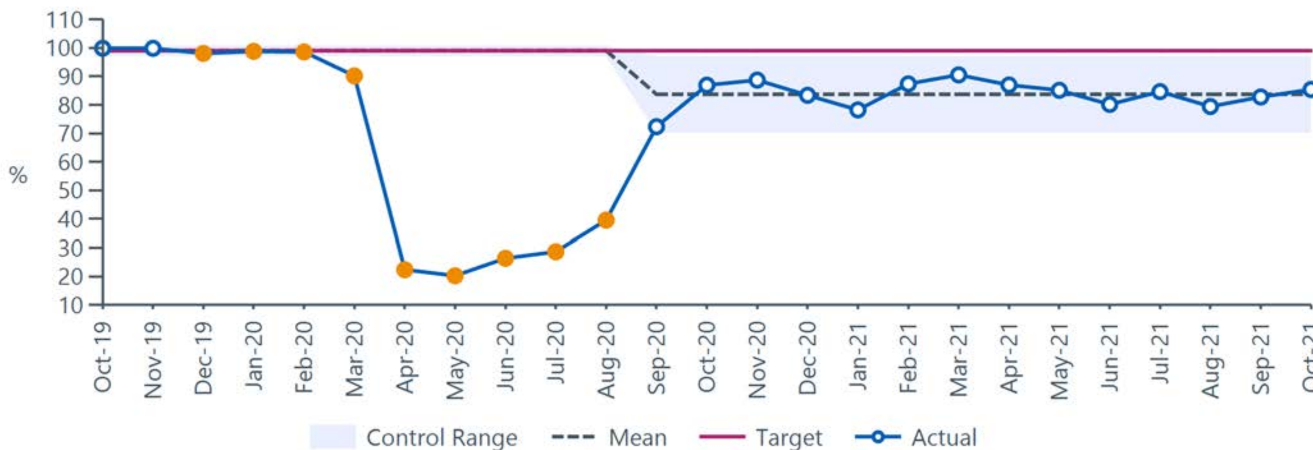
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/Plan (H1&H2)
99.00%	85.42%			



What these graphs are telling us

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

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 85.42%. This equates to 202 patients who waited beyond 6 weeks. The breaches occurred in the following modalities:
- MRI (157 - with 152 dated)
- Ultrasound (2 dated)
- CT (42 - with 30 dated)
- DEXA (1 dated)

The Trust are currently providing mutual aid for the system within CT until the end of November; this has impacted the number of patients who waited beyond 6 weeks for a CT scan. Prior to providing mutual aid we were 100% compliant with CT scans.

It must be noted that both MRI and CT activity was over 100% of the H2 plans.

Actions

The Trust is currently providing system mutual aid to support urgent priorities in our system. Focus is being given to the 'D' prioritisation to ensure urgent patients are seen. This Mutual Aid agreement is in place until the end of November.

A paper was recently discussed to explore capacity options for MRI. A decision has now been taken to replace just the current scanner. In addition, a further paper is being presented to the Senior Leadership Group to explore options of increased staffing and extend working hours within Radiology.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
86.92%	88.70%	83.37%	78.24%	87.38%	90.53%	86.99%	85.13%	80.17%	84.66%	79.43%	82.78%	85.42%

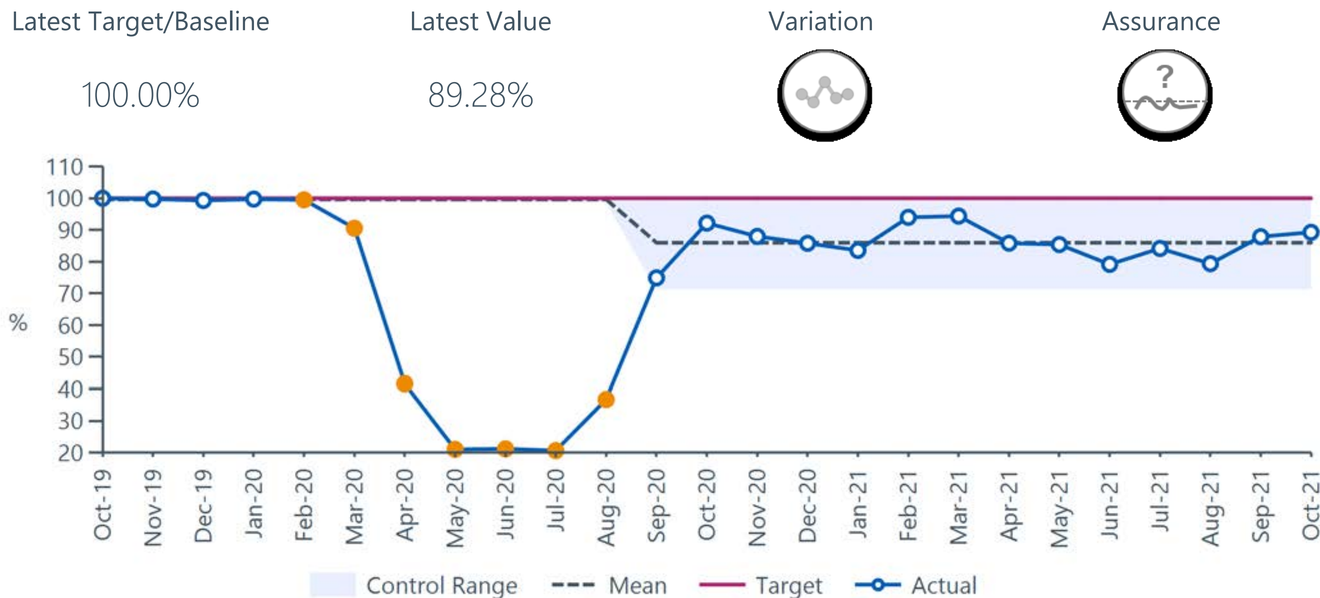
8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	89.28%		

Trajectory/Plan (H1&H2)



What these graphs are telling us

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

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 89.28%. This equates to 73 patients who waited beyond 8 weeks. The breaches occurred in the following modalities:
- MRI (65 dated)
- CT (8 - with 2 dated)

The Trust are currently providing mutual aid for the system within CT until the end of November; this has impacted the number of patients who waited beyond 8 weeks for a CT scan. Prior to providing mutual aid we were 100% compliant with CT scans.

It must be noted that both MRI and CT activity was over 100% of the H2 plans.

Actions

The Trust is currently providing system mutual aid to support urgent priorities in our system. Focus is being given to the 'D' prioritisation to ensure urgent patients are seen. This Mutual Aid agreement is in place until the end of November.

A paper was recently discussed to explore capacity options for MRI. A decision has now been taken to replace just the current scanner. In addition, a further paper is being presented to the Senior Leadership Group to explore options of increased staffing and extend working hours within Radiology.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
92%	87%	85%	83%	94%	94%	85%	85%	79%	84%	79%	87%	89%

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Bed Occupancy – All Wards – 2pm

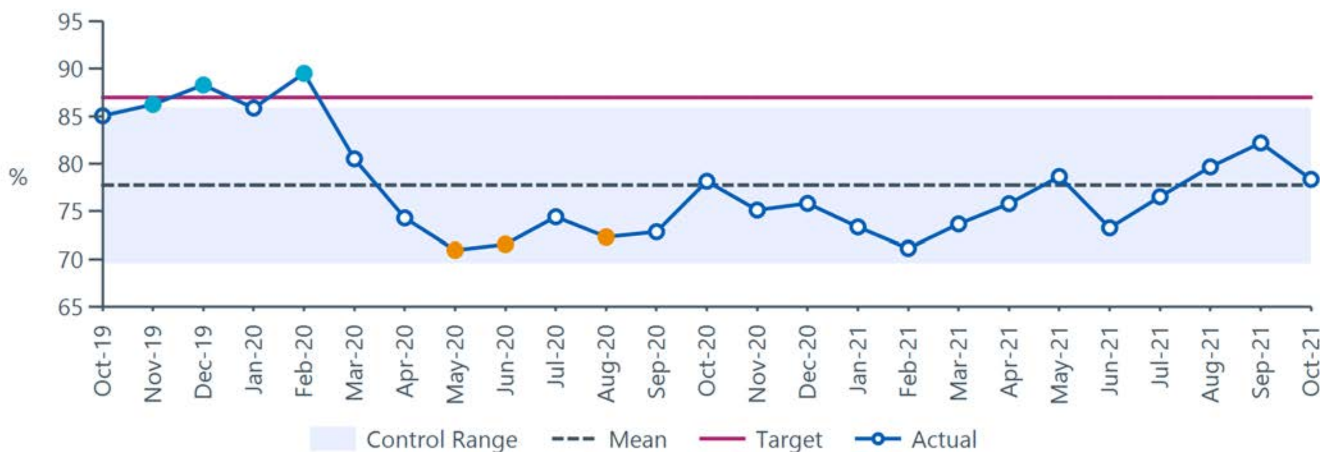
% Bed occupancy at 2pm

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	78.37%		

Trajectory/Plan (H1&H2)

Actual
Trajectory



What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 78.37% for October. The breakdown below gives the October occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:

MSK Unit:
- Clwyd - 75.27% - compliment of 22 beds throughout month
- Powys - 80.90% - compliment of 22 beds for majority of the month
- Kenyon - 67.74% - ward open to 12 beds some days per week
- Ludlow - 73.60% - compliment of 15 beds open throughout month

Specialist Unit:
- Alice - 63.34% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 71.85% - compliment of 10 beds open throughout month
- Gladstone - 85.15% - compliment of 29 beds open throughout month
- Wrekin - 86.33% - compliment of 15 beds open throughout month
- Sheldon - 82.89% - compliment of 20 beds open throughout month

Actions

With regular review, we continue to flex our bed base whenever possible to have sufficient beds open for the anticipated activity numbers based on the existing bed model. This includes assessing the variability of occupancy by weekday. Flexing has included ward and bed closures and redeployment of staff to other areas of the Trust.

Consideration and assessment of length of stay and delayed transfers of care are considered when monitoring our occupancy.

Bed Occupancy is expected to increase, in line with increased activity levels. The Specialist Unit are contributing to system working with an increase of geographical catchment that will increase occupancy on Sheldon ward. The Alice ward occupancy is expected to increase through additional paediatric trauma mutual aid activity.

New IPC guidance has been reviewed but will not impact on our beds.

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
78.17%	75.14%	75.84%	73.37%	71.15%	73.68%	75.81%	78.67%	73.27%	76.54%	79.68%	82.21%	78.37%

Expenditure

All Trust expenditure including Finance Costs

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
10,026	10,113	N/A to SPC	Moving Target

Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

Overall £87k adverse in month:

Pay £45k favourable
- Vacancies net of bank & agency

Non Pay £132k adverse
- Private patient implants adverse
- Pass through drugs & devices

Note: Vaccination hub/workforce services £136k of costs recharged to SCHT in month (excluded from the above figures).

Actions

Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
8967	9640	9045	8760	9542	10769	9311	9409	9451	10004	9517	10969	10113

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st October 2021

Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	101,706	8,140	8,171	30	57,247	58,880	1,633
System Top Up Funding	4,834	373	373	0	2,970	2,978	8
Non NHS income support	1,537	110	110	0	988	988	0
Covid-19 Funding	2,822	228	228	0	1,680	1,680	0
Private Patient income	4,101	403	627	223	2,281	4,246	1,965
Other income	6,365	621	604	(17)	3,594	3,273	(321)
Pay	(71,102)	(6,058)	(6,013)	45	(40,393)	(40,968)	(575)
Non-pay	(40,955)	(3,419)	(3,552)	(133)	(23,100)	(23,937)	(838)
EBITDA	9,307	399	547	149	5,267	7,140	1,873
Finance Costs	(6,616)	(549)	(548)	1	(3,875)	(3,870)	5
Capital Donations	4,750	(122)	852	974	1,618	1,523	(95)
Operational Surplus	7,442	(272)	851	1,124	3,010	4,793	1,782
Remove Capital Donations	(4,750)	122	(852)	(974)	(1,618)	(1,523)	95
Add Back Donated Dep'n	540	45	47	1	314	327	13
Control Total	3,231	(105)	46	151	1,706	3,597	1,890
EBITDA margin	8.0%	4.2%	5.6%	1.4%	8.0%	10.3%	2.3%

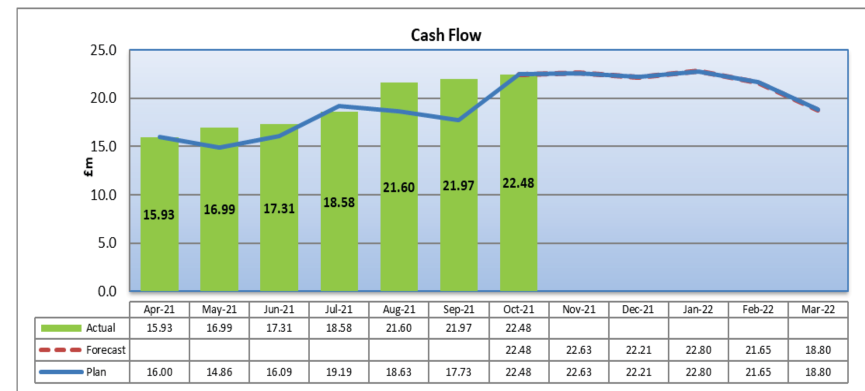
Sustainability (Recurrent) Plan 2021/22			
Category	Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	60,837	60,837	(0)
System Top Up Funding	0	0	0
Non NHS income Support	0	0	0
Covid-19 Funding	0	0	0
Private Patient income	3,212	3,212	(0)
Other income	3,872	3,855	(17)
Pay	(41,266)	(41,266)	0
Non-pay	(24,377)	(24,377)	0
EBITDA	2,277	2,260	(17)
Finance Costs	(3,931)	(3,930)	0
Capital Donations	1,835	1,523	(312)
Operational Surplus	181	(147)	(328)
Remove Capital Donations	(1,835)	(1,523)	312
Add Back Donated Dep'n	314	328	14
Control Total	(1,340)	(1,342)	(2)

Statement of Financial Position £'000s				
Category	Sep-21	Oct-21	Movement	Drivers
Fixed Assets	79,193	79,591	398	Additions less depreciation
Non current receivables	1,305	1,198	(107)	
Total Non Current Assets	80,498	80,789	291	
Inventories (Stocks)	1,384	1,319	(65)	
Receivables (Debtors)	6,957	6,376	(581)	Payments received for pay award back pay
Cash at Bank and in hand	21,974	22,482	508	
Total Current Assets	30,315	30,177	(138)	
Payables (Creditors)	(16,553)	(15,716)	837	Capital programme payments
Borrowings	(1,428)	(1,434)	(6)	
Current Provisions	(683)	(673)	10	
Total Current Liabilities (< 1 year)	(18,664)	(17,823)	841	
Total Assets less Current Liabilities	92,149	93,143	994	
Non Current Borrowings	(3,791)	(3,950)	(159)	Salix loan increase
Non Current Provisions	(974)	(957)	17	
Non Current Liabilities (> 1 year)	(4,765)	(4,907)	(142)	
Total Assets Employed	87,384	88,236	852	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,396)	(22,396)	0	
Revenue Position	(3,942)	(4,794)	(852)	Current period surplus
Revaluation Reserve	(24,938)	(24,938)	0	
Total Taxpayers Equity	(87,384)	(88,236)	(852)	

Draft Finance Metrics (New Single Oversight Framework)

Performance against Financial Plan		Underlying financial plan	
Expenditure run rate		Overall trend in reported financial position	

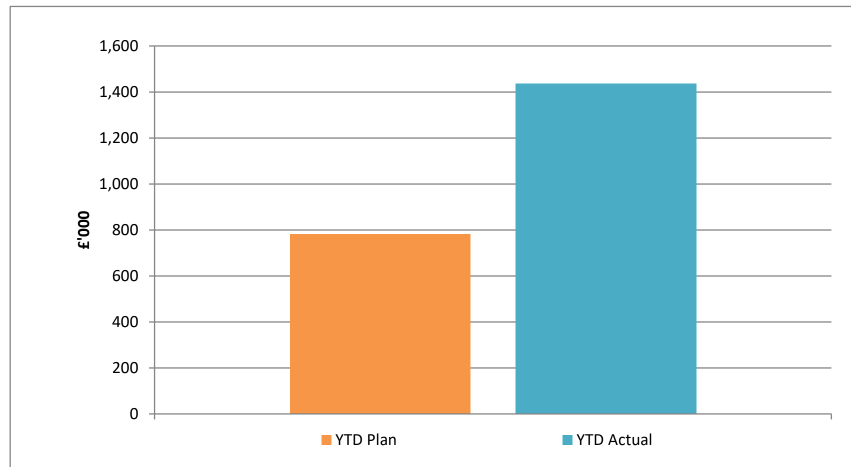
	YTD
Debtor Days	20
Creditor Days	51



Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Finance Dashboard 31st October 2021

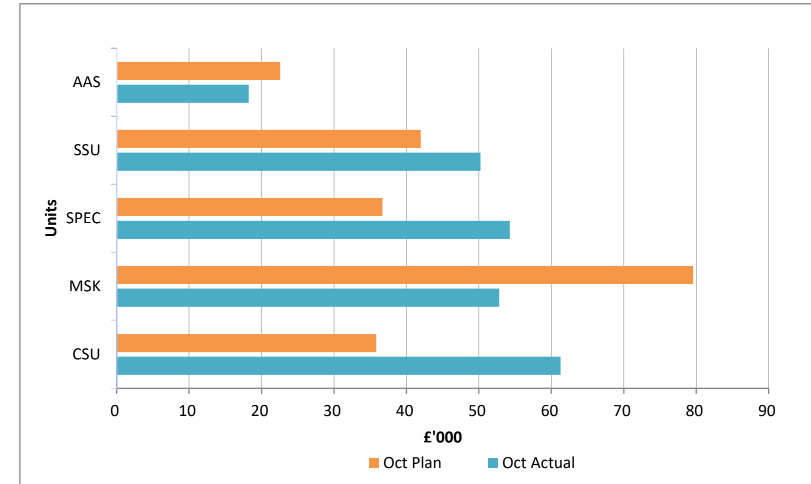
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



In Month Efficiencies

In Month Efficiencies Achievement £000's



Capital

Position as at	2122-07	Capital Programme 2021-22						
Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn
Backlog maintenance	600	96	90	6	450	328	122	750
I/T investment & replacement	300	0	0	0	140	-4	144	300
Capital project management	100	8	10	-2	58	70	-12	120
Equipment replacement	500	50	0	50	250	293	-43	520
Diagnostic equipment replacement	1,701	0	5	-5	600	99	501	2,901
Diagnostic equipment replacement PDC	99	0	0	0	0	0	0	99
Contingency	500	100	43	57	200	78	122	460
EPR planning & implementation	2,000	0	0	0	200	0	200	750
Invest to save	200	0	25	-25	50	25	25	100
Donated medical equipment	200	0	125	-125	150	235	-85	250
Veterans' centre	4,500	485	496	-11	2,075	1,288	787	4,500
Total Capital Funding	**10,700**	**739**	**794**	**-55**	**4,173**	**2,413**	**1,760**	**10,750**
Donated medical equipment	-200	0	-125	125	-150	-235	85	-250
Veteran's facility	-4,500	-485	-496	11	-2,075	-1,288	-787	-4,500
Capital Funding (NHS only)	**6,000**	**254**	**173**	**81**	**1,948**	**890**	**1,058**	**6,000**

Forecast

Category	Forecast			
	Plan	Actual	Variance	Notes
Clinical Income	101,706	103,339	1,633	H1 overperformance driven by pass through drugs, elective recovery fund income for Q1 and impact of pay award
CCG Growth Funding	4,834	4,842	8	
System Top up Funding	1,537	1,537	0	
Covid-19 Funding	2,822	2,822	0	
Private Patient income	4,101	6,401	2,300	Overperformance and volume gains
Other income	6,365	6,174	(191)	H1 shortfalls for Denbighs, Car Parking & Research
Pay	(71,102)	(71,802)	(700)	Impact of pay award offset by covid underspends
Non-pay	(40,955)	(42,108)	(1,153)	Pass through drugs & PP implants
EBITDA	9,308	11,205	1,897	
Finance Costs	(6,616)	(6,611)	5	
Capital Donations	4,750	4,655	(95)	
Operational Surplus	7,443	9,250	1,807	
Remove Capital Donations	(4,750)	(4,655)	95	
Add Back Donated Dep'n	539	552	13	
Control Total	3,231	5,146	1,915	

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

Board Assurance Framework and Corporate Objectives

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	23 November 2021
Executive Sponsor:	Stacey Keegan, Interim Chief Executive	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Finance, Planning and Digital Committee	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to the Finance, Planning and Digital Committee and what input is required?

The Finance, Planning and Digital Committee is asked to consider the risks cited on the Board Assurance Framework (BAF) which sit within its remit.

2. Executive Summary

2.1. Context

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

2.2 Summary

The Board has delegated responsibility for matters aligned to the Committee which must provide assurance to the Board after each meeting. This paper presents an update of the BAF which has been aligned to the objectives for 2021/22.

The risks were last reviewed by the Audit and Risk Committee in October 2021 and has been reviewed by the Senior Leader Teams before onward presentation at the Board in November 2021.

Updates have been provided against the actions to address any identified gaps in assurance and controls – noted in blue text.

There is a recommendation within the framework to close the following risks:

- Objective - maintain high infection standards to support the restoration of activity
    - 2.1 – inability to respond quickly enough to rapidly changing infection control national guidance
    - 2.2 - inability to align the capital programme with the quickly changing operating environment and funding movements

2.3. Conclusion

The Committee is asked to:

- Note the content of the BAF risks which fall within its remit
- Consider and agree whether assurance can be provided to the Board on the basis of the mitigations identified or whether further actions are required.
- Recommend the risks to be closed alongside the Quality and Safety Committee

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

Caring for Patients — OBJ 1

Principal Objective: Deliver the work to restart elective services

This objective can be broken down into four key components, developing and delivering an activity plan, management of the patient waiting backlog, full implementation of clinical prioritisation and harms review processes and sustaining clinical outcomes.

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Key Measures:

- ✓ Modelling plan delivered to the Board
- ✓ Response to planning requirements beyond half year
- ✓ Accurate patient waiting data
- ✓ Minimisation of patients waiting over 52 weeks
- ✓ NJR outcomes
- ✓ PROMs
- ✓ KPI delivery within IPR
- ✓ GIRFT reviews
- ✓ Model hospital data top quartile performance for orthopaedic pathways
- ✓ Participation in National Clinical Improvement Programme
- ✓ Report on leadership arrangements for delayed discharges
- ✓ Number of delayed discharges (without mitigations)

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Progress Update:

H1 plan developed, and patient care activity delivered as reported through Finance Planning and Digital Committee and the Board of Directors.

The patient waiting backlog is being monitored through the Finance Planning and Digital Committee this includes the monitoring of wait list size, clinical prioritisation groups, waiting time, referral rates. There is regular reporting to Trust Performance Board and SLG in place with regional benchmarking considered.

Patients are managed in order of clinical priority and are managing to a trajectory of zero non-spines patients waiting 104 weeks by March 22. Clinical prioritisation extended and now includes both elective and diagnostic wait lists.

Harms process reported monthly to the Harms Group and Q&S Committee.

H2 plan has been discussed at Finance Planning and Digital Committee and submitted with anticipated change in patient care activity levels.

Supporting Programmes of Work:

- Delayed discharge leadership review
- National Clinical Improvement Programme roll out
- System clinical prioritisation programme
- Outpatients Transformation Programme
- Delayed discharges improvement plan
- Midlands Elective Delivery Programme

Risks:

BAF1.1	Insufficient core capacity to meet demand
BAF 1.2	Potential for increased harm to patients as waiting times increase
BAF 1.3	Inability to benchmark outcomes across all specialties

Lead Director:

Chief Executive

Lead Committee:

Finance Planning and Digital Committee / Quality and Safety Committee

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

Board Assurance Framework 2021-22

BAF 1.1 Accelerate the work to restore patients cared for to pre Covid levels — OBJ 1

Principal Risk: Insufficient core capacity to meet demand

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

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

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

Assurance: Source of Assurance 3

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

Gaps In Controls:

- C1: Lack of line of sight on system demand and capacity requirements
- C2: Potential for Gaps in job planning and governance processes to ensure full capacity utilised
- C3: Clear leadership for discharge planning
- C4: Impact on capacity of increasing complexity of cases due to increased waiting times
- C5: Lack of line of sight on use of Trust infrastructure (theatres/op rooms) utilisation

Gaps in Assurance:

- ~~A2: Patient Experience Strategy overdue for review~~
- A3: Key performance indicator of job plans reviewed and in date required.
- A4: Clinical annual leave reporting oversight
- A5 Discharge Policy overdue for review

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Development of a system orthopaedic PTL	Director of Performance	~~Sep 21~~ Nov 21	CSU have been contracted to deliver this piece of work. IG issues created delay to process. On track for delivery end of Nov 21
C3	Review of leadership for discharge planning with clear escalation structure to be articulated and actioned	Chief Nurse	~~Jul 21~~ ~~Oct 21~~ Nov 21	Audit of compliance with current policy undertaken and considered by SLG. Recommendations and action plan being developed. Policy reviewed and going to Q&S in November
C4	Establish reporting on impact of complexity and consider mitigating actions	Chief Medical Officer	~~Jul 21~~ ~~Oct 21~~ Jan 22	Complexity review underway with focus on long waiters and P2 patients and establishing the average case per session for these patients. Update to go to Q&S after going through Clinical Effectiveness Committee
A2	Review of Patient Experience Strategy	Chief Nurse	~~Dec 20~~ ~~Mar 21~~	Completed

			~~Apr 21~~ ~~Aug 21~~ Oct 21	
A3	Creation of KPI's in relation to job planning to be added to people committee IPR.	Director of Performance	Dec 21	On track, in development to produce for month nine (December) results
C5	Regular reporting in place of room and theatre usage at room and theatre level	MD for Support Services	Dec 21	
A4	Quarterly report through People Committee	MDs for MSK & Specialist Unit	Nov 21	Initial report received in people committee in Nov.

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

Board Assurance Framework 2021-22

BAF 1.2 Accelerate the work to restore patients cared for to pre Covid levels — OBJ 1

Principal Risk Potential for increased harm to patients as waiting times increase

As a result of national clinical prioritisation criteria and social distancing requirements there is potential for patients to wait longer and they are therefore exposed to the risk of harm, potentially resulting in poorer outcomes or more extensive procedures being required.

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Harms review process in place
- ✓ Following national NHS clinical prioritisation guidance
- ✓ Communication with patients regarding the current situation
- ✓ Access Policy in place
- ✓ Patient quality and safety monitoring via KPIs
- ✓ PROMs reporting in place
- ✓ Waiting time reporting in place
- ✓ KPI to hold or reduce patients waiting over 52 weeks by Mar 22
- ✓ KPI to stabilise wait list to Sept 21 levels

Assurance: — Source of Assurance ~~2~~ 3

- ✓ Patient Harms Group, Patient Safety Committee and Quality and Safety Committee to provide oversight of Harms Process
- ✓ Monthly reporting to Trust Performance Board on 104 week waiters
- ✓ Bi-weekly reporting to NHSEI regional team on 104 week waiters
- ✓ Regional benchmarking
- ✓ Board and Committees Integrated Performance Report of KPI's

Gaps In Controls:

- C5: Resource to address backlog in harms reviews
- C5: Process for clinical prioritisation of outpatients

Gaps in Assurance:

- ~~A2: Key metrics and reporting of Harms Reviews to be established and embedded~~

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
A2	Assurance reporting on Harms Reviews to be embedded with improvement in compliance	MD for Clinical Support Services and MD for Specialist Services	Sept 21	Regular updates being presented to Q&S Committee and is ongoing - completed
C5	Review of harms process to ensure efficient use of clinical resource	MD for Clinical Support Services and MD for Specialist Services	Nov 21	Backlog of harms reviews being tracked but review of process within specialties being undertaken with a view to introducing a triage system across the Trust so that clinical resource can be directed to those patients requiring review. Clinical prioritisation being reviewed with a view to aligning with the harms process.

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

BAF 1.3 Deliver the work to restart elective services — OBJ 1

Principal Risk Inability to benchmark outcomes across all specialties

Potential delay in identifying quality issues and outlying performance resulting in missed opportunities for improvement and poorer patient outcomes.

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Patient quality and safety monitoring via KPIs
- ✓ Monitoring of other outcome based indicators such as infections, readmissions etc
- ✓ GIRFT recommendations implemented

Assurance: Source of Assurance 3

- ✓ Clinical Effectiveness Committee Oversight
- ✓ Proms and NJR results
- ✓ GIRFT reviews

Gaps In Controls:

- C1: Specialty level quality dashboards not available across all disciplines

Gaps in Assurance:

- A1: Benchmarking tools not available across all specialties
- A2: Clinical Effectiveness Committee is new and not yet embedded
- A3: Ability to benchmark outcomes in the post-Covid period against pre-Covid treatment and care

Action Plan to Address Gaps:

Ref	Action	Lead	Due	Progress
C1	Speciality level quality dashboards to be rolled out for every specialty	Chief Nurse and Trust Secretary / Director of Governance	~~Aug 21~~ Oct 21	Rollout has nearly completed with dashboards now available for most specialties and full access to be available by the end of October - completed.
A1	Rollout of NCIP	Chief Medical Officer	Aug 21	Completed
A2	Clinical Effectiveness Committee to be embedded	Chief Medical Officer	Aug 21	1st meeting has taken place with Terms of Reference agreed and full schedule of meetings in place - completed

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

Board Assurance Framework 2021-22

Caring for Patients — OBJ 2

Principal Objective: Maintain high infection control standards to support the restoration of activity

This objective will focus on minimising zero nosocomial infections with a focus on prevention and learning and ensuring that new or revised infection prevention and control guidance is implemented

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Key Measures:

- ✓ Number of outbreaks
- ✓ Compliance with the IPC Board Assurance Framework
- ✓ Audit programme in place with % measures of compliance and regular reporting via the IPC Committee
- ✓ Quarterly report to Quality and Safety Committee

Progress Update:

MRSA outbreak declared and one staff covid outbreak with the Trust's SI and outbreak processes being followed. Full RCAs will be submitted to the IPC Committee. In addition an IPC Governance review is being undertaken and will be presented to the Quality and Safety Committee.

Enhanced cleaning business case has been approved internally and at system level with funding being explored.

Business case developed for increased IPC resource, this will be taken through the Trust's internal approval process in due course.

Supporting Programmes of Work:

- IPC work plan
- Estates programme
- HSE Inspection Document – implementation of findings
- Roll out of Perfect Ward to include IPC Audits

Risks:

BAF 2.1	Inability to respond quickly enough to rapidly changing infection control national guidance
BAF 2.2	Inability to align the capital programme with the quickly changing operating environment and funding movements

New risks to be added in relation to impact of changing government restrictions on staff and patient compliance – awaiting the national guidance and the risks around IPC governance pending the outcome of the review, risk to patient safety of bringing staff back or not.

Lead Director:

Chief Nurse and Patient Safety Officer

Lead Committee:

Quality and Safety Committee and Finance Planning and Digital Committee

Board Assurance Framework 2021-22

BAF 2.1 Maintain high infection control standards to support the restoration of activity – RECOMMENDATION TO CLOSE APPROVED BY Q&S COMMITTEE **OBJ 2**

Principal Risk: Inability to respond quickly enough to rapidly changing infection control national guidance

Potential for non-compliance resulting in risks to staff and patient safety. Inability to maintain an up to date suite of policies for use in the organisation and staff engagement with new policies.

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ IPC Board assurance framework in place and has been revised in January 2021
- ✓ Policy Committee in place to facilitate prompt ratification of changes to policy
- ✓ System and Regional IPC networks in place with RJAH engagement
- ✓ Lateral flow testing being rolled out and robust staff Covid reporting and testing in place
- ✓ New Covid Infection Control Policy in place
- ✓ IPC Governance Lead established

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

- ✓ Oversight from Infection Control Committee which reports to Q&S Committee
- ✓ Recent CQC review of IPC BAF
- ✓ Flu Working Group chaired by DIPC
- ✓ H&S Committee oversight

Gaps In Controls:

- ~~C1: H&S resource and capacity constraints to input into risk assessments~~

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Review of H&S resource and capacity requirements with recommendation to SLG for resource solution	Chief Nurse and Patient Safety Officer	~~Nov 20~~ ~~Feb 21~~ ~~Mar 21~~ May 21	Review has been undertaken with initial agreement to increase resource whilst system options considered – further meeting held to discuss resource scheduled in March and additional support from Governance Team to be outlined - Completed

BAF 2.2 Maintain high infection control standards to support the restoration of activity RECOMMENDEDATION TO CLOSE APPROED BY FPD COMMITTEE **OBJ 2**

Principal Risk: Inability to align the capital programme with the quickly changing operating environment and funding movements

The operating environment is changing quickly to respond to developments with the Covid pandemic and changing infection control guidance and requirements and this has potential to impact on the Trust's capital requirements to support restoration. There is system prioritised restoration and backlog funding and the allocation of this is not yet determined which leaves uncertainty and potential for the Trust to have a shortfall or for there to be a limitation of the capital programme which in turn may impact on restoration.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	2
Likelihood	4	3 ↓	2
Total	16	12↓	4

Risk Details:

Opened: November 2020

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Capital Management Group in place
- ✓ Revised capital programme
- ✓ Scenario planning
- ✓ Bed capacity scheme identified to support restoration
- ✓ System capital delegated limit in place

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

- ✓ Finance Planning and Digital Committee Oversight
- ✓ Regulatory and System oversight

Gaps In Controls:

- A2: ICS approval required for 5 year capital plan

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A2	Detailed plan to be submitted and approved	Chief of Finance	Nov 21	Detailed plan has been submitted and approved - completed

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Caring for Patients — OBJ 3

Principal Objective: Play an active part in the wider healthcare system

This objective will focus on seeking delivery of an ambition to operate as one orthopaedic system for the ICS, playing an active part in the ICS Board and ICS Committee arrangements and supporting, and where appropriate, leading the mobilisation of the STW MSK Transformation

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Key Measures:

- ✓ Attendance at ICS meetings
- ✓ RJAH plan which supports the system plan
- ✓ Single orthopaedic system proposal
- ✓ Reporting to Board on STW MSK Transformation

Progress Update:

The resetting of STW MSK Transformation programme has taken place, with year one of the programme identifying decision for one orthopaedic system in Q4. SRO is RJAH executive.

A system orthopaedic PTL is in development, with a P2 and 104 week waites PTL already operational.

RJAH chair STW Planned Care Operational Delivery Board.

RJAH is represented at all committees of the ICS and delivery groups as appropriate

Supporting Programmes of Work:

- System winter planning
- System Governance Framework
- Programme plans for system restoration
- Midlands Elective Delivery Programme
- System planning submission

Risks:

BAF 3.1	Management capacity inhibits engagement with the ICS
BAF3.2	Insufficient core capacity to meet demand

Lead Director:

Chief of Performance, Improvement & OD ~~and Chief Nurse and Patient Safety Officer~~

Lead Committee:

Finance Planning and Digital Committee

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Board Assurance Framework 2021-22

BAF 3.1 Play an active part in the wider healthcare system — OBJ 3

Principle Risk: Management capacity inhibits engagement

Senior management capacity is impacted as a result of carrying out dual roles at local and system level resulting in reduced pace / decision making, conflicting priorities

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Regular CEO forum
- ✓ Regular updates at Senior Leadership Group
- ✓ Chair reports from HTP, MSK Transformation received

Assurance: **Source of Assurance** 3

- ✓ Oversight from Shadow ICS Board
- ✓ CEO Forum oversight
- ✓ ICS Governance Framework in place with identified membership for committees

Gaps In Controls:

- C2: Absence of a system performance framework
- ~~C3: NHSEI Single oversight framework yet to be published~~
- C4 Lack of line of sight on decision making framework that supports meeting architecture.
- C5: Ambiguity of roles, responsibilities and authority in system lead roles.
- C6: Lack of agreed protocols; committee workplans, information request timelines
- C7: Lack of standardised ICS performance reporting

**It should be noted that C4-C7 are gaps outside of RJAH control however the SLG Team are working to support the ICS with its development and to address these gaps*

Gaps in Assurance:

- A1: ICS Governance Framework in its infancy
- A3: ICS Risk Management architecture not developed

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	ICS Governance Framework to be embedded and linked in with Trust's own governance	Chief Executive / Trust Secretary	~~May 21~~ Oct 21	Chairs reports produced to now be submitted to RJAH committees going forward – these are not consistently received but being added into work plans to ensure they are requested
C2	ICS Performance framework in development, once consulted will be shared with SLG	Chief of Performance	~~Aug 21~~ TBC	Draft proposal has been shared with SLG on 20 July and final framework although expected has been delayed with system colleagues. Framework has been delayed.
C3	SoF consultation closed, expect publication in July, will be shared with BoD	Chief of Performance	~~Jul 21~~ Sept 21	On Board agenda for September - Completed
A3	RJAH to support work with development risk management architecture for the ICS	Trust Secretary	~~Nov 21~~ Jan 22	Trust Secretary has taken over responsibility for the ICS Board Assurance Framework and will be taking this forward.

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

Caring for Patients — OBJ 4

Principal Objective: Continuously improve the delivery of services

This objective will focus on commencing the work to deliver the Headley Court Veteran's Centre, specifying a microbiology service to support the work on infection control, preparing and (if commissioned) delivering the MDT knee revision service, deliver the next stages of the business case for the new EPR, introduction of the 'Perfect Ward' and ensuring stable and effective EPRR arrangements

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Key Measures:

- ✓ Delivery of the veteran's service to time and budget
- ✓ Production of the microbiology service specification in 2021/22
- ✓ Reporting on the MDT knee revision service
- ✓ Specified stages of the EPR Business case and delivery of these
- ✓ Project plan for the Perfect Ward with full roll out by November 2021
- ✓ Delivery of actions from the 2021 review into EPRR

Progress Update:

Veteran's Centre on track and work on microbiology service ongoing. EPR Business Case progressing and being taken through Finance Digital and Planning Committee. Perfect Ward has been established. EPRR arrangements have been reviewed and recommendations taken forward.

Perfect Ward has been rolled out and project closure report to go to Patient Safety Committee. The focus now is how this will be incorporated into committee reporting (green)

Supporting Programmes of Work:

- Business continuity planning
- EPRR exercise programme

Risks:

BAF 4.1 Lack of designated EPRR resource

Lead Director:

Chief Nurse and Patient Safety Officer and Chief Medical Officer

Lead Committee:

Audit and Risk Management Committee

BAF 4.1 Maintain emergency responsiveness — OBJ 4

Principle Risk: Lack of designated EPRR resource

Potential inability to provide a co-ordinated response to an interruption in service, lack of clarity around ownership and responsibilities and the required capability and expertise.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	4	3
Likelihood	5	2	2
Total	20	8	6

Risk Details:

Opened: November 2020

Reviewed Date: Sept 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ EPRR procedures and business continuity plans in place
- ✓ Tried and tested command and control structure
- ✓ Agreements in place across the system for mutual aid
- ✓ EPRR exercise programme
- ✓ National co-ordination of Covid pandemic

Assurance: Source of Assurance: 3

- ✓ Risk Management Committee oversight
- ✓ Compliance with EPRR Core Standards – substantial assurance for 19/20 submission
- ✓ NHSI/E oversight
- ✓ CSU Review of EPRR arrangements

Gaps In Controls:

- C3: Implementation of CSU recommendations to be completed

Gaps in Assurance:

- A1: N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C3	Implementation of CSU recommendations	Chief Nurse and Patient Safety Officer	~~Jul 21~~ ~~Sept 21~~ Feb 22	Implementation ongoing – delays have been experienced with full implementation due to

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

Board Assurance Framework 2021-22

Caring for Staff — OBJ 5

Principal Objective: Focus on providing an environment for our workforce to 'flourish at work'

This objective will focus on delivering a recruitment plan and new staffing models established from the recovery modelling option, improving staff wellbeing, addressing any system inequalities staff may be experiencing, ensuring a safe and Covid secure environment, delivering the milestones set out in the nursing workforce strategy

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Key Measures:

- ✓ Staff survey results and sickness absence rates
- ✓ Board report on staff risk assessments
- ✓ Action plan to address any system inequalities
- ✓ All staff to have access to PPE and relevant training
- ✓ Recruitment of 15 IR nurses
- ✓ 0 HCSW vacancies
- ✓ Increase in student placements by 22
- ✓ First cohort of Nursing Associates
- ✓ Deliver an orthopaedic practice course

Progress Update:

Promotion of sources of support for staff with psychological wellbeing. Working as a system on four key themes of wellbeing for staff

Consultant recruitment underway with staff expected in post next year as per the plan.

Health care support worker recruitment behind plan but all other aspects of the nursing workforce strategy are on track.

Issues with nursing staffing levels with an enhanced bank system being introduced to mitigate this.

Supporting Programmes of Work:

- Task and finish groups
- Its Just Cricket (BAME) Network
- LGBTQ+ network
- Women's network
- Staff experience and improvement group
- Staff survey focus group
- Unit development sessions; Business Partner training & Operational Managers
- Schwartz rounds
- Hybrid working group
- Consultant workforce capacity group

Risks:

BAF 5.1	Failure to improve staff engagement linked to communication between managers and the workforce
BAF 5.2	Potential inability to have the right workforce in the right place at the right time
BAF 5.3	Impact of Covid-19 on the workforce
BAF 5.4	Lack of designated ED& I resource and expertise

Lead Director:

Chief of People and Chief Nurse and Patient Safety Officer

Lead Committee:

People Committee

Board Assurance Framework 2021-22

BAF 5.1 Focus on providing an environment for our workforce to 'flourish at work' **OBJ 5**

Principal Risk Failure to improve staff engagement linked to communication between managers and the workforce

Inability to improve the culture and behaviour of the workforce, difficulties attracting staff to the organisation leading to poor patient experience and impact on staff morale and wellbeing

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	4	3	2
Likelihood	4	3	2
Total	16	9	4

Risk Details:

Opened: April 2017

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Ward / department budding with escalation of issues to SLG
- ✓ Communications and engagement strategy
- ✓ Six monthly back to the floor events / virtual visits
- ✓ Leadership training and bite-sized modules for wider organisation
- ✓ Performance framework in place
- ✓ Weekly update from CEO
- ✓ Comms bulletin
- ✓ Q&A sessions with members of the Senior Leadership Team
- ✓ Staff experience group
- ✓ Staff networks

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

- ✓ Regular updates to People Committee and the Board
- ✓ NHS I PRM
- ✓ Staff Survey
- ✓ NHS I Oversight Framework
- ✓ Oversight from People Committee
- ✓ Health and Safety Committee oversight of staff health

Gaps In Controls:

- C1: Identified delays in Occ Health referrals, particularly in relation to work related stress
- C2: Covid restrictions restricting face to face engagement

Gaps in Assurance:

- ~~A2: Sub-committees of People Committee to be fully established and developed~~
- A3: ED&I Committee effectiveness

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A2	Additional focus on People Committee sub committee agenda, workplan and attendance with recommendations	Chief of People	~~Nov 20~~ ~~Apr 21~~ Jul 21	Completed
A3	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	~~Dec 20~~ Mar 22	Delayed due to pause in committee meetings, focus on BAME continuing in line with national agenda. Committee meetings recommenced and ED&I internal audit planned for Q4 of next financial year
A3	Requirement for EDI expertise in RJAH to ensure statutory requirements are met	Chief of People	Oct 21	External review undertaken with recommendations going to ED&I Committee in November
A2	People Plan to be aligned to the People Committee sub structure	Chief of People	Dec 21	Completed

Board Assurance Framework 2021-22

BAF 5.2 Focus on providing an environment for our workforce to 'flourish at work' — OBJ 5

Principal Risk: Potential inability to have the right workforce in the right place at the right time

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

Risk Rating:

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

Risk Details:

Opened: March 2018

Reviewed Date: Sept 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Recruitment plans to target vacancy hotspots
- ✓ Sickness absence management
- ✓ Staff turnover monitoring
- ✓ Leadership training to support effective management and engagement of staff
- ✓ Theatre recruitment plan in place
- ✓ Emergency staffing requirements in place to address Covid impact
- ✓ System mutual aid and redeployment MOU in place
- ✓ KPI in place for overtime hours by unit
- ✓ IPR includes breakdown of activity for IJP & OJP at point of delivery
- ✓ Recruitment timeline KPI
- ✓ Theatre staffing reporting in place incl. trajectory
- ✓ Vacancy rates by professional staff group

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

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

Gaps In Controls:

- C1: Lack of emergency planning and resilience resource impacting on ability to respond to potential second wave of Covid
- C2: Nursing strategy required
- C3: Nursing associate roles on hold due to Covid
- C4: International recruitment in progress
- C5: Flexible workforce model creates over reliance on premium cost workforce
- C6: CSU recommendations for EPRR resource to be implemented
- ~~C7: Reporting/monitoring of overtime/additional hours~~
- ~~C8: Measurements in relation to IJP & OJP~~
- C9: Unit workforce plans
- ~~C10: Recruitment timeline KPIs~~
- C11: Turnover of senior management creating loss of corporate memory

Gaps in Assurance:

- A1: Alignment of workforce to optimise capacity
- A2: Workforce plan monitoring against actual performance
- A3 Succession plan
- A4 Talent management strategy

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C2, C3, C5	Nursing strategy to be developed to include Nursing Associates	Chief Nurse	~~Nov 20~~ ~~Mar 21~~	Work ongoing as per previous update to Board. Nursing Associate roles rolled out

			~~Sep 21~~ Feb 22	Nursing strategy on a page completed with work ongoing on full strategy – Full strategy to be completed Feb 22
C4, C5	International recruitment to be completed	Chief Nurse	Mar 21	First cohort recruited - complete
C6	Implementation of CSU recommendations	Chief Nurse and Patient Safety Officer	~~Jul 21~~ ~~Sep 21~~ Feb 22	Implementation ongoing - delayed due to issues with accessing training
C10	Recruitment timeline KPI's to be included in support unit dashboard	Chief of Performance, Improvement and OD	Sept 21	Completed
C11	Handover and induction arrangements to be reviewed for senior staff	Chief Executive / Trust Secretary	Nov 21	Completed

BAF 5.3 Focus on providing an environment for our workforce to 'flourish at work' — OBJ 5

Principal Risk Impact of Covid-19 on the workforce

Inability to recruit internationally or access required training to develop the workforce. Potential for absence rates to go up as staff isolate and key areas with single points of failure will have increased vulnerability. Requirement for workforce to work more flexibly, increased working from home and increased reliance on IT and Information. Increased challenges of providing a safe working environment. Potential for a third wave

Risk Rating:

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

Risk Details:

Opened: November 2020

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Resilience plans in place for departments
- ✓ Minimum nursing staffing levels in place to maintain safety
- ✓ System wide mutual aid with regard to staffing
- ✓ Listening sessions
- ✓ Improved IT infrastructure
- ✓ Mutual aid in place across the system
- ✓ Staff risk assessments in place
- ✓ Clinically vulnerable staff supported with redeployment / work from home opportunities
- ✓ Staff wellbeing package in place through national, system and local intiiatives

Assurance: — Source of Assurance 3

- ✓ Performance reporting
- ✓ Staff surveys
- ✓ NHSE/I Oversight
- ✓ People Committee Oversight
- ✓ System People Board and establishment of a System People Committee

Gaps In Controls:

- C1: Productivity measures for delivery in flexible/hybrid working

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Hybrid/flexible working discussion to commence in Trust to establish working parameters to develop policy	Chief of Performance, Improvement and OD	Jan 22	Proposal agreed by SLG and being implemented, policy on track for publication in December with focus groups on implementation with managers scheduled for January

BAF 5.4 Focus on providing an environment for our workforce to 'flourish at work' — OBJ 5

Principal Risk Lack of dedicated ED&I resource and expertise

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

Risk Rating:

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

Risk Details:

Opened: April 2021

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ ED&I Committee members taking ownership to drive the agenda forward
- ✓ New Head of Organisational Development role in place and taking an active role in ED&I

Assurance: — Source of Assurance: 3

- ✓ Staff surveys
- ✓ NHSE/I Oversight
- ✓ People Committee Oversight
- ✓ System People Board and establishment of a System People Committee
- ✓ Executive lead in place both for patients and staff
- ✓ ED&I Committee oversight
- ✓ WRES and EDS2 returns

Gaps In Controls:

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

Gaps in Assurance:

- A1: Effectiveness of ED&I Committee
- A2: ED&I ~~Committee work plan requires review to ensure adequate~~ oversight of statutory requirements

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
A1	Review of ED&I effectiveness to be undertaken	Trust Secretary / Director of Governance	~~Dec 20~~ Mar 22	Delayed due to pause in committee meetings, focus on BAME continuing in line with national agenda. Committee meetings recommenced and ED&I internal audit planned for Q4 of next financial year
A2	Review of ED&I work plan	Chief of People / Chief of Improvement, Performance and OD / Trust Secretary	~~May 21~~ Sept 21	Completed
C1	ED&I resource to be secured	Chief of People	~~May 21~~ Apr 22	Work commissioned for statutory compliance analysis and being presented to ED&I Committee in November. System collaboration with effective date of 1 April 2022

Caring for Staff — OBJ 6

Principle Objective: Deliver the Covid and flu vaccination programme

This objective will focus on increasing the number of vaccinators and ensuring 100% of staff are offered the vaccine

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Key Measures:

- ✓ 100% of staff offered vaccine

Progress Update:

Flu vaccines started in September. 100% of staff have been offered the covid vaccine, booster and flu vaccine.

Metric is 85% of staff to have flu vaccine and letter issued by Department of Health and Social Care requires all staff undertaking CQC regulated activity to be double vaccinated by end of Mar 2022.

Supporting Programmes of Work:

- IPC work plan

Risks:

Potential risk around personal choice and impact on staff leaving to be worked up

Lead Director:

Chief Nurse and Patient Safety Officer

Lead Committee:

People Committee / Quality and Safety Committee

Caring for Finances — OBJ 7

Principle Objective: Deliver Financial Plan

This objective will focus on aligning the Trust's decision making policy with the revised System financial framework, delivering the efficiency programme, management of the activity plan within the available sources of funding, remove Covid driven costs in a timely manner, delivery of the agreed cost base, delivery of the agency control total and maintain cash balances at trajectory

Objective Delivery / Forecast:

Q1	Q2	Q3	Q4	Full Year Forecast

Objective Details:

Opened: April 2021

Reviewed Date: Nov 2021

Key Measures:

- ✓ Deliver on budget by 31 March 2022
- ✓ Deliver agreed activity within resources
- ✓ Board reporting
- ✓ Stabilising the recurrent financial position
- ✓ Delivering a 3% efficiency programme

Progress Update:

H2 guidance has been issued and plan has been agreed via Finance Planning and Digital Committee based on assumed ERF funding and delivery of agreed efficiency plans. H2 submission due in November.

Cash balances are above plan.

Supporting Programmes of Work:

- Restoration Group
- Consultant Job Planning Task and Finish Group
- Recruitment plan
- Cost improvement programme

Risks:

BAF 7.1	Failure to achieve activity and income within agreed cost base
BAF 7.2	Inability to meet baseline activity due to heavy reliance on OJP
BAF 7.3	Impact of the new system financial framework

Lead Director:

Chief Finance Officer

Lead Committee:

Finance Planning and Digital Committee

BAF 7.1 Deliver Financial Plan — OBJ 7

Principal Risk: Failure to achieve activity and income within planned cost base

Potential impact on the Trust's financial stability, inability to grow and invest as required, impact on cash balances, single oversight framework ratings adversely affected

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	2
Likelihood	5	4	2
Total	25	16	4

Risk Details:

Opened: March 2018

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Cost improvement schemes identified
- ✓ QIPP schemes identified to required level
- ✓ Carter recommendations embedded in savings discussions
- ✓ Access to good quality benchmark information as per model hospital
- ✓ Tracking of theatre productivity
- ✓ Risks reviewed on a monthly basis and addressed through performance reviews

Assurance: — Source of Assurance: 3

- ✓ Monitoring of CIP delivery via performance meetings
- ✓ Oversight by FPD Committee and Performance and Improvement Board
- ✓ QIPP monitored by RJAH and CCG at contract meetings
- ✓ NHS I oversight
- ✓ KPI monitoring
- ✓ QIA process in place to ensure quality not impacted
- ✓ Restoration Board oversight

Gaps In Controls:

- C1: Reliance on flexible premium cost workforce for capacity in excess of core, some of which is not based in contract
- C2: Improved process around job planning needed
- C3: Demand and capacity completed but shows need to increase core capacity
- C4: Alignment of workforce to maximise core capacity
- ~~C5: Restoration of non NHS income~~
- C6: Slippage on cost improvement programmes

Gaps in Assurance:

- A1: Audit of compliance with consultant job plans

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1,C3	Exploration of opportunities to expand core capacity through recruitment	Chief of People	~~Dec 20~~ ~~Apr 21~~ Oct 21	Consultant recruitment programme in place with regular updates to People Committee – 2 weekly progress meetings.
C4	Review alignment of workforce with a view to varying workforce to address any identified gaps	Chief of People	~~Dec 20~~ ~~Apr 21~~ Oct 21	H2 Workforce plan complete with regular reviews taking place
C5	Non NHS income to be restored	Chief of Finance	~~Dec 20~~ Ongoing	Completed

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

BAF 7.2 Deliver Financial Plan — OBJ 7

Principal Risk: Inability to meet baseline activity due to heavy reliance on high proportions of out of job plan work

Potential for inability to meet activity levels if out of job plan work not accepted by required workforce, premium costs to deliver required activity levels.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	5	2
Likelihood	5	3	2
Total	25	16	4

Risk Details:

Opened: March 2021

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Demand and capacity modelling provides intelligence on high risk areas
- ✓ Forward view allocation process for out of job plan work
- ✓ Consultant Job Planning Policy

Assurance: **Source of Assurance** 3

- ✓ Internal audit on Consultant Job Planning
- ✓ NHS I oversight
- ✓ KPI monitoring
- ✓ Restoration Board oversight
- ✓ People Committee Oversight

Gaps In Controls:

- C1: E-Job planning still being rolled out
- C2: Recruitment plan required with resulting recruitment to reduce OJP reliance

Gaps in Assurance:

- A1: Follow up audit of job planning (planned for 21/22)

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	E-job planning roll out being progressed	MD for Support Services	Apr 21	Completed
C2	Development of recruitment plans to address gap	Chief of People	~~Dec 20~~ Apr 21	H2 Workforce plan complete with regular reviews taking place
A1	Follow up audit to be completed	Chief of People	Dec 21	

BAF 7.3 Deliver Financial Plan — OBJ 7

Principal Risk: Impact of new system financial framework

Potential for impact on the Trust's ability to deliver the statutory requirement of a break even position and reduction in autonomy for appointment and investment decisions.

Risk Rating:

	Inherent Risk	Residual Risk	Target Risk (Tolerance)
Consequence	5	4	2
Likelihood	5	3	2
Total	25	12	4

Risk Details:

Opened: March 2021

Reviewed Date: Nov 2021

Source of Risk:

Corporate Risk Register

Controls:

- ✓ Efficiency programme in place
- ✓ Income generation from outside of the system including private work
- ✓ Effective cost controls in place

Assurance: — Source of Assurance: 3

- ✓ ICS Shadow Board oversight
- ✓ ICS Financial Sustainability Committee oversight
- ✓ Finance Planning and Digital Committee oversight
- ✓ NHSE/I oversight

Gaps In Controls:

- C1: Exploration of further income generation opportunities outside of the system
- C2: Further participation in transformational improvement programme
- C3: Loss of autonomy over investment decisions

Gaps in Assurance:

- N/A

Action Plan to Address Gaps

Ref	Action	Lead	Due	Progress
C1	Further income generation opportunities to be explored	Chief of Finance	Ongoing	Good progress made on private patient income but the business model has changed for car parking and catering
C2	Further participation in transformational improvement programme	Chief of Finance	Ongoing	The Trust is supporting the six big ticket schemes
C3	Engagement in the system financial stabilisation programme	Chief of Finance	Ongoing	The Trust is supporting the programme and the Trust Chair is chairing the Sustainability Committee. System financial recovery presented to Board.

Board of Directors and Assurance Committee Dates 2022/23

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Shelley Ramtuhul, Trust Secretary	Paper Category:	Governance
Paper Reviewed by:	Senior Leaders Group	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board of Directors is asked to consider and approve the suggested times and dates for the meetings scheduled within the new financial year.

2. Executive Summary

2.1. Context

The paper presents the suggested dates for the Board of Directors and the Trust's assurance Committee meetings throughout 2022/23

2.2. Summary

The papers outlines the:

- proposed times and dates for the meetings
- explanation behind the changes implemented

2.3. Conclusion

The Board of Directors is asked to ***consider*** and ***approve*** the dates.

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

3. The Main Report

3.1. Introduction

The paper presents the proposed meeting dates which will be scheduled between April 2022 and March 2023 to ensure timely and well organised diary management.

The meetings which will be scheduled are as follows:

- Board of Directors
- Quality and Safety Committee
- People Committee
- Audit and Risk Committee
- Finance Planning and Digital Committee
- Council of Governors
- Annual General Meeting
- Charitable Funds Committee
- Joint Audit & Risk and Quality & Safety Committee

3.2. Proposed Dates

The suggested dates are tabled below:

Board of Directors (monthly including Strategy Board highlighted in blue)	
Thursday 28th April 2022	9.30am – 2.00pm
Thursday 26th May 2022	9.30am – 2.00pm
Thursday 30th June 2022	9.30am – 2.00pm
Thursday 28th July 2022	9.30am – 2.00pm
Thursday 25th August 2022	9.30am – 11:30am
Thursday 29th September 2022	9.30am – 2.00pm
Thursday 27th October 2022	9.30am – 2.00pm
Thursday 24th November 2022	9.30am – 2.00pm
Thursday 26th January 2023	9.30am – 2.00pm
Thursday 23rd February 2023	9.30am – 2.00pm
Thursday 30th March 2023	9.30am – 2.00pm

Quality and Safety Committee (monthly)	
Thursday 21st April 2022	2.00pm – 4.00pm
Thursday 19th May 2022	2.00pm – 4.00pm
Thursday 23rd June 2022	2.00pm – 4.00pm
Thursday 21st July 2022	2.00pm – 4.00pm
Thursday 22nd September 2022	2.00pm – 4.00pm
Thursday 20th October 2022	2.00pm – 4.00pm

Thursday 17th November 2022	2.00pm – 4.00pm
Thursday 19th January 2023	2.00pm – 4.00pm
Thursday 16th February 2023	2.00pm – 4.00pm
Thursday 23rd March 2023	2.00pm – 4.00pm

People Committee (monthly)	
Thursday 14th April 2022	2.00pm – 4.00pm
Thursday 12th May 2022	2.00pm – 4.00pm
Thursday 16th June 2022	2.00pm – 4.00pm
Thursday 14th July 2022	2.00pm – 4.00pm
Thursday 15th September 2022	2.00pm – 4.00pm
Thursday 13th October 2022	2.00pm – 4.00pm
Thursday 10th November 2022	2.00pm – 4.00pm
Thursday 12th January 2023	2.00pm – 4.00pm
Thursday 9th February 2023	2.00pm – 4.00pm
Thursday 16th March 2023	2.00pm – 4.00pm

Audit and Risk Management Committee (Quarterly)	
Tuesday 10th May 2022	2.00pm – 4.00pm
Tuesday 12th July 2022	2.00pm – 4.00pm
Tuesday 11th October 2022	2.00pm – 4.00pm
Tuesday 10th January 2023	2.00pm – 4.00pm

Finance Planning and Digital Committee (monthly)	
Tuesday 26th April 2022	2.00pm – 4.00pm
Tuesday 24th May 2022	2.00pm – 4.00pm
Tuesday 28th June 2022	2.00pm – 4.00pm
Tuesday 26th July 2022	2.00pm – 4.00pm
Tuesday 27th September 2022	2.00pm – 4.00pm
Tuesday 25th October 2022	2.00pm – 4.00pm
Tuesday 22nd November 2022	2.00pm – 4.00pm
Tuesday 24th January 2023	2.00pm – 4.00pm
Tuesday 21st February 2023	2.00pm – 4.00pm
Tuesday 28th March 2023	2.00pm – 4.00pm

Council of Governors (Quarterly)	
Thursday 26th May 2022	2.00pm – 3.00pm
Thursday 28th July 2022	2.00pm – 3.00pm
Thursday 24th November 2022	2.00pm – 3.00pm
Thursday 30th March 2023	2.00pm – 3.00pm

Annual General Meeting (Annually)	
Thursday 29th September 2022	2.00pm – 3.00pm

Charitable Funds Committee (Quarterly)	
Thursday 30th June 2022	2.00pm – 3.00pm
Thursday 27th October 2022	2.00pm – 3.00pm
Thursday 26th January 2023	2.00pm – 3.00pm
Thursday 30th March 2023	2.30pm – 3.30pm

3.2 Identified Changes

Board of Directors

The Board of Directors meeting in May has not been brought forward for the receipt of the Annual Report and Accounts. The rationale for this is that these documents will be reviewed thoroughly by the Audit and Risk Committee and by the Quality and Safety Committee. The Trusts' external auditors will also review the documents.

It has been noted that by the time the reports are presented to the Board it is effectively a rubber stamp exercise as the reports have been reviewed by all Non-Executive Directors and Senior Leaders. The required Board approval can be sought via either email or a team's meetings which will enable greater flexibility to finalise the reports and preventing the issues an earlier meeting which in turn would generate issues when compiling reports.

Finance, Planning and Digital Committee

There will be no meeting in August 2022, the performance report and other matters arising will be discussed at the informal Board of Directors which is scheduled for 25th August.

Joint Audit and Risk Management Committee

This meeting is no longer required following the amalgamation of the two Committees.

Change in meeting days/times:

The Audit & Risk Committee has been scheduled for Tuesday afternoons instead of Monday mornings.

The People Committee has been scheduled for Thursday afternoons instead of Thursdays mornings.

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

This is to standardise the working pattern of the Committees as going forward the meetings will be organised for a Tuesday or Thursday afternoon and Board being the last Thursday of the month.

3.3. Next Steps

Once the Board of Directors has approved the dates, the Board Programme will be created along with the assurance committee work plans.

The meeting invitations will be sent to those individuals who are required to attend each meeting.

3.4. Conclusion

The Board is asked to ***consider*** and ***approve*** the proposed outline for 2022/23.

Matters Reserved for the Board Policy

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Stacey Keegan, Interim Chief Executive Officer	Paper Category:	Policy
Paper Reviewed by:	Audit and Risk Committee – 11.10.2021	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

The policy is shared with the Trust Board for approval.

2. Executive Summary

2.1. Context

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

2.2. Summary

The Policy review date has expired; therefore, the document has been amendment.

Following a review, there have been no changes to the policy.

2.3. Conclusion

Following presentation at the Audit and Risk Committee in October, the Committee recommend the Board approve the policy.

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Matters Reserved to the Board		
Unique Identifier:	POL029	**Document Type:**	Policy
Version Number:	3.0	**Status:**	
Responsible Director:	Chief Finance and Planning Officer		
Author:	Trust Secretary		
Scope:	Trust wide		
Replaces:	Version 2.0		
To be Read in Conjunction with the Following Documents: (list related policies)	Standing Financial Instructions Trust Constitution		
Keywords:			

Considered By Executive Owner:	Trust Secretary	**Date Considered:**	04/10/2021
Endorsed By:	Audit and Risk Committee	**Date Endorsed**	11/10/2021
Approved By:	Trust Board	**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

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 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

Policy Framework

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Stacey Keegan, Interim Chief Executive Officer	Paper Category:	Policy
Paper Reviewed by:	Senior Leaders Group – 19.10.2021	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

The policy is shared with the Trust Board for approval.

2. Executive Summary

2.1. Context

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

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

2.2. Summary

The Policy review date has expired; therefore, the document has been amendment. The amendments have been highlighted in blue text.

There have been no material changes to the framework.

2.3. Conclusion

Following presentation at the Senior Leaders Group in October, the Group recommend the Board to approve the policy framework.

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Policy Framework Strategy		
Unique Identifier:	POL012	Document Type:	Policy
Version Number:	11.0	Status:	
Responsible Director:	Chief Nurse and Patient Safety Officer		
Author:	Trust Secretary/Director of Governance		
Scope:	Trust Wide		
Replaces:	Version 10.0		
To be Read in Conjunction with the Following Documents: (list related policies)	• Corporate Records Management Policy • Equality Impact Assessment Procedure		
Keywords:	Policy, Procedure, SOP, document management		

Considered By Responsible Director:	Chief Nurse and Patient Safety Officer	Date Endorsed:	19/10/2021
Endorsed By:	Senior Leaders Group	Date Approved:	19/10/2021
Approved By:	Trust Board	Date Approved:	25/11/2021
Issue Date:	25/11/2021	Review Date:	25/11/2021
Security Level:	Open Access ✓	Restricted	Confidential

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Version Control Sheet

Record of Amendments to: Policy Framework v10.~~9~~.0				
Amendments approved by: Senior Leader Group 19/10/2021				**Date**
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**
Page one	Front sheet			Change of titles and dates
Page five	Change of title			
Page five	Update to the Committee names			
Page six	Update to the Committee names			
Page eight	Reporting timeframe			Aligned to the Audit and Risk Committee

Policy Framework

(Policy for the Development and Management of Policies)

1.0 Introduction

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

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

2.0 Purpose and Scope

2.1 Purpose

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

2.2 Scope

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

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

3.0 Definitions

Strategy
A long term plan to achieve an objective.

Policy
A policy is a set of guiding or governing principles, which meets all or most of the following criteria:

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

Procedures
A procedure is a required series of steps followed in a regular order in order to achieve a defined outcome.

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

Matters Reserved to the Board
Document agreed by the Board which formally sets out the matters which it reserves to itself to approve.

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

4.0 Roles and Responsibilities

4.1 Board of Directors

Are responsible for setting the strategic context in which organisational documents are developed, and for ensuring that the formal review and approval of documents takes place.

Responsible for determining which policies it reserves to itself for approval.

4.2 Chief Executive Officer

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

4.3 ~~Director of Nursing~~ Chief Nurse and Patient Safety Officer

Is accountable to the Trust Board for ensuring compliance with this policy in all parts of the Trust.

4.4 Executive Directors

Directors are accountable to the Chief Executive for identifying and developing policies relevant to their area of responsibility and for ensuring that these policies are reviewed and reapproved prior to their review date.

They have a responsibility for ensuring that policies are implemented.

4.5 Trust Secretary

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

4.6 Document Author

The Document Author must ensure policies are:

- developed, reviewed and consulted on in accordance with this policy:
- accompanied by a front sheet
- Submitted for approval to the relevant committee or subcommittee prior to the date of review.
- disseminated to appropriate staff
- ensure that the policy has been sent to the Trust Secretary for uploading to the intranet once approved along with a copy of the ratifying minute and a completed Equality Impact Assessment.
- ensure that any publicity or training as outlined in the policy takes place
- if required by the document, ensures that staff evidence that they have received the document.

4.7 All Staff, Contractors and Students

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

4.8 Audit and Risk Committee, Quality and Safety Committee, Finance Planning and ~~Investment~~Digital Committee and People Committee~~and Risk Management Committee~~

Will ensure that the formal review and approval of policies relevant to their remit takes place.

4.9 Clinical ~~Governance and Quality~~Effectiveness Committee

Is responsible for ensuring that all clinical policies comply with best practice and approving those clinical policies that come within their remit.

4.10 Information Governance Committee

Is responsible for advising on policies which could impact on information governance and for approving those policies which come within their remit.

4.11 Health and Safety Committee
Is responsible for approving those policies which come within their remit.

4.12 Charitable Funds Committee
Is responsible for approving those policies which come within their remit.

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

5.1 Policy Development

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

5.1.2 Policy Style and Format
All policies should be written in a style which is concise and clear using unambiguous terms and language and follow the criteria set out below:

- All policies should use the template attached at Appendix One.
- The contents page should be linked to the document for easy navigation (use Heading 1 for those headings that need to appear in the contents page)
- Arial font should be used throughout the document (12pt Bold for headings, 10pt Bold for sub-headings and 10pt for the main text).
- All references should be in italic font and hyperlinks should be added where possible

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

5.1.4 Consultation
Consultation is a key part of the policy development. The policy author should identify any relevant stakeholders and their level of involvement.

5.2 Policy Ratification

All policies must identify the Committee which is responsible for their approval. An overview of the approval routes is shown in the table below

Category	Ratifying Body
Strategic and overarching policies	Trust Board
Policies reserved for the Board	Trust Board
Strategic and overarching policies as delegated by the board	Audit and Risk Committee Quality & Safety Committee ~~Business Risk and Investment Committee~~Finance Planning and Digital Committee and People Committee - As per their remits
Clinical Policies	~~Clinical Governance and Quality~~Clinical Effectiveness Committee
Risk Management Policies	Audit and Risk ~~Management~~ Committee

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

Information Governance Policies	Information Governance Committee
Health & Safety Policies	Health and Safety Committee
Human Resources Policies	~~Workforce Development Group~~People Committee
Charitable Funds Policies	Charitable Funds Committee

5.2.1 New Policies

All new policies must be consulted on with relevant staff groups before being submitted to the appropriate ratifying body for ratification.

5.2.2 Review of existing policies

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

If a policy is updated within its review date the following options are available to the author:

For minor changes which do not materially change the spirit of the policy can be made with the approval of the responsible Executive Director without recourse to the ratifying body.

If a review results in material changes to spirit of the policy or will impact on existing processes, the policy must be submitted to the ratifying body for approval.

5.3 Publication of a Policy

The Document Author is responsible for ensuring the policy, once ratified is published on the Trust Intranet. In order to publish a policy the following must be submitted to the Trust Secretary:

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

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

6.0 Implementation and Monitoring of the Policy Framework

6.1 Implementation plan

All new or revised Procedural Documents which are agreed after this policy has been issued must comply with the policy template at Appendix One. Policies will be amended to comply with this policy as and when their review dates become due.

6.2 Training and Dissemination

This policy will be sent to all senior managers and Document leads.

A copy of this policy will be placed on TrustNet and staff notified of the updated policy via internal communications.

All committees will be provided with a copy of the policy to note at their next meeting in order to raise awareness of the new template and ratification requirements.

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

6.3 Monitoring

Compliance with this policy will be monitored on a rolling basis by the Trust Secretary, as part of the checks which are performed prior to any policy being uploaded onto the intranet, any policy

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

which is not compliant will be returned to the document author for amendment. The results of this review will be reported to the Audit Committee once a year.

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

6.4 Review

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

Appendix One

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Title:	*Policy Framework Strategy Enter the Title in the [ ]*		
Unique Identifier:	*To be allocated by Trust Secretary*	**Document Type:**	*Choose Policy, Procedure (SOP) or Guidelines*
Version Number:	*To be provided by Trust Secretary*	**Status:**	*Choose 'Draft' or 'Approved'*
Responsible Director:	*Post of person responsible as Executive Owner*		
Author:	*Name and Post of person responsible for drafting document*		
Scope:	*Which staff groups?* *Which departments or Trust wide?*		
Replaces:	*Document(s) or version the document replaces*		
To be Read in Conjunction with the Following Documents:	*List related procedural documents*		
Keywords:	*To assist search functionality when filed electronically.* *Separate keywords using a comma*		

Considered By Responsible Director:	*Executive Director who is the document owner.*	**Date Considered:**	DD/MM/YYYY
Endorsed By:	*Committee/Group which endorsed document*	**Date Endorsed:**	DD/MM/YYYY
Approved By:	*Committee/Group which approved document*	**Date Approved:**	DD/MM/YYYY
Issue Date:	*Date document to take effect from* DD/MM/YYYY	**Review Date:**	*Date by which doc must be reviewed* DD/MM/YYYY
Security Level:	**Open Access** **Restricted** **Confidential** ✓ please tick relevant option		

Trust Values

Note items marked in red italics are guidelines for the document author to follow and should be replaced by the author with the actual information required in black font (not italics) or deleted.

Contents

The table of contents should be inserted using the references tool to ensure quick and easy navigation of the policy.

Instruction to insert table of contents:
References Tab – Table of Contents – Insert table of contents – select classic and 3 levels

To utilise table of contents function the style 'Heading 1' should be used for the headings that need to appear in the contents page.

Version Control Sheet

Record of Amendments to:				
Amendments approved by:				**Date**
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**

Version control guidance

Policies being submitted to a committee for ratification or policies being updated with minor amendments that do not require committee approval should be referenced as a new version i.e a policy that is version 2.0 should become 3.0.

1.0 Introduction
An overview of the importance and role of the policy and procedural documents

2.0 Purpose and Scope
This should make clear what the objective of the policy is and what is included and excluded in terms of the scope of the policy

3.0 Definitions
Provide a list of definitions helpful for reading the policy

4.0 Roles and Responsibilities
Specify the roles and responsibilities within this procedural document for key committees and individuals by role

5.0 Detail of the Procedural Document
This provides the main body of the policy and should clearly set out all policy requirements to include hyperlinks to further reading and guidance and appendices as appropriate.

Use sub headings as appropriate for the procedural document as follows:

1.0
1.1.
1.2
1.2.1
1.2.2

The main heading for each section should use the style 'Heading 1' to ensure that the contents page links to the document.

6.0 Implementation and Monitoring
This section should outline how the Document Author plans to implement the policy and monitor compliance. This section should include the following headings:

Implementation Plan
If the procedural document represents a significant change, or affects a number of people, this will require an implementation plan. This may be included as a separate annex.
For small changes or departmental SOPs a brief sentence explaining the implementation process will suffice.

Training and Dissemination
How will staff be made aware of the new procedural document? How any training needs will be assessed and delivered? A generic statement is shown below which may be used where appropriate.
*To ensure there is equity of access to all aspects of learning and development for all staff employed by the Trust, the Trust has developed a Learning and Development Policy. The training required for this subject / document (insert specific subject / document details**) is planned, delivered and audited in accordance with the Trust Learning and Development policy and delivered in accordance with the Learning and Development procedures document. The policy and procedures documents describe how the training needs analysis is undertaken, training/learning and development activity is advertised and how attendance monitored and followed up.*

Implementation Plan
If the procedural document represents a significant change, or affects a number of people, this will require an implementation plan. This may be included as a separate annex.
For small changes or departmental SOPs a brief sentence explaining the implementation process will suffice.

Monitoring / Audit
Outline how compliance with the procedural document will be monitored; this should include who will be responsible for this monitoring and where any results will be reported.

Review Date

All procedural documents must have a date by which time it has been reviewed. This will normally be a maximum of three years from the date of approval and the following standard wording should be used:

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

7.0 References

This section should include all applicable references and hyperlinks where applicable. Delete if not required

Note items marked in red italics are guidelines for the document author to follow and should be replaced by the author with the actual information required in black font (not italics) or deleted.

Month 6 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Senior Information Analyst	Paper date:	28 October 2021
Executive Sponsor:	Kerry Robinson, Chief of Performance, Improvement and OD	Paper Category:	Performance
Paper Reviewed by:	Senior Leader Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

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

The committee is asked to note the overall performance as presented in the month 6 (September) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

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

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

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

2.2. Overview

The Board through this IPR should note the following;

The impacts of covid continue to be seen in the delivery of our statutory targets and will continue not to be met due to pausing of elective services last year. Therefore assurance cannot be given for meeting the targets, hence assurance should be through the processes in place to manage such impact. The Trust will be reviewing targets and trajectories in upcoming months aligning to H2 plans.

Patients continue to be booked in line with guidance regarding clinical priority as a primacy rather than date order, illustrated in the long wait patients impact.

Caring for Staff;

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

- Sickness Absence
  - Metric showing normal variation but now exceeded target for four consecutive months, currently c.1% above target.
  - Long term sickness above target for four consecutive months

Caring for Patients;

- Never Events;
  - Low number of incidents have taken place
- RJAH Acquired E. Coli. Bacteraemia
  - Low number of incidents have taken place
- Cancer 62 Days Standard
  - Performance reported below 85% target at 28.57%
- 18 Weeks RTT Open Pathways
  - Metric is showing special cause variation of an improving nature; although consistently failing the target as expected from covid impact which will continue for a significant time.
- Patients Waiting Over 52 Weeks
  - Both English and Welsh showing special cause variation with increases reported this month.
  - BCU Transfers show an improvement with reductions since November.
- 6 and 8 Week Wait for Diagnostics
  - Both metrics indicate common cause variation with variable achievement of Welsh target and consistently failing English
  - Whilst operating over and above 19/20 capacity MRI is the predominant area of impact.

Caring for Finances;

- Total Elective Activity
  - 74.06% of baseline target (19/20); underachieving the regulatory target of 85%
  - Underachieving the regulatory target of 85% completing 305 cases below the requirement.
  - Cases per session at 1.95 against plan of 2.06
  - 89.88% sessions used against plan;
    - Whilst in normal variation, below target for two consecutive months
- Total Outpatient Activity
  - 82.91% of baseline target (19/20); underachieving the regulatory target of 85%
  - % Virtual below 25% target at 19.58%
  - DNA rate consistently failing target
- Bed Occupancy – All Wards – 2pm
  - Metric is consistently failing target
- H1 Plan Performance
  - Deficit in month
- Income
  - Adverse position in month
- Recurrent Financial Performance (Sustainability Plan)
  - Adverse variance in month

2.3. Conclusion

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

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

Integrated Performance Report September 2021 – Month 6

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

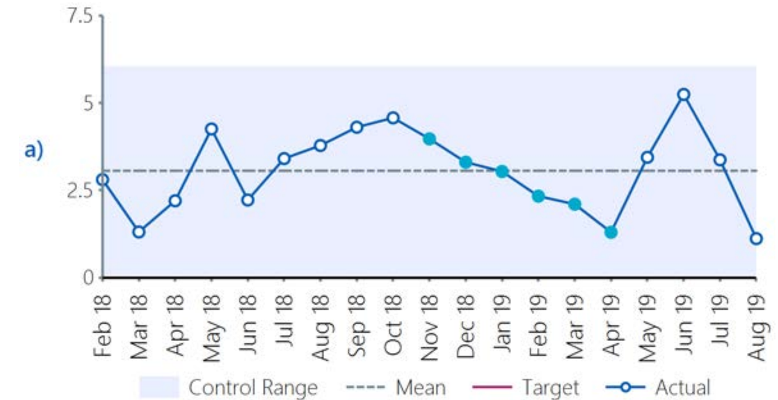
Some examples of these are shown in the images to the right:

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

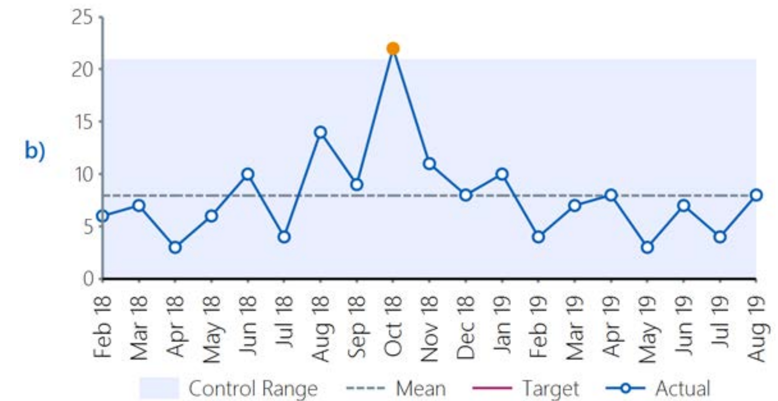
b) shows a point of concern sitting above the control range.

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

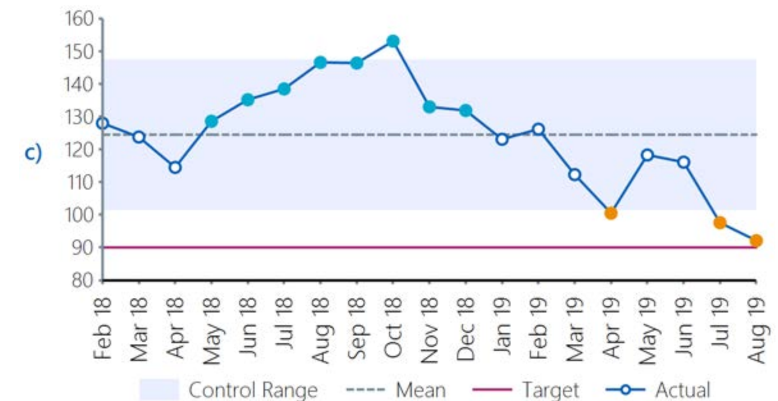
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

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

Data Quality Rating Reading Guide

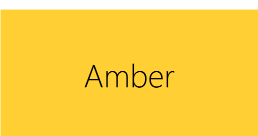
The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

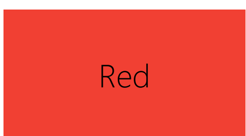
When rated, each KPI will display colour indicating the overall rating of the KPI

No improvement required to comply with the dimensions of data quality

Satisfactory - minor issues only



Requires improvement



Siginficant improvement required

Dates

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

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	4.55%			?	+	27/02/20
Voluntary Staff Turnover - Headcount	8.00%	7.66%			?		24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	0		N/A to SPC	?		
Never Events	0	1		N/A to SPC	?	+	16/04/18
Number of Complaints	8	11			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Unexpected Deaths	0	0		N/A to SPC	P		16/04/18
31 Days First Treatment (Tumour)*	96%	100%		H	?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85.00%	28.57%			?	+	24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
18 Weeks RTT Open Pathways	92.00%	55.71%		H	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,504	1,276	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	645		H	F	+	24/06/21
6 Week Wait for Diagnostics - English Patients	99.00%	82.78%			F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	87.91%			?	+	

Summary - Caring for Finances

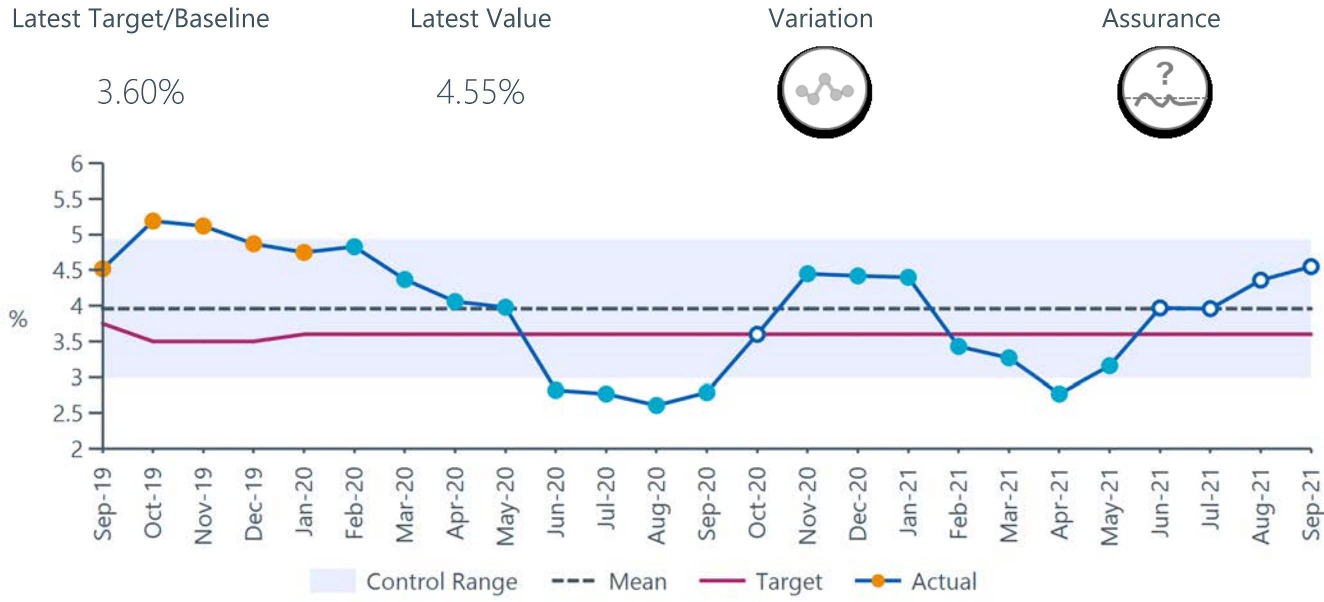
KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	1,176	871	1,069	N/A to SPC	Moving Target	+	24/06/21
Bed Occupancy – All Wards – 2pm	87.00%	82.21%			F	+	05/09/19
Total Outpatient Activity	17,609	14,599	15,626	N/A to SPC	Moving Target	+	24/06/21
H1 Plan Performance	40.98	-18.00		N/A to SPC	Moving Target	+	
Income	10,074	10,905		N/A to SPC	Moving Target	+	
Expenditure	10,078	10,969		N/A to SPC	Moving Target		
Efficiency Delivered	94	201		N/A to SPC	Moving Target		
Cash Balance	17,728.81	21,974.00		H	Moving Target		
Capital Expenditure	1,010	611		N/A to SPC	Moving Target		
Recurrent Financial Performance (Sustainability Plan)	-353	-407		N/A to SPC	Moving Target	+	

Sickness Absence

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

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
3.60%	4.55%		



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

Although the latest data is showing normal variation, the sickness rate has been above target for four consecutive months. Unit level detail below for those areas that are above target:
* MSK Unit - overall sickness was 5.24% for September and has been above target for four consecutive months
* CSU Unit - overall sickness was 5.35% for September and has been above target for five consecutive months
* Specialist Unit - overall sickness was 5.93% for September and has been above target for four consecutive months

Anxiety/stress/depression is the highest reason for sickness across all three Units.

Actions

Actions within each Unit detailed below:
* MSK Unit - Theatres sickness absence policy to be reviewed and Surgical wards are doing some targeted work reviewing management and compliance with the sickness absence policy.
* CSU Unit - Work is underway on highlighting the wellness conversations throughout areas of the Unit and proactive support for staff in line with sickness absence policy.
* Specialist Unit - People Services Business Partner providing support and coaching to managers in sickness absence actions - training where required, reminders to managers to highlight importance of accurate data input to ESR, triangulate 'hot spot areas' with other KPIs, unit wellness discussions, unit morale/motivation discussions.

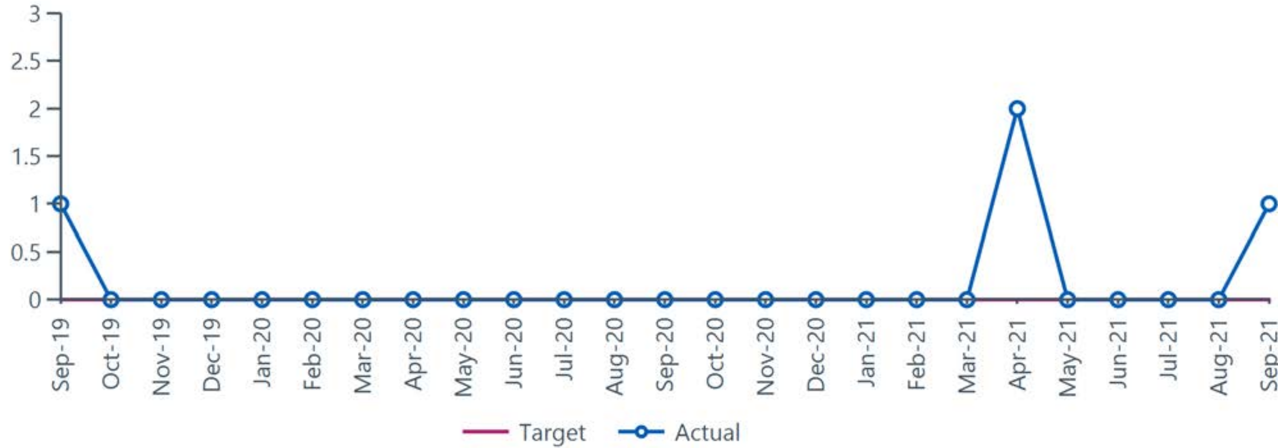
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
2.79%	3.60%	4.45%	4.42%	4.40%	3.43%	3.27%	2.77%	3.16%	3.97%	3.96%	4.36%	4.55%

Never Events

Number of Never Events Reported in Month

Exec Lead:
Chief Nurse and Patient Safety Officer

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/H1 Plan
0	1			



What these graphs are telling us

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

Narrative

There was one never event reported in September. The incident related to a wrongly sized prosthesis following an operation that took place in May this year.

Actions

Due to the timing of this never event and the subsequent actions taken from the previous, following review no further immediate actions were required.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
0	0	0	0	0	0	0	2	0	0	0	0	1

RJAH Acquired E. Coli Bacteraemia

Number of cases of E. Coli Bacteraemia in Month.

Exec Lead:
Chief Nurse and Patient Safety Officer

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/H1 Plan
0	1			

What these graphs are telling us

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

Narrative

There was one RJAH Acquired E. Coli Bacteraemia reported in September.

Actions

At the time of IPR production, a post infection review meeting was scheduled for late October. A probable cause has been identified with appropriate training already implemented.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
1	2	0	0	0	0	0	0	0	0	0	0	1

Cancer Plan 62 Days Standard (Tumour)*

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/H1 Plan
85.00%	28.57%			

What these graphs are telling us

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

Narrative

The Cancer 62 Day Standard is reported at 28.57% in August; this measure is reported in arrears. This equates to six pathways where RJAH was whole or part accountable for the care of each patient. Two patients met the 62 day target, whilst four breached the standard. A breakdown is provided below to explain this:
- Patient 1 - Shared Pathway - 0.5 Breach
- Patient 2 - Shared Pathway - 0.5 Breach
- Patient 3 - Whole Pathway - 1 Breach
- Patient 4 - Shared Pathway - 0.5 Breach
- Patient 5 - Shared Pathway - 0.5 In Target
- Patient 6 - Shared Pathway - 0.5 in Target

Due to small volumes the impact on % achievement is heavily impacted when breaches are reported.

Actions

The Trust believe only one of the breaches should be accountable to RJAH which for the month of would have improved our performance to 67%. A review is to be undertaken to ensure the Tumour Unit has a robust process of reviewing submitted data at the appropriate times, in line with NHS Digital timeframes in relation to upload/edits/generation deadlines. The Trust provides data in a timely manner with accurate Trust position information, however subsequent late submissions close to deadline date by other Trusts may on occasion lead to changes in the national allocation of the breaches which the Trust does not recognise. The Trust processes to strengthen is the 24 hour window after final submissions from all providers to ensure inaccuracies from other providers are challenged and rectified.

The breach that was accountable to RJAH was due to the complex nature of the investigations required.

In November NHS Digital have a window for revisions of data for the period of April-21 to September-21 where the Operational Manager will work with the staff in the Tumour Unit to utilise and ensure corrections to pathways are confirmed and updated so it reflects in overall reporting. Any updates to data will be made in the IPR following this.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
50%	100%	0%	50%	100%	100%	0%	100%	100%	100%	100%	28%	

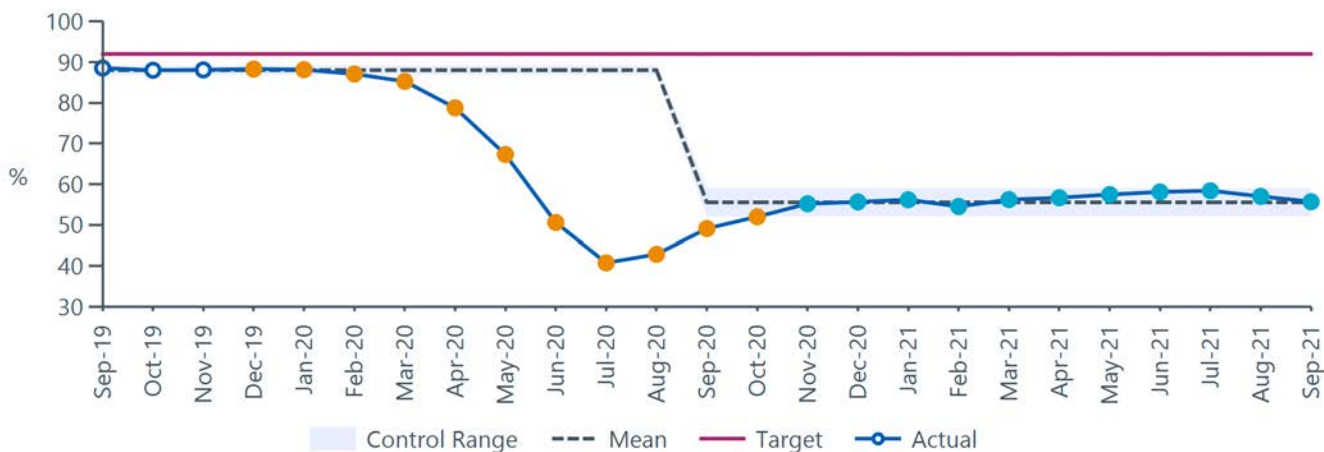
18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	55.71%		

Trajectory/H1 Plan



What these graphs are telling us

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

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

Narrative

Our September performance was 55.71% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows: MS1 - 7405 patients waiting of which 1948 are breaches, MS2 - 1185 patients waiting of which 754 are breaches, MS3 - 4303 patients waiting of which 3008 are breaches.

Actions

H2 planning guidance documents that as a Trust we should stabilise waiting lists around the level seen at the end of September 2021.
The Trust has plans and actions to manage demand. These are inclusive of:
- Increasing available Theatre sessions
- Exploring options to increase Cases per Session (CPS): - CPS when compared with 2019/20 is being impacted by complexity of patients presenting as high priority.
- More clock stops in non-admitted pathways - Capacity in delivery area (i.e. Radiology or MOPD) is continually assessed.

Spinal Disorders continues to be a pressured area for the Trust which is a proportion of our overall waiting lists. Actions inclusive of mutual aid discussions and recruitment actions for this service are in progress.

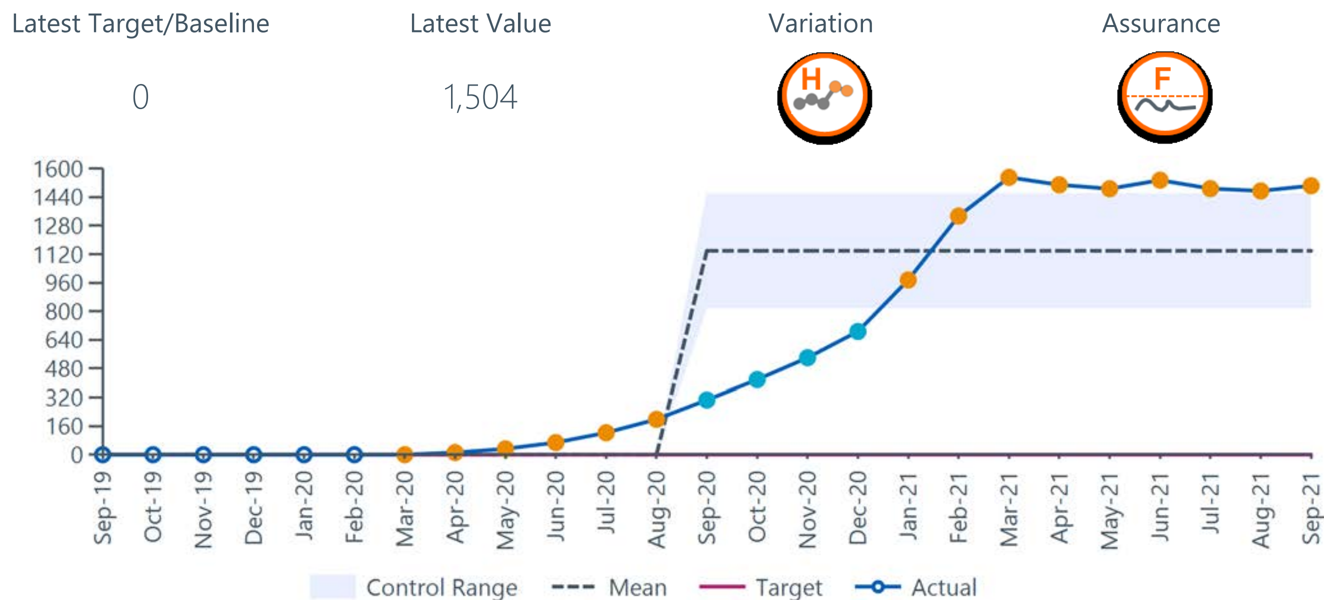
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
49.13%	52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	56.68%	57.46%	58.10%	58.40%	57.02%	55.71%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1,504	H	F



Trajectory/H1 Plan

What these graphs are telling us

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

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

Narrative

At the end of September there were 1504 English patients waiting over 52 weeks; above our trajectory figure of 1276.

The patients are under the care of the following sub-specialities; Spinal Disorders (567), Knee & Sports Injuries (311), Arthroplasty (302), Upper Limb (162), Spinal Injuries (71), Foot & Ankle (64), Tumour (11), Metabolic Medicine (7), Paediatric Orthopaedics (3), Geriatrics (3), Neurology (1), Physiotherapy (1) and SOOS Physiotherapy (1).

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 930 patients
- >78 to <=95 weeks - 443 patients
- >95 to <=104 weeks - 69 patients
- >104 weeks - 62 patients

Actions

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

For Spinal Disorders mutual aid discussions are on-going.
A number of workforce actions are being undertaken inclusive of a locum consultant being appointed and a registrar also being recruited to support. An additional Senior Fellow will also join the cohort in February for 6 months. Further workforce actions also being explored and progressed.

H2 planning guidance documents that as a Trust we should hold or where possible reduce the number of patients waiting over 52 weeks.

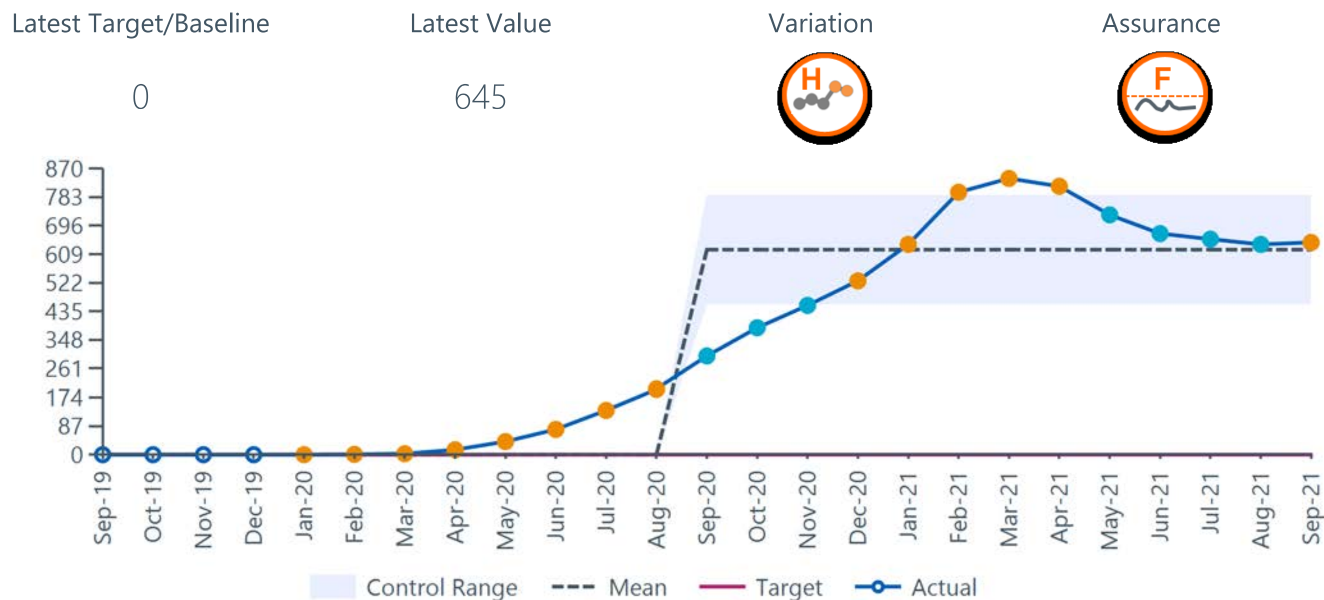
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
306	418	540	687	976	1334	1551	1509	1487	1535	1488	1475	1504

Patients Waiting Over 52 Weeks – Welsh

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	645	H	F



Trajectory/H1 Plan

What these graphs are telling us

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

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

Narrative

At the end of September there were 645 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (357), Arthroplasty (98), Knee & Sports Injuries (86), Upper Limb (51), Foot & Ankle (19), Spinal Injuries (19), Paediatric Orthopaedics (5), Tumour (4), Neurology (3) and Metabolic Medicine (3).

The patients are under the care of the following commissioners; BCU (370), Powys (262), Hywel Dda (11), Aneurin Bevan (1) and Cardiff & Vale (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks -346 patients
- >78 to <=95 weeks - 187 patients
- >95 to <=104 weeks - 50 patients
- >104 weeks - 62 patients

Actions

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

For Spinal Disorders mutual aid discussions are on-going.
A number of workforce actions are being undertaken inclusive of a locum consultant being appointed and a registrar also being recruited to support. An additional Senior Fellow will also join the cohort in February for 6 months. Further workforce actions also being explored and progressed.

H2 planning guidance documents that as a Trust we should hold or where possible reduce the number of patients waiting over 52 weeks.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
299	385	453	528	639	798	840	816	729	672	655	639	645

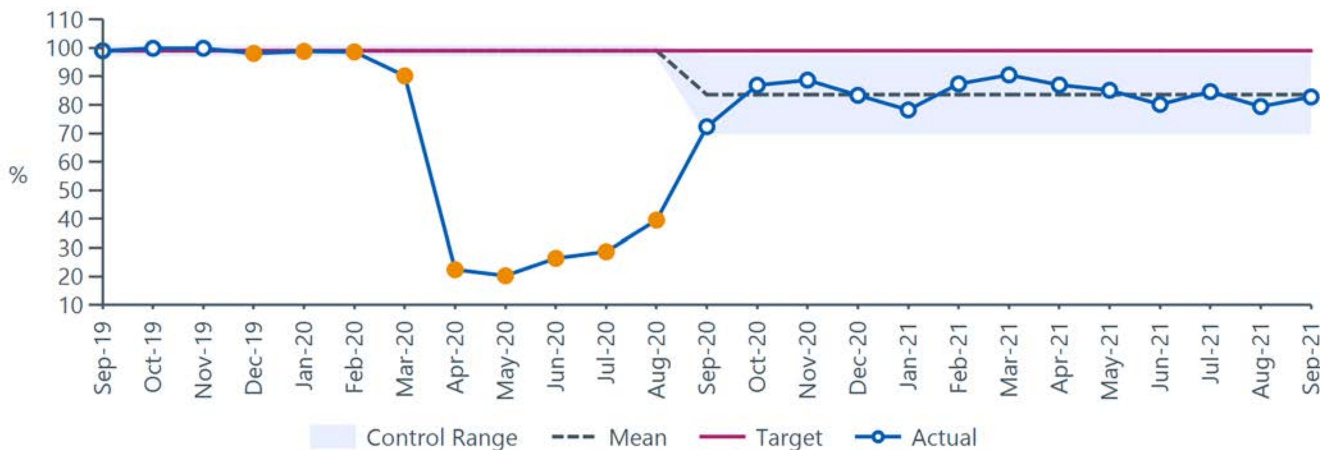
6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	82.78%		

Trajectory/H1 Plan



What these graphs are telling us

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

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 82.78%. This equates to 212 patients who waited beyond 6 weeks. The breaches occurred in the following modalities:
- MRI (191 - with 188 dated)
- Ultrasound (13 dated)
- CT (8 - with 4 dated)

It must be noted that all modalities - MRI, CT and Ultrasound activity was over 100% of the H1 plans.

Actions

The system has CT capacity constraints and actions are being taken to ensure equitable access that could further impact RJAH performance as more mutual aid is being offered.

With regards to MRI, an options appraisal paper is currently being composed to assess future equipment/staffing models that could be implemented at RJAH or within the system. External suppliers feedback has been requested to support this piece of work. Findings will be presented to the Senior Leadership Group.

The Trust will continue to monitor demand for ultrasound as we have seen an increase in this area.

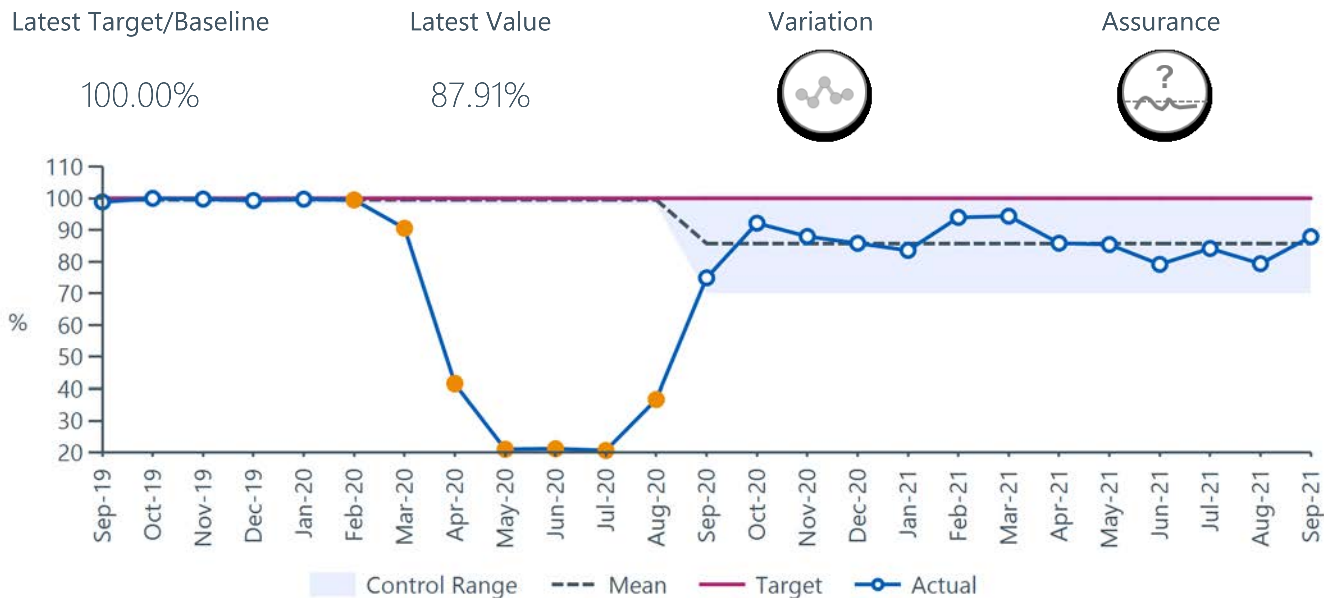
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
72.35%	86.92%	88.70%	83.37%	78.24%	87.38%	90.53%	86.99%	85.13%	80.17%	84.66%	79.43%	82.78%

8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/H1 Plan
100.00%	87.91%			



What these graphs are telling us

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

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 87.91%. This equates to 67 patients who waited beyond 8 weeks. The breaches occurred int he following modalities:
- MRI (64 dated)
- CT (2 - with 1 dated)
- Ultrasound (1 dated)

It must be noted that all modalities - MRI, CT and Ultrasound activity was over 100% of the H1 plans.

Actions

The system has CT capacity constraints and actions are being taken to ensure equitable access that could further impact RJAH performance as more mutual aid is being offered.

With regards to MRI, an options appraisal paper is currently being composed to assess future equipment/staffing models that could be implemented at RJAH or within the system. External suppliers feedback has been requested to support this piece of work. Findings will be presented to the Senior Leadership Group.

The Trust will continue to monitor demand for ultrasound as we have seen an increase in this area.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
74%	92%	87%	85%	83%	94%	94%	85%	85%	79%	84%	79%	87%

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

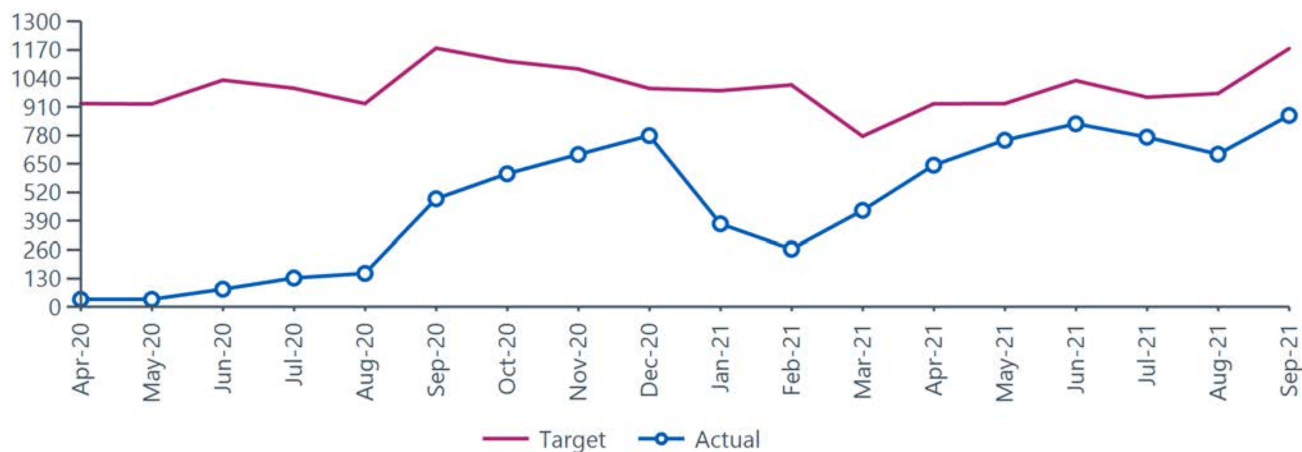
Total Elective Activity

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

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
1,176	871		

Trajectory/H1 Plan



What these graphs are telling us

This measure has a moving target.

Following guidance from NHS EI we have updated the SPC graphs throughout the IPR to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. To recognise all elective work following the impact of COVID-19 , this new committee measure was added in 21/22. With the impacted months now excluded from the control range calculations on relevant KPIs throughout the IPR, this now leaves this measure without enough data points for robust reporting in SPC, so this measure is now displayed as a line graph.

Narrative

Total elective activity undertaken in September was 871, below the H1 plan for September of 1069; represented in the trajectory line above. September activity represents 74.0% of the 19/20 baseline figure of 1176; the September target, as set by NHS EI, was to meet 85% of baseline 19/20 activity.

September had a stretch target of 92.4% of baseline 19/20 activity. The Trust has a known shortfall in Theatre staffing that is currently impacted by vacancies and maternity leave. The Trust has a recruitment plan in place to address this. Mitigations currently include flexibility of current workforce and agency staff on a short-term basis. For September, the Trust achieved 92% of it IJP capacity and all core staffed Theatre sessions were utilised. Plans were to further deliver 283 cases via OJP of which the Trust achieved 144 (50.88%) due to current constraints of staffing and mitigations.

During Q3 the Trust also has plans to increase short-term agency staff to further address current gaps

More robust SPC analysis will be possible as data points are added.

Actions

Continued focus on transformation schemes, actions for which include:
* Maximise theatre sessions through efficient scheduling. Pilot introduced by individual surgeons and increased cases per session with focus on bespoke sessions for spines and high complex cases
* Reduce cancellations - on-going monitoring and taking remedial action to improve
* Locum consultant appointed supporting mitigations in Spinal Disorders as a key risk area to the Trust
* A review is being undertaken, at sub-specialty level, to determine those not reaching IJP planned levels
* Theatre staffing is being further recruited to inclusive of International recruits x7. Five on site in the country, two expected in quarter four. Ongoing scoping for further international candidates
* Significant recruitment is also underway to the nurse bank (for registered and unregistered staff)

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
491	605	693	779	377	263	438	644	758	833	772	694	871

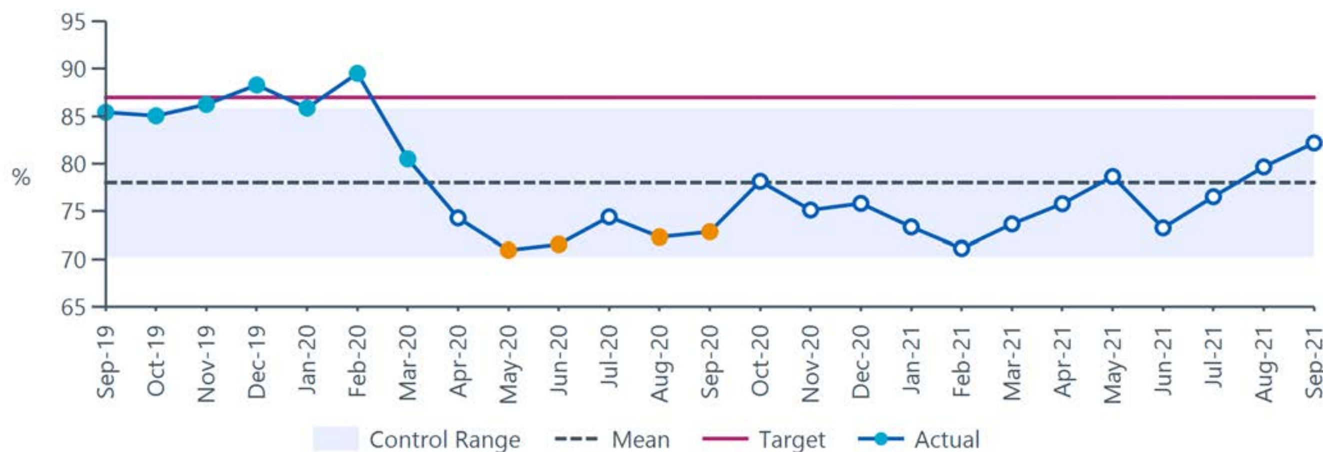
Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	82.21%		

Trajectory/H1 Plan



What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 82.21% for September. The breakdown below gives the September occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:

MSK Unit:
- Clwyd - 77.09% - compliment of 22 beds for majority of the month
- Powys - 82.79% - compliment of 22 beds for majority of the month
- Kenyon - 47.90% - ward open to 12 beds some days per week
- Ludlow - 84.21% - compliment of 15 beds open throughout month

Specialist Unit:
- Alice - 61.15% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 79.87% - compliment of 10 beds open throughout month
- Gladstone - 89.27% - compliment of 29 beds open throughout the month
- Wrekin - 90.95% - compliment of 15 beds open throughout the month
- Sheldon - 89.93% - compliment of 20 beds open throughout month

Actions

We continue to monitor our occupancy across the Trust. As can be demonstrated in the SPC graph, September occupancy was the highest since March-20 and now showing three months of consistent increase. With regular review, we continue to flex our bed base whenever possible to have sufficient beds open for the anticipated activity numbers based on the existing bed model. This includes assessing the variability of occupancy by weekday. Flexing has included ward and bed closures and redeployment of staff to other areas of the Trust. Bed Occupancy is expected to increase, in line with increased activity levels. New IPC guidance currently under review that could impact in this area.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
72.86%	78.17%	75.14%	75.84%	73.37%	71.15%	73.68%	75.81%	78.67%	73.27%	76.54%	79.68%	82.21%

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (H1), Catchment Based)

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/H1 Plan
17,609	14,599			

What these graphs are telling us

Currently this measure is not appropriate to display as SPC. Analysis will improve as more data points are added. It is recommended that 15+ data points are required for robust analysis. This measure has a moving target.

Narrative

This measure aligns with the NHS E/I inclusions/exclusions for restoration monitoring; consultant-led activity, non consultant-led and unmatched/unbundled activity. The target for this measure is the 2019/20 baseline activity that was delivered, with the H1 plan included as a trajectory in the trajectory graph. In September the total Outpatient activity undertaken was 14599; 93.43% of our H1 plan and 82.91% of our baseline. This is broken down as follows:

- Consultant led - 81.06% (10772 against target of 13289)
- Non consultant-led - 193.69% (2826 against target of 1459)
- Unbundled/unmatched - 113.88% (1001 against target of 879)

As at 7th October (5th working day) there were 267 missing outcomes so once administrative actions are taken with these data entries, the September position will alter. Taking into account the missing outcomes, this would mean that the Outpatient activity for September was 14866, 760 below our H1 plan of 15626. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs.

Actions

The Managing Director of the Clinical Services Unit is leading an Outpatient Transformation Group focusing on multiple processes that on activity delivery. This will be inclusive of, but not limited to;

- Utilisation of outpatient areas
- Staffing in place
- Virtual uptake
- Patient initiated follow ups
- DNAs
- Clinic templates

The group will review and agree the areas for further focus.

Recently released new IPC guidance is also under review which could further impact outpatient delivery.

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
13027	13091	14148	13244	12969	14599

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

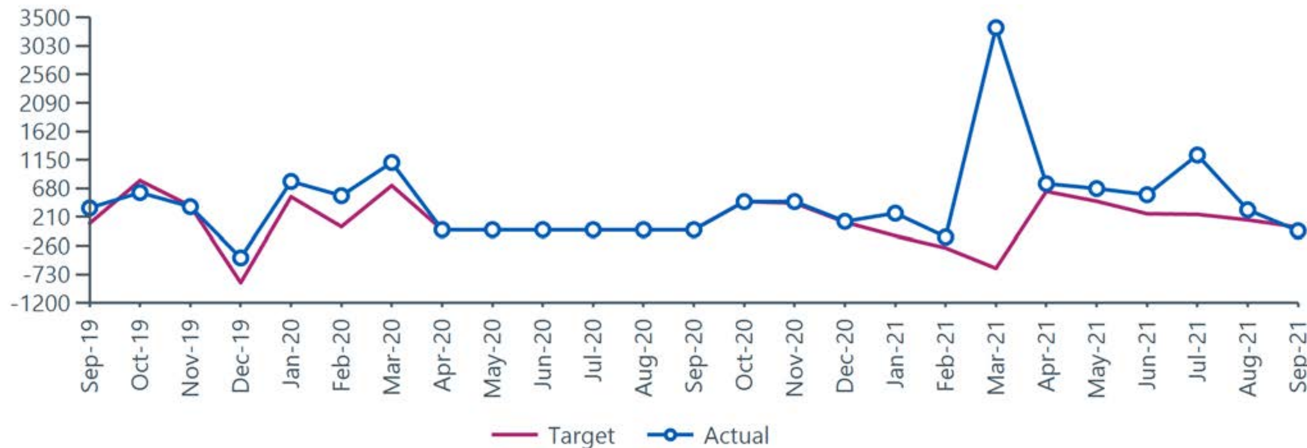
H1 Plan Performance

Surplus/deficit adjusted for donations under the interim COVID financial framework

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
40.98	-18.00		

Trajectory/H1 Plan



What these graphs are telling us

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

Narrative

Overall £18k deficit in month, £58k adverse to plan
YTD £3,550k surplus, £1,739k favourable to plan

H2 plan has yet to be finalised, trajectories will be updated at M7 once the plan is completed and signed off

Actions

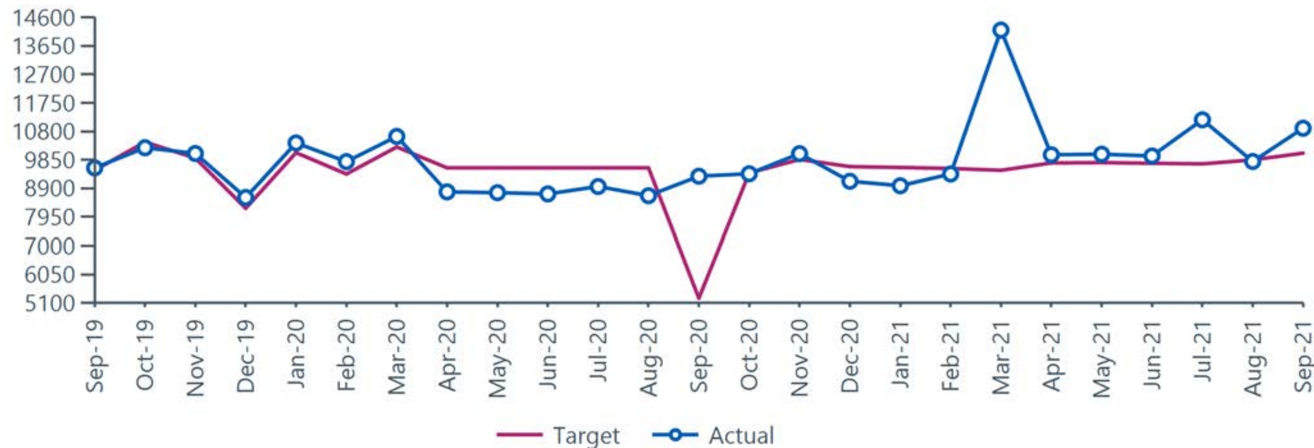
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
0	462	463	137	272	-117	3331	757	677	576	1231	327	-18

Income

All Trust Income, Clinical and non clinical

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance	Trajectory/H1 Plan
10,074	10,905			



What these graphs are telling us

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

Narrative

Income £95k adverse (excluding impact of pay award):

- Elective recovery fund (ERF) income adverse
- Private Patient income favourable driven by activity

H2 plan has yet to be finalised, trajectories will be updated at M7 once the plan is completed and signed off

Actions

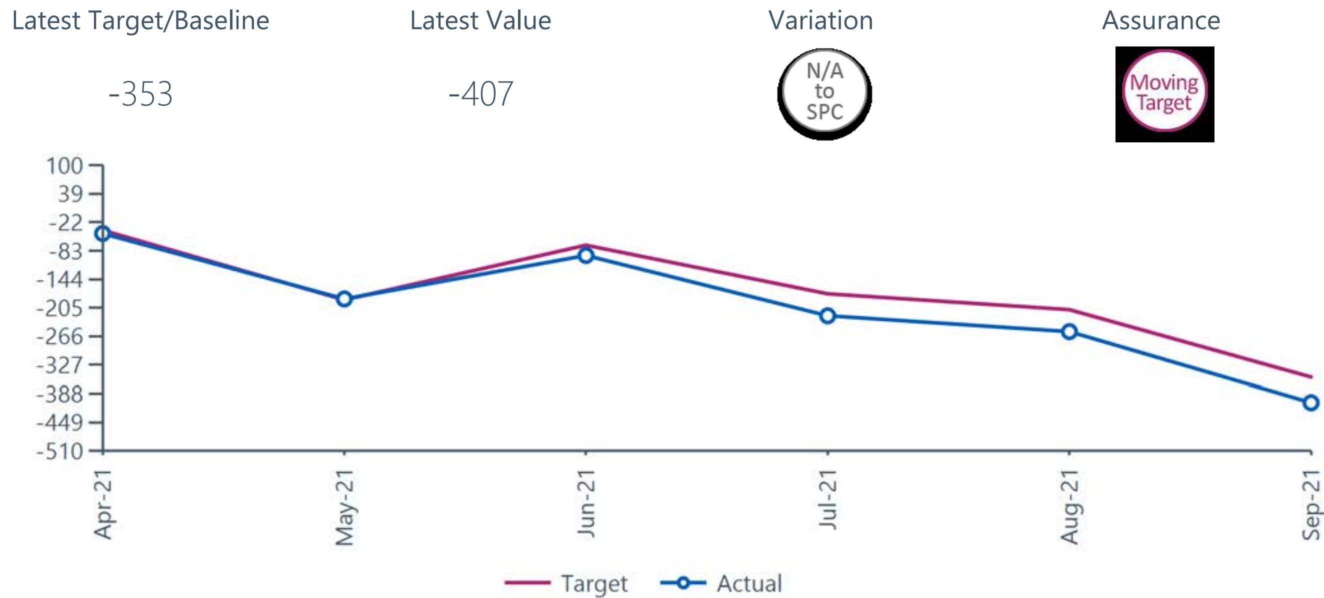
Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
9306	9387	10058	9138	8988	9380	14180	10021	10039	9981	11188	9797	10905

Recurrent Financial Performance (Sustainability Plan)

Surplus/deficit normalised to represent the recurrent financial position under the intelligent fixed payment system

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
-353	-407	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

£54k adverse variance in month against the sustainability plan, £169k ytd. Mainly driven by efficiency phasing

H2 plan has yet to be finalised, trajectories will be updated at M7 once the plan is completed and signed off

Actions

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
-46	-186	-93	-222	-256	-407

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

Performance Against H1 Plan £'000s							
Category	H1 Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	49,107	8,467	9,020	553	49,107	50,709	1,603
System Top Up Funding	2,597	427	434	8	2,597	2,605	8
Non NHS income support	878	120	120	0	878	878	0
Covid-19 Funding	1,452	242	242	0	1,452	1,452	0
Private Patient income	1,877	315	656	341	1,877	3,619	1,742
Other income	2,973	503	432	(71)	2,973	2,669	(304)
Pay	(34,334)	(5,849)	(6,735)	(886)	(34,334)	(34,955)	(620)
Non-pay	(19,681)	(3,675)	(3,681)	(6)	(19,681)	(20,385)	(704)
EBITDA	4,869	551	489	(62)	4,869	6,592	1,724
Finance Costs	(3,326)	(554)	(553)	1	(3,326)	(3,323)	3
Capital Donations	1,740	510	0	(510)	1,740	672	(1,068)
Operational Surplus	3,283	506	(64)	(570)	3,283	3,941	659
Remove Capital Donations	(1,740)	(510)	0	510	(1,740)	(672)	1,068
Add Back Donated Dep'n	269	45	47	2	269	280	12
Control Total	1,811	41	(18)	(58)	1,811	3,550	1,739
EBITDA margin	8.6%	5.7%	4.6%	-1.0%	8.6%	11.1%	2.5%

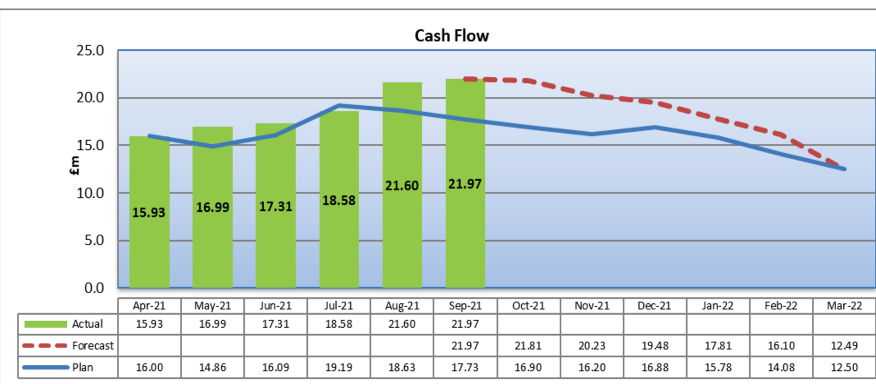
Sustainability (Recurrent) Plan 2021/22						
Category	In Month Position (£'000)			Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	8,679	8,680	1	52,073	52,073	0
System Top Up Funding	0	0	0	0	0	0
Non NHS income Support	0	0	0	0	0	0
Covid-19 Funding	0	0	0	0	0	0
Private Patient income	404	404	0	2,639	2,644	5
Other income	553	539	(14)	3,319	3,274	(45)
Pay	(5,881)	(5,893)	(12)	(35,233)	(35,279)	(47)
Non-pay	(3,591)	(3,630)	(39)	(20,731)	(20,878)	(147)
EBITDA	164	99	(65)	2,066	1,833	(234)
Finance Costs	(562)	(553)	8.50	(3,369)	(3,323)	46
Capital Donations	510	0	(510)	1,957	671	(1,285)
Operational Surplus	112	(454)	(566)	654	(819)	(1,473)
Remove Capital Donations	(510)	0	510	(1,957)	(671)	1,285
Add Back Donated Dep'n	45	47	2	269	281	12
Control Total	(353)	(407)	(54)	(1,034)	(1,210)	(175)

Statement of Financial Position £'000s				
Category	Aug-21	Sep-21	Movement	Drivers
Fixed Assets	78,978	79,193	215	Additions less depreciation
Non current receivables	1,274	1,305	31	
Total Non Current Assets	80,252	80,498	246	
Inventories (Stocks)	1,408	1,384	(24)	
Receivables (Debtors)	6,592	6,957	365	Pay award income
Cash at Bank and in hand	21,600	21,974	374	Veteran's centre donation offset by PDC dividend payment
Total Current Assets	29,600	30,315	715	
Payables (Creditors)	(15,410)	(16,553)	(1,143)	Veteran's centre donation received on account
Borrowings	(1,421)	(1,428)	(7)	
Current Provisions	(687)	(683)	4	
Total Current Liabilities (< 1 year)	(17,518)	(18,664)	(1,146)	
Total Assets less Current Liabilities	92,334	92,149	(185)	
Non Current Borrowings	(3,912)	(3,791)	121	Salix loan principal payment
Non Current Provisions	(974)	(974)	0	
Non Current Liabilities (> 1 year)	(4,886)	(4,765)	121	
Total Assets Employed	87,448	87,384	(64)	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,396)	(22,396)	0	
Revenue Position	(4,006)	(3,942)	64	
Revaluation Reserve	(24,938)	(24,938)	0	
Total Taxpayers Equity	(87,448)	(87,384)	64	

Draft Finance Metrics (New Single Oversight Framework)

Metric	Rating
Performance against Financial Plan	Green
Underlying financial plan	Amber
Expenditure run rate	Amber
Overall trend in reported financial position	Green

	YTD
Debtor Days	20
Creditor Days	48

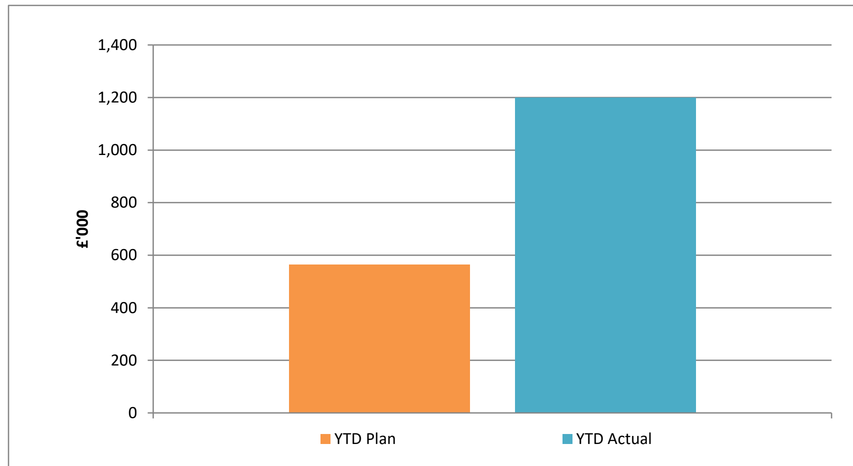


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	15.93	16.99	17.31	18.58	21.60	21.97						
Forecast						21.97	21.81	20.23	19.48	17.81	16.10	12.49
Plan	16.00	14.86	16.09	19.19	18.63	17.73	16.90	16.20	16.88	15.78	14.08	12.50

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

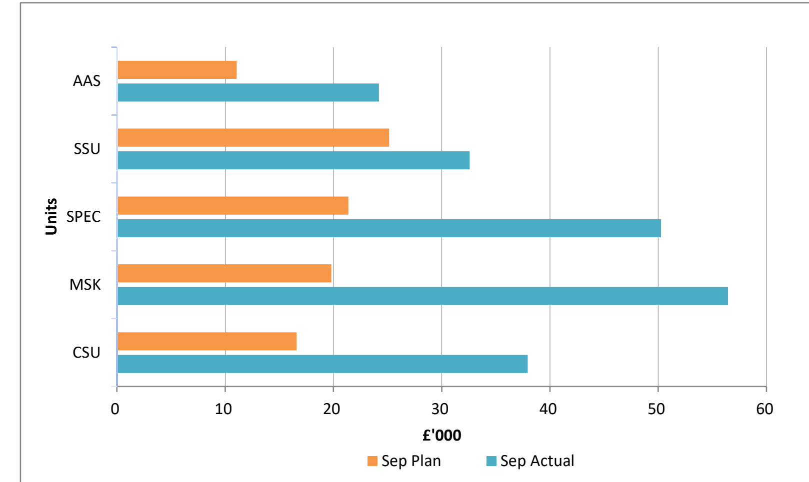
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



In Month Efficiencies

In Month Efficiencies Achievement £000's



Capital

Position as at	2122-06	Capital Programme 2021-22						
Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn
Backlog maintenance	600	91	75	16	354	238	116	600
I/T investment & replacement	300	100	0	100	140	-4	144	300
Capital project management	100	9	11	-2	50	60	-10	100
Equipment replacement	500	50	294	-244	200	293	-93	500
Diagnostic equipment replacement	1,701	0	0	0	600	94	506	1,701
Diagnostic equipment replacement PDC	99	0	0	0	0	0	0	99
Contingency	500	0	0	0	100	36	64	500
EPR planning & implementation	2,000	200	0	200	200	0	200	2,000
Invest to save	200	50	0	50	50	0	50	200
Donated medical equipment	200	25	0	25	150	111	39	250
Veterans' centre	4,500	485	231	254	1,590	792	798	4,500
Total Capital Funding	10,700	1,010	611	399	3,434	1,620	1,814	10,750
Donated medical equipment	-200	-25	0	-25	-150	-111	-39	-250
Veteran's facility	-4,500	-485	-231	-254	-1,590	-792	-798	-4,500
Capital Funding (NHS only)	6,000	500	380	120	1,694	717	977	6,000

Forecast

Forecast to be updated as part of H2 planning exercise

Chair's Assurance Report
Quality and Safety Committee – 14th October 2021

0. Reference Information

Author:	Mary Bardsley Assistant Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Quality and Safety Committee on 14th October 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of patient safety and quality to the Quality and Safety Committee. This Committee is responsible for seeking assurance on the quality and safety of the services.

It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended and noted as quorate
- The Committee were provided with an assurance report on increased patient contact
- The Committee received a quarterly report on infection control and learning from deaths
- The Committee received the standard agenda items, Performance Report and Board Assurance Framework for consideration and approval before onward presentation at the Board
- The Committee considered the patient experience and complaint annual report, patient experience strategy and the health and safety annual report
- Chair assurance reports were provided

2.3. Conclusion

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

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

Chair's Assurance Report
Quality and Safety Committee – 14th October 2021

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 14th October 2021. The meeting was quorate with 2 Non-Executive Director and 2 Senior Leaders in attendance. The full list of attendees is listed below:

Attendance:		
Chris Beacock	Non-Executive Director	(Chair)
David Gilburt	Non-Executive Director	
Hilary Pepler	Trust Board Advisor	
Stacey-Lea Keegan	Interim CEO	
Shelley Ramtuhul	Trust Secretary	
Ibs Roushdi	Deputy Chief Medical Officer	
Ash Donoghue Harrison	Governance Lead for Support Services Unit	
Nicki Bellinger	Assistant Chief Nurse for Specialist Services Unit	
Sue Sayles	Infection Prevention and Control Nurse	
Phil Davies	Head of Estates and Facilities	
Victoria Brownrigg	Head of Financial Management and Planning	
Amanda Roberts	Governance Lead for Clinical Services Unit	
Teresa Jones	Research Manager	
Dawn Forrest	Managing Director for Clinical Services Unit	
Heather Pickering	Minute Secretary	
Apologies:		
Ruth Longfellow, Sara Ellis Anderson and Paul Kingston		

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declarations of Interest		
None to note	N/A	
Increase in Patient Contact		
The Committee received an assurance report on the increased patient contact which was commended. The Committee will receive an update in February 2021.	Yes	
Infection Control Quarterly Report		
The Committee noted the report and approved for onward presentation at the Board.	Yes	
Learning from Deaths Quarterly Report		

Chair's Assurance Report
Quality and Safety Committee – 14th October 2021

The Committee noted the report. There has been one death in the past 4 months.	Yes	
Serious Incidents and Never Events		
The Committee noted the report. The Committee requested for the action plans to be reviewed and an update is to be provided at the next meeting – there were no concerns raised in relation to the process.	Yes	
Harms Review		
The Committee noted the great progress within the report and noted the improved assurance provided in the past two months.	Yes	
Safe Sharps Update		
The Committee noted the report and agreed for the presentation of data to be reported on a quarterly basis as the Trust continues to be complaint.	Yes	
Legal Claims Update		
The paper was deferred to the next meeting – November	N/A	
Committee Self-Assessment and Annual Report		
The paper was deferred to the next meeting – November	N/A	
Performance Report (M6)		
The Committee noted the performance report. There has been one serious incident. Clarification was requested on the WHO report and methodology due to discrepancies.	Partial	Further information to be provided at the next meeting - November
CIP Impact Assessment		
The Committee noted the report, and it was acknowledged that all schemes have been signed off.	Yes	
Board Assurance Framework		
The Committee noted the framework. The Committee agreed to close a new risk relating to infection control and rapidly changing national guidance – a recommendation will be made to Board. A new risk relating to the MRSA outbreak was considered.	Yes	
Clinical Services Unit Report		
The Committee noted the unit report. It was noted that the Managing Director continues to monitor risks monthly.	Yes	
Patient Experience and Complaints Annual Report (appendix one)		
The Committee noted the annual report and approved for onward presentation at the Board of Directors. Discussion were held regarding the noted dissatisfaction of patients waiting for surgery and the Trust agreed to add an explanation to the website, a radio interview has been scheduled and the information may be placed on the my recovery app.	Yes	
Health and Safety Annual Report (appendix two)		
The Committee noted the annual report and approved for onward presentation at the Board of Directors.	Yes	

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

There has been a noted reduction in health and safety matters due to the pandemic.		
Patient Experience Strategy		
The Committee noted the strategy and approved for onward presentation at the Board of Directors.	Yes	
Policy Tracker		
The Committee noted the tracker and was assured with the process in place to identify overdue documents.	Yes	
Chair Reports		
Research Committee Areas highlighted included: • commercial study which was unable to proceed due to lack of imaging and the stance of the Radiology department – a verbal update was provided, and discussion are tabled for the SLG agenda.	Yes	
Trust Performance and Operational Board The Committee noted the Chairs' report.	Yes	
Health and Safety Committee Areas highlighted included: • Response to RIDDOR and further education required • Reporting of local inductions • Occupational health issues relating to uncompleted questionnaires • PAM reporting to an assurance Committee The Committee will continue to monitor through the next report.	Partial	The Committee were assured with the processes. The highlighted areas will be monitored through the H&S chair report.
Medical Devices Committee The Committee noted the Chairs' report.	Yes	
Safeguarding Committee *Areas highlighted included:* • DoLs and MCA Level 3 training is flagged as an area of concern and queried a plan to address this for frontline clinicians	Partial	Further work to be completed to ensure staff are trained. At least one trained staff member is always onsite.
Clinical Effectiveness Committee The Committee noted the verbal update.	Yes	
Committee workplan and attendance matrix		
The Committee noted the workplan and the attendance matrix.	Yes	
Any Other Business		
A Non-Executive Director encouraged the members of the meeting to read an article from the Health Service Journal – 'The Trust Rubbish the Accuracy of Vital Covid Vaccination Figures'	N/A	

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

Chair's Assurance Report
Quality and Safety Committee – 14th October 2021

A letter of thanks will be written to the Vaccination Hub.		

3.4 Approvals

Approval Sought	Outcome
Patient Experience Strategy	Approved

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

3.6 Conclusion

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

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

Patient Experience and Complaints Annual Report

Author:	Alison Harper Interim MSK Governance Lead	Paper date:	25 November 2021
Executive Sponsor:	Sara Ellis, Interim Chief Nurse	Paper Category:	Governance and Quality / Performance
Paper Reviewed by:	Quality and Safety Committee – 14.10.21	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

The purpose of this report is to provide the Trust with insight into what patients think about their experience of care received at the RJAH between April 2020 and March 2021.

The annual report was considered and noted at the Quality and Safety Committee on 14th October 2021.

2. Executive Summary

The report outlines the Trust's performance and includes trends and themes arising from formal complaints, PALS concerns and other sources of patient feedback between April 2020 and March 2021.

It provides a valuable insight into how we can improve and design services better improving services. The report outlines the Trust's performance and includes trends and themes arising from formal complaints, PALS concerns and other sources of patient feedback.

The table below shows overall patient feedback received in 2020/21 compared to 2019/20:

Feedback	2020/21	2019/20	Diff from 2020/21 to 2019/20
Complaints	71	112	-41
PALS concerns	201	355	-154
PALS enquiries	2509	1085	1424
Compliments	4937	4996	-59

The overall evidence collected in this report provides assurance that the hospital is delivering services of a high quality in terms of the patient experience that patient has received.

#Caring for Patients
Patient Experience Annual Report
April 20 – March 2021

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Summary	
Highlights of good performance or practice	• Complaints for 2020/21 was 71 and decreased from 2029/20 by 41. • Average number of working days taken to close a complaint was 22 within target and 84% complaints were closed within 25 working days • 9008 patients completed a FFT survey and 98% of patients (inpatients and outpatients) said they would rate their experience as good or very good. • Results from the 2020 inpatient survey show that patients continue to give outstanding patient feedback about the quality of care and experience they have received at the RJAH in line with other years. • Patient Forum members were involved in several Trust activities • 4996 compliments were received across the Trust and patient stories continue to be collected
Areas for Improvement	• PALS enquiries have increased significantly by 1270 compared to 2019/20 which is reflective of the uncertainty for many patients in the current climate with queries about when then can expect to have their treatment. • Ensure 100% of complaints are responded to within 25 days • Ensure 100% of action plans are completed improve effective learning from complaints • 12 complaints were re-opened • FFT- 193 patients during 2020/21 did not rate their experience as good or very good • National Survey, only one question has been identified as requiring improvement Q2, “did you not mind waiting as long as did for admission” which had decreased from 86% in 2019 to 59% in 2020 for patients giving a positive score
Actions being taken	• FAQ updated on website to help inform patient and signpost patient to departments to resolve queries. • SOPS and advice have been provided by the Safe-guarding Lead to help PALS staff respond to PALS enquires for those patients who are anxious whilst waiting for their treatment. • Governance Leads to monitor and document reasons for complaints not being responded to within 25 working days. Unit Managing Directors are involved in signing off complaints. • The insight from negative FFT scores helped develop the quality priorities for 2021/22 looking at improved communication to patients accessing outpatient services including waiting times.

Patient Experience Heat map

	target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Complaints received in month	8	2	7	5	3	2	4	8	10	4	9	7	10
% Complaints Response Rate Within 25 Days (from KPI)	100%	71.4%	50.0%	71.4%	80	100%	100%	100%	83.33%	80.00%	100%	100%	71.43%
avg days to close a complaint	25	28.5	23	24	14	17	20	25	20	17	22.1	25	24
Nos of complaints closed in 25 working days due to close	no target	1	5	4	3	2	3	5	8	3	4	9	5
% Complaints progressed from PALS	no target	50%	29%	60%	33%	0%	25%	25%	20%	25%	22%	71%	30%
Complaints progressed from PALS	no target	1	1	3	1	0	1	2	2	1	2	5	3
Complaint FULLY upheld	no target	0	0	0	0	0	0	1	3	3	3	1	2
Complaint NOT upheld	no target	0	5	2	2	1	2	6	2	1	3	5	6
Complaint PARTIALLY upheld	no target	2	2	3	1	1	2	1	5	0	3	1	2
re-opened complaint	0	0	0	1	1	3	1	2	1	1	1	0	1
Complaints with action plan	100%	100%	86%	40%	33%	100%	25%	13%	90%	33%	22%	43%	60%
Complaints referred to the Ombudsman	0	0	0	0	2	0	0	0	0	0	1	0	0
Local resolutions	no target	1	3	1	1	3	1	3	3	2	6	4	2
PALS concerns	no target	8	23	14	24	19	13	29	17	10	12	9	23
PALS enquries	no target	113	126	181	186	186	211	224	261	204	258	234	325
FFT	95%	99.2%	97.9%	97.4%	97.0%	97.8%	97.3%	97.9%	96.8%	97.5%	97.7%	98.0%	97.9%
Compliments	no target	116	68	97	199	201	594	538	626	643	600	585	670

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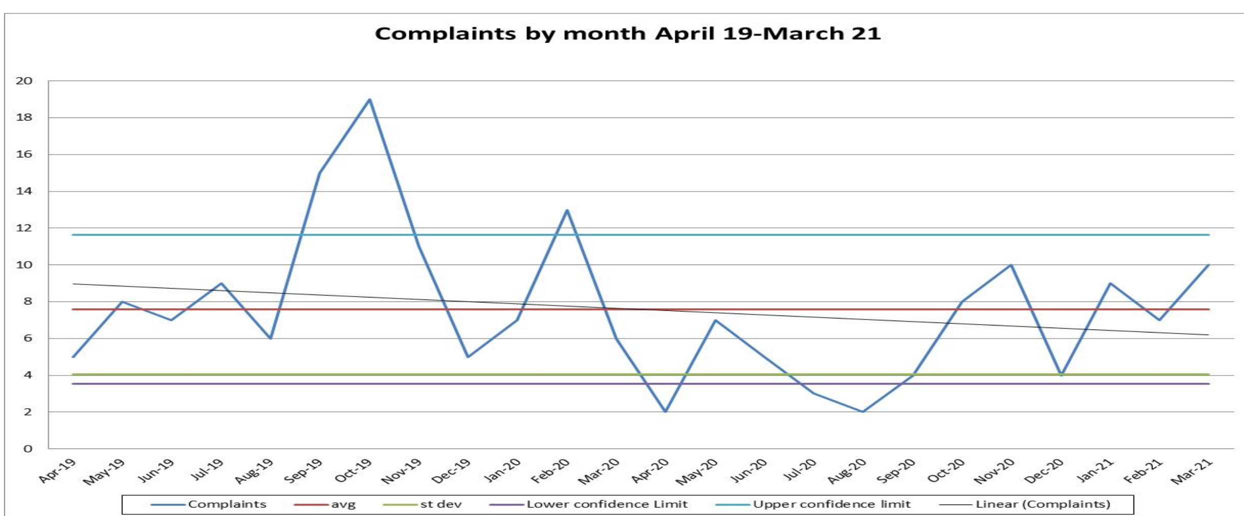
Formal Complaints received

Between April 2020 and March 2021, there were 71 complaints received this was 41 less than the previous year 2019/20.

Complaints have decreased compared to the previous year and one reason for this decrease can be attributable to the pause of elective surgery during several months in 2020/2021 due to the current pandemic.

PALS enquiries have increased significantly which is reflective of the uncertainty for many patients in the current climate with queries about when then can expect to have their treatment. Patients do not want to make a complaint as they understand that the country is in the midst of a pandemic.

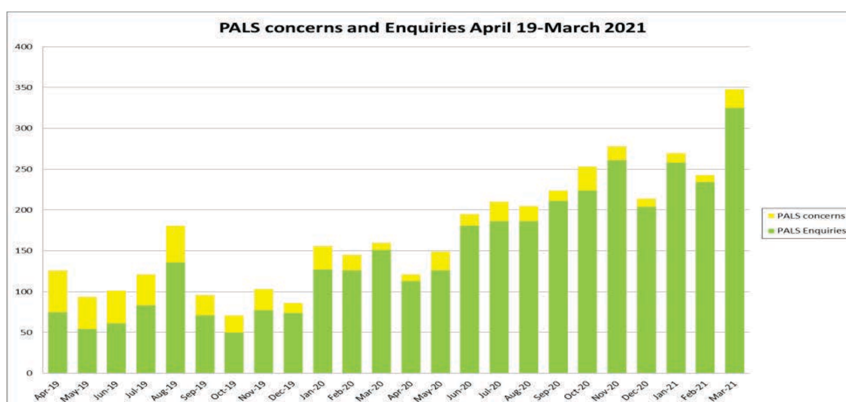
The graph below shows a decreasing trend and little variation of complaints to what is expected. The low number of complaints received in April 2020 is aligned to the start of the pandemic and patients support for the NHS and in August 2020 complaints are also historically low due to the summer holiday period.



Patient Advice and Liaison Service (PALS) contacts

For 2020/21, there were 2710 patients/or relatives contacting PALS, this is a significant increase from 2019/20 (1440) by 1270. This total also includes enquiries from the website. PALS concerns (201) have reduced by 154 compared to 2019/20 (355).

Since the start of the pandemic and resultant pause of elective services for many months, there has been a significant increase in patients enquiring about when their treatment is likely to start or continue whilst PALS concerns have decreased like complaints.



Complaint Performance

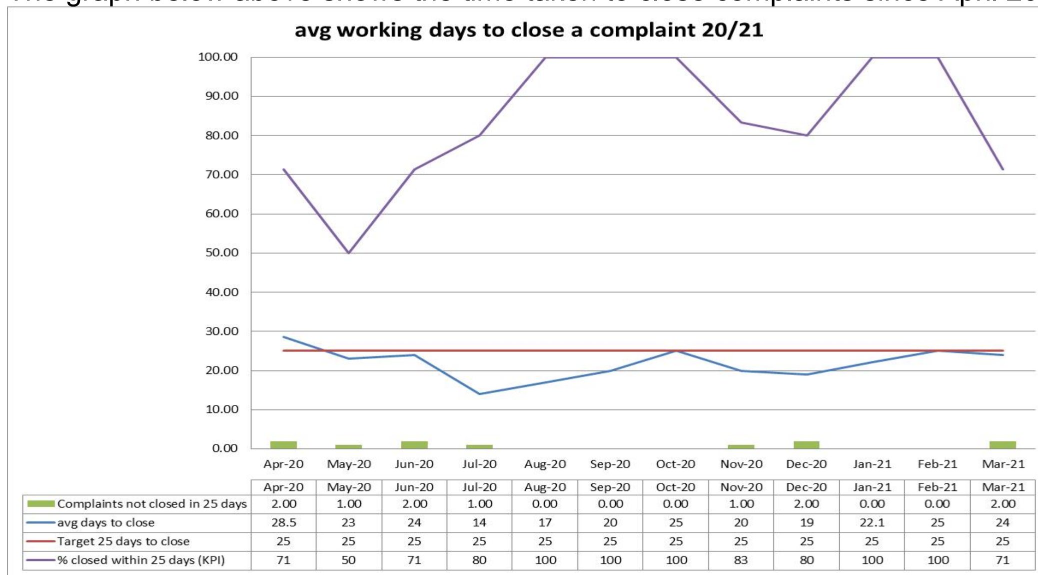
The Trust is required to acknowledge all responses within three working days; this target was met,

The timescale for responding to each complaint can depend upon the nature of the issues raised and the level of investigation required. There is a Trust internal target to resolve complaints within 25 working days and this is extended for complex cases in liaison with the complainant.

In 2020/21

- 100% of complaints were acknowledged in 3 working days.
- The average number of working days taken to close a complaint was 22 which is 3 days less than in 2019/20.
- 84% of complaints were closed within the internal target of 25 working days which is an improvement from 2019/20 which was 60%.
- For those complaints not closed (11) on time, numbers remain low with each month and reasons for delay include Governance staff sickness in first 6 months of the year, complex complaints involving several contributors including complaints across other organisations, approval of final draft.
- 22 complaints progressed from PALS 33%, 14 were initiated by the patient and 8 were initiated by the Trust and 19 were blank.

The graph below above shows the time taken to close complaints since April 2020.

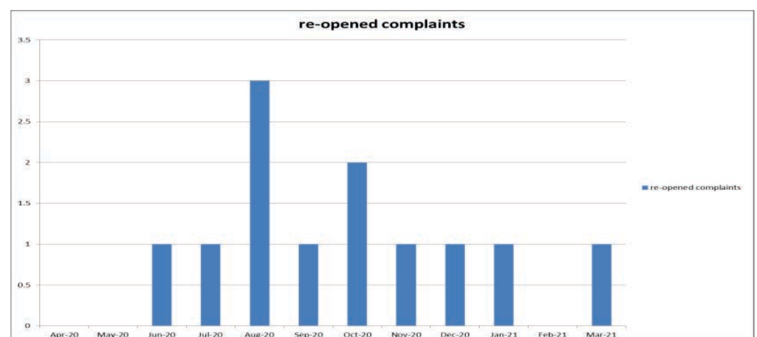


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Complaints not closed in 25 days	2.00	1.00	2.00	1.00	0.00	0.00	0.00	1.00	2.00	0.00	0.00	2.00
avg days to close	28.5	23	24	14	17	20	25	20	19	22.1	25	24
Target 25 days to close	25	25	25	25	25	25	25	25	25	25	25	25
% closed within 25 days (KPI)	71	50	71	80	100	100	100	83	80	100	100	71

Re-opened complaints

In 2020/21, there were 12 re-opened complaints which is consistent to re-opened complaints received in 2019/20 (11). Reasons for re-opened complaints include dissatisfaction with initial reply or further queries raised. See graph of re-opened complaints by month

There were 3 complaints in August 2020, re-opened all asking for more information in complaint: 1 from Gladstone, 1 from pre-op and 1 from Ludlow ward.

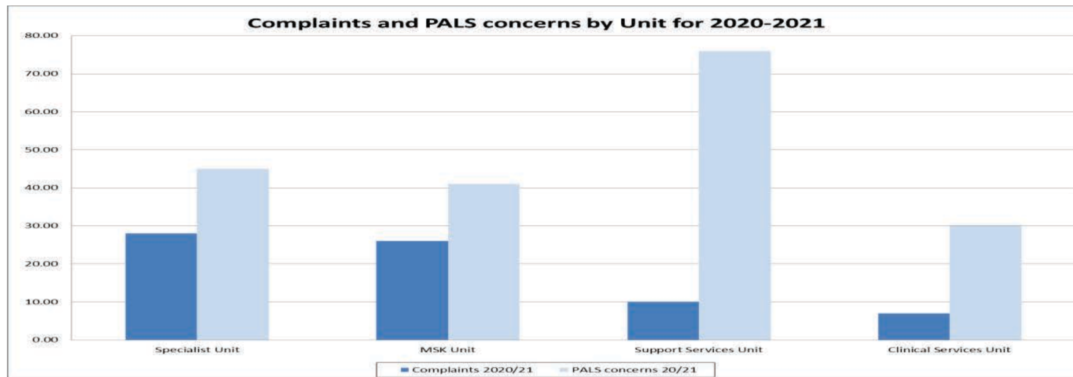


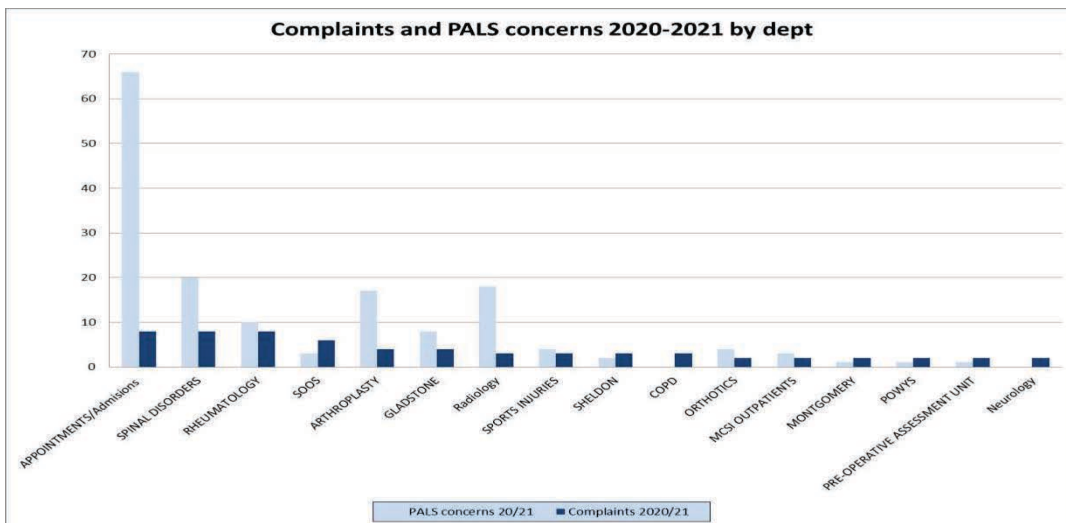
Complaints Upheld

For 2020/21 there were 13 fully upheld complaints, 35 not upheld and 23 partially upheld. (If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld. Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld. 14. If a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld, the complaint should be recorded as partially upheld.

PALS and Complaints by Unit and Department

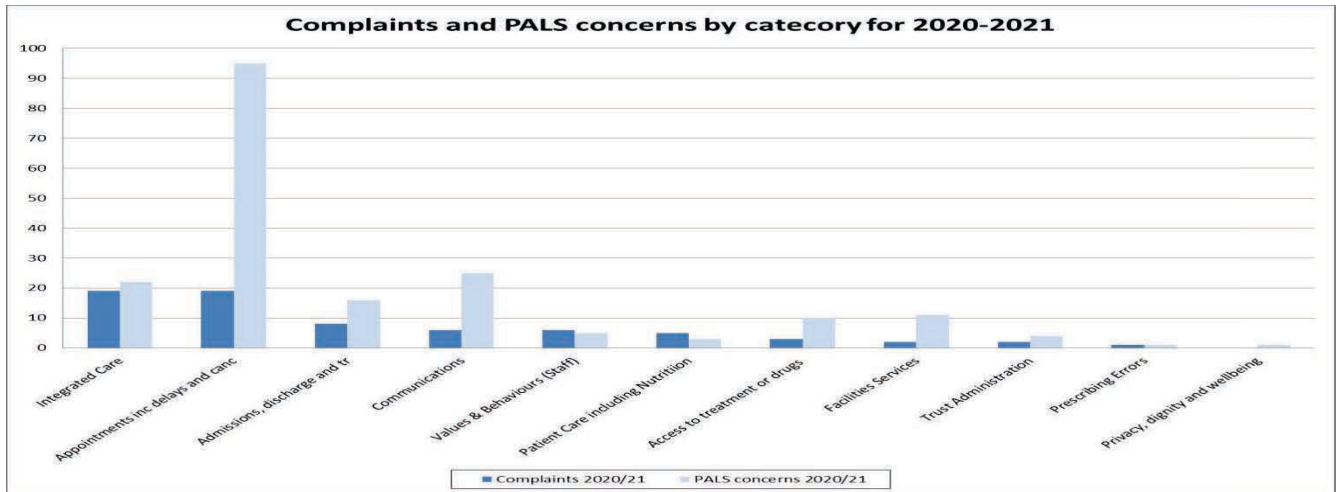
For complaints the Specialist Unit received the most complaints and for PALS, it was the Support Services. Before August 2020, waiting time/admission PALS concerns were recorded under Support Services unit and after that logged under the relevant speciality.





PALS and Complaints by category of contact

The main reason for patients making a complaint was Integrated care and complaints about appointments/cancellations.



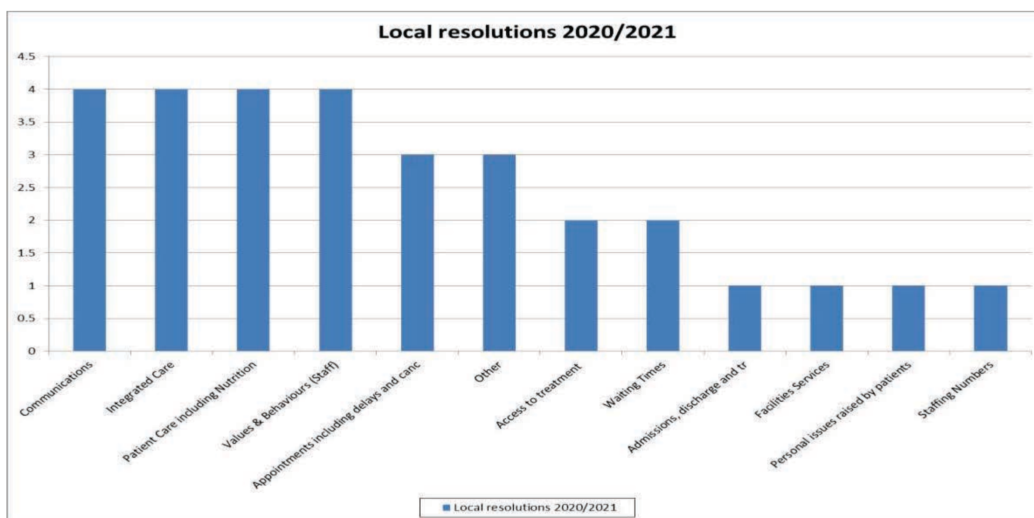
The table below shows complaints/PALS concerns top 5 categories compared to 2019/2020

Complaints on staff attitude and patient care have decreased significantly from 2019/2020

Complaints by catecory	Complaints 2020/21	Complaints 2019/20	Diff	PALS 2020/2021	PALS 2019/2020	Diff
Appointments including delays and canc + waiting times	19	19	0	95	135	-40
Integrated Care	19	15	4	22	0	22
Admissions, discharge and tr	8	6	2	16	28	-12
Communications	6	13	-7	25	47	-22
Values & Behaviours (Staff)	6	26	-20	5	16	-11
Patient Care	5	15	-10	3	60	-57

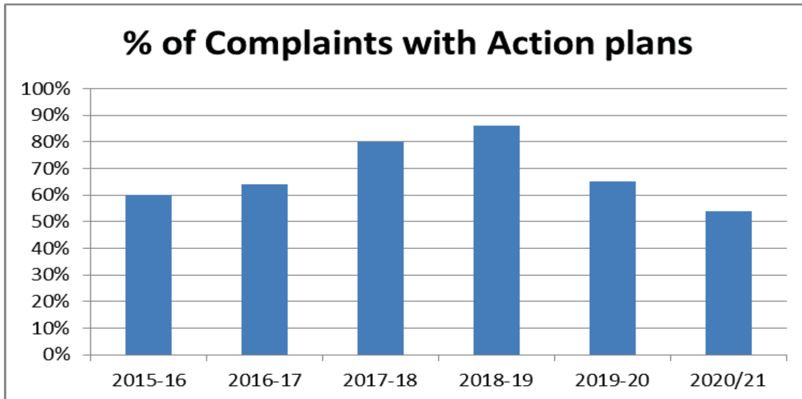
Locally resolved issues

There were 30 local resolutions recorded for 2020/21, 1 more than the previous year. These are concerns resolved by ward or department staff.



Learning from Complaints/PALS concerns

The Trust recognises the opportunity patient feedback provides to identify areas for improvement and it is for this reason it committed to increasing the percentage of complaints with resultant action plans. Only 54% of complaints, 36 had an action plan, this has reduced from last year due to a higher percentage of complaint being received about waiting times/treatment dates with no learning identified.



Please see below some examples of actions following a complaint/or PALS concern:

PALS: Outpatients Mum of a patient raised a concern about the language used in a patient leaflet for patients with "special needs".
Outcome.
Leaflet updated and website based on recommendations for suggested language. Mum invited to join leaflet editorial panel

or concern;
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PALS: Xray: Patient raised several concerns with car parking page on website not up to date and did not sate to take card payment, patients were not socially distant in waiting area and chairs not sanitised between users.
Outcome: PALS replied. Website was updated, seats are wiped down on regular basis and patients are advised to sit socially distant in waiting areas.

Complaint: SOOS Several issues raised with communication to arrange an appointment and lack of succession management for new Clinician.
Outcome:
Website and appointment letters updated with correct contact details, telephone number and email. Explanation of recruitment in progress and interim use of bank/fixed term hours

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

There were 3 cases received from the Ombudsman.

- July 2020 – regarding a complaint from 2019, (CRP0719-02) about a patient who had complications following their spinal surgery in 2015, 2017 and 2019 and PHSO are looking into the care received from April 2019 - Sept 2019. The PHSO have reviewed the complaint in November 2020 and decided to take no further action.

- July 2020, 1 regarding a PALS concern from Dec 2019 about a patient's treatment for spinal surgery from May 2019 in relation to back pain and proposed surgery. The PHSO were sent the information requested and no further contact.
- Jan 2021 regarding a complaint CRP 1019-01, from October 2019, delay to paediatric patient getting a formal diagnosis for their back pain. The PHSO were sent the information requested and no further contact.

Collecting Patient feedback: Friends and Family Test (FFT)

The FFT question "Overall, how was your experience of our service" was updated nationally in April 2020 and was designed to be a quick and simple mechanism for patients and other people who use NHS services to give their feedback. The collection of FFT data was paused nationally from April 2020- November 2020 due to the Covid-19 pandemic.

FFT data is collected in real time using the IQVIA patient feedback system and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment). From December 2020 further departments were added to the SMS texting process to cover most wards and clinics. The use of paper surveys and iPads to collect the data was discouraged during the pandemic due to Infection control reasons.

For 2020/21, 9008 patients completed a FFT survey and 98% of patients (inpatients and outpatients) said they would rate their experience as good or very good.

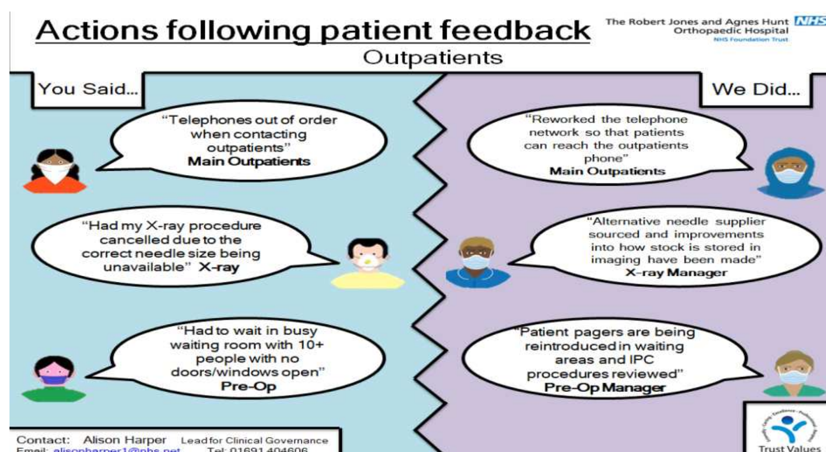
The results for the Trust over the last five years are as follows based on the average percentage of FFT score.

	2016/17	2017/18	2018/19	2019/20	2020/21
National Average	96%	96%	96%	96%	95%*
Highest Score	100%	100%	100%	100%	100%*
Lowest Score	75%	64%	76%	73%	41%*
Robert Jones and Agnes Hunt	100%	99%	99%	99%	98%

* National data for Dec 20-Feb 21)

Listening to Patients and Carers feedback

The Trust is committed to improving the percentage of patients who would rate their experience as good or very good and and recognise that there is always room to improve our patient's perception of their experience. Staff are sent an email alert as soon as a FFT low score is received as feedback is immediately uploaded and available for staff to respond and action for their department in IQVIA. The suggestions for improvements or negative comments are shared with the relevant clinical areas to ensure that any areas for improvement can be addressed.



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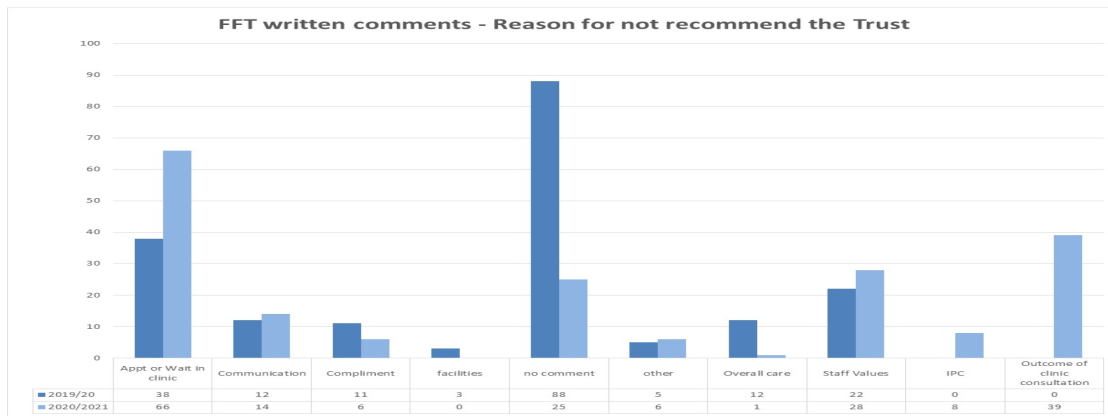
For the patients (193) who did not rate their care as good or very good, the top theme from the comments was waiting time in clinic. This insight helped develop the quality priorities for 2021/22 looking at improved communication to patients accessing outpatient services including waiting times.

See graph below of themes for negative FFT scores:



Patients are also asked several other questions as part of the FFT survey and the results by question are shown in the below heat maps:

Inpatients 01/04/20 - 31/03/21

Ward/Clinic	Surveys	Overall experience of the service?	Ward was clean?	Staff welcoming and friendly?	Staff caring and compassionate?	Privacy/dignity protected?	Acceptable night noise levels?	Good hand hygiene?	Did you like the food provided?	Admission date changed?	Support from staff after discharge?	Involved in decisions in your care?	**Total**
Baschurch	618	98	99	99	99	99	98	99	94	91	95	95	**97**
Clwyd	101	99	100	99	99	99	83	99	89	84	92	96	**94**
Gladstone	100	91	96	96	93	96	78	98	82	91	85	79	**89**
Kenyon	42	97	98	98	98	99	77	100	87	89	85	88	**92**
Ludlow	47	99	100	100	99	100	91	99	92	91	98	97	**97**
Oswald	94	97	99	98	97	98	95	99	90	91	92	93	**95**
Powys	68	99	98	99	99	100	83	99	85	87	95	93	**94**
Recovery	1	100	100	100	100	100	100	100	100	66	100	50	**92**
Wrekin	47	98	99	96	96	100	89	97	85	96	90	93	**94**
Overall	**1118**	**97**	**98**	**91**	**99**	**99**	**89**	**99**	**99**	**90**	**93**	**93**	**95**

Outpatients 01/04/20 - 31/03/21

Ward/Clinic	Surveys	Overall experience of the service?	Ward was clean?	Staff welcoming and friendly?	Staff caring and compassionate?	Privacy/dignity protected?	HCP explain procedure?	informed on waiting times?	HCP introduce themselves?	HCP listen to you?	**Total**
Main Outpatients	6042	96	99	98	98	99	98	83	97	99	**96**
MCSI Outpatients	129	97	99	99	99	99	99	94	98	99	**98**
Montgomery	182	99	99	99	99	99	99	89	100	100	**98**
MRI	1	50	100	50	75	75	75	75	100	100	**78**
Pre-Op	1027	95	99	98	98	99	98	79	99	100	**96**
SOOS - non-RJAH	4	94	100	94	94	100	100	94	100	100	**97**
SOOS - RJAH	301	96	97	96	97	99	98	73	98	99	**95**
Overall	**7687**	**96**	**99**	**98**	**98**	**99**	**98**	**83**	**97**	**99**	**96**

National Inpatient Survey 2020 results

The NHS Adult Inpatient Survey runs every year, and all NHS Trusts in England are required to conduct the survey. The Picker Institute carries out the survey on behalf of the RJAH.

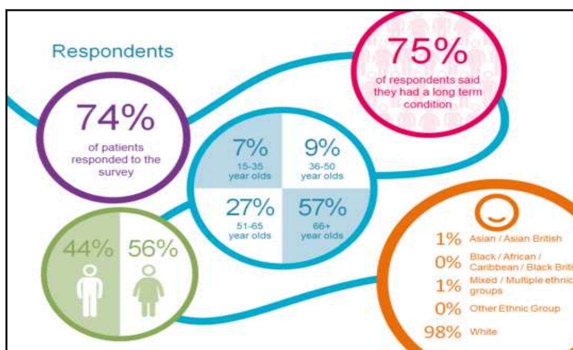
At the time of writing this report the CQC have not published the national results so the results in the report are using comparisons with Trusts (75) who use Picker.

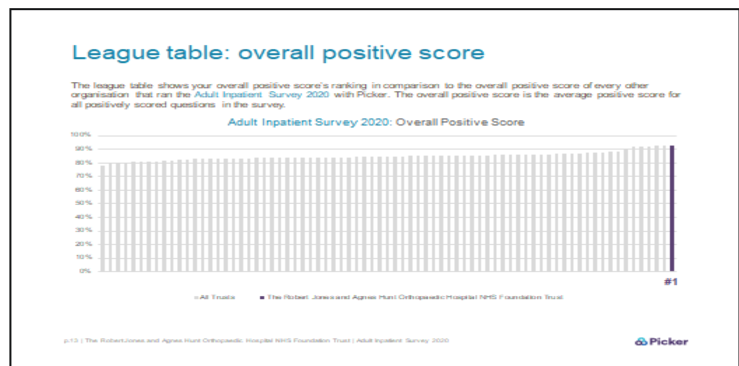
For RJAH a total of 1,250 patients were asked to complete the survey and 74% of patients returned the survey (910).

- The sampling instruction was discharges between 30th November 2020 to July 2020.
- A total of 57 questions were asked and 25 can be compared to the 2019 survey. The questionnaire was re-evaluated to reduce its length and ensure the content remained in line with current policy and practice.
- The survey mode changed from paper only to mixed mode of paper/online survey.
- Demographic data was also collected – see background of patients of patients completing the survey:

2020 results to celebrate!

Results from the 2020 survey show that patients continue to give outstanding patient feedback about the quality of care and experience they have received at the RJAH in line with other years.
For those Trusts (75) that used Picker, the RJAH was ranked top for patients rating their overall experience.





Highest scoring questions, 100% or 99%

Hospital: Room or ward very or clean – 100%
Hospital: Got enough help from staff to wash or keep clean – 99%
Hospital: Got enough to drink – 99%
Doctors: Doctors answered questions clearly – 99%
Doctors: Had confidence and trust in the doctors – 100%
Doctors: Doctors included patient in conversation – 99%
Nurses: Nurses answered questions clearly – 100%
Nurses: Had confidence and trust in the nurses – 100%
Nurses: Nurses included patient in conversation – 99%
Nurses Always or sometimes enough nurses on duty – 99%
Care & Treatment: Felt able to discuss worries and fears with staff – 99%
Care & Treatment: Given enough privacy when being examined or treated – 100%
Care & Treatment: Staff helped control pain – 100%

Care & Treatment: Staff helped when needed attention – 100%
Overall: Treated with respect and dignity overall – 100%

Comparisons with last year's survey from 2020 to 2019

5 questions improved their score from 2019:

Most improved scores	Trust 2020	Trust 2019
Q10. Able to take own medication when needed to	94%	87%
Q38. Given written/printed information about what they should or should not do after leaving hospital	90%	84%
Q44. Got enough support from health or social care professionals after discharge	85%	80%
Q12. Food was very good or fairly good	90%	87%
Q40. Knew what would happen next with care after leaving hospital	96%	93%

Action Plan for questions requiring improvement:

From the Picker results only one question has been identified as requiring managing closely and requiring improvement Q2, "did you not mind waiting as long as did for admission" which had decreased from 86% in 2019 to 59% in 2020 for patients giving a positive core

Patient Panel Forum

The Trust has an active Patient Panel (PP) forum which works in partnership with our patients, staff and stakeholders to develop concepts and models of co-production to ensure services are patient cantered. PP members comprise of Healthwatch Shropshire, Shropshire Patient Group, Powys Community Health Council, Trust Governors, League of Friends, Rheumatology Association, Shropshire Council Carers, Shropshire CCG, current and previous patients and staff representation.

Even though the PP face to face meetings have been paused during the COVID-19 pandemic, members have been involved with reviewing patient leaflets, staff recruitment stakeholder panel, judges for the staff celebration awards, attending the accessible care group, the patient experience committee, patient stories, outpatient improvement work.

Patient Stories and Patient Comments

The Trust regularly listens to patient stories and the Board welcomes hearing about both positive and negative experiences to help us re-design and improve services according to patients' varying needs. Sharing any lessons learnt through positive stories is valuable way of promoting good practice and to take forward suggestions for improvement with Clinical teams.

Covid-19 has brought challenges with presenting patient stories at Board due to the meetings being held virtually so the Trust introduced videoing patient stories to ensure the patient voice can still be heard by the Board.

Three patient stories have been shared at the Trust Board meeting between April 2020-March 2021 with actions identified for improvement as below:

- Following a patient having wrist surgery as a day case patient in March 2020 improvements have been made on keeping patients better informed about waiting times in the Baschurch Unit. As wells staff offering patients a bed to wait if one is available rather than the waiting room if the wait is causing them concern.

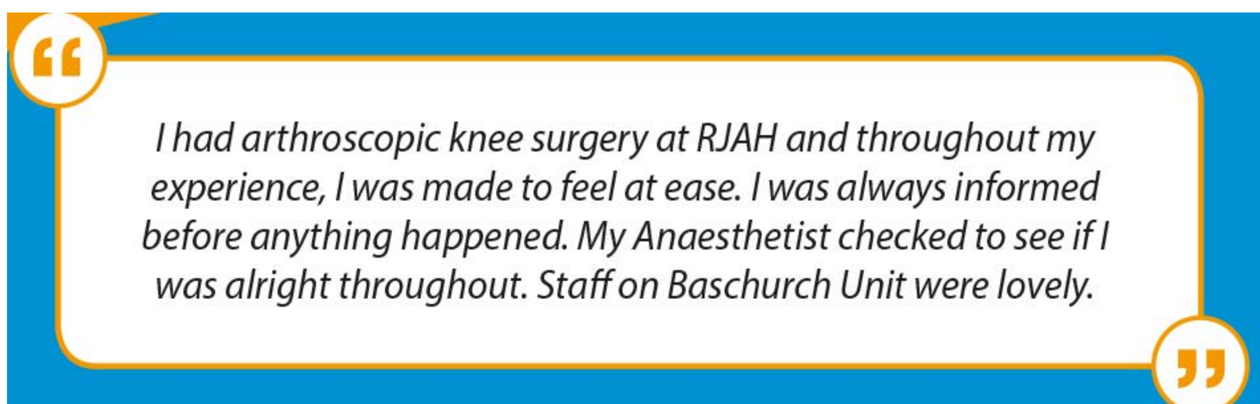
- A digital patient story was shared at the January 2021 Trust Board meeting from a hand trauma patient who had two operations. The patient was happy with their overall care and improvements have been made to the COVID screening processes to reduce staff handling of paper questionnaires as well as a fast-track process for low-risk patients on a green pathway.

- A patient story was shared at the March 2021 Trust Board meeting from a patient who had spinal surgery in November 2020.They reported on the little things that make a big difference including staff going the extra mile and friendly staff. The patient felt that there was not much we could improve on apart from more signage to advise patients that assistance was available if the walk from the main entrance to Menzies was causing difficulties. A poster has since gone up to advise this

The Trust also collects patient comments and narratives from many mediums including the NHS choices website, the Meridian feedback system, compliments letters and social media received via twitter and face book. These are shared with the clinical teams and any suggestions for improvement are followed up by the Governance team.

During 2020/21,

- There were 4996 compliments received across the departments
- 4 Comments were posted on the NHS website, all compliments.



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Health and Safety Annual Report

0. Reference Information

Author:	Ian Gingell, Health and Safety Advisor	Paper date:	25 November 2021
Executive Sponsor:	Sara Ellis Anderson, Interim Chief Nurse	Paper Category:	Strategy / Governance
Paper Reviewed by:	Quality and Safety Committee – 14.10.2021	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. This paper presents the Trust's position on health and safety and is for information purposes. The Trust Board is asked to note the Trust's position.
The annual report was considered and noted at the Quality and Safety Committee on 14th October 2021 before onward presentation at the Board.

2. Executive Summary

2.1. Context

- This paper highlights the health and safety aspects of risk management undertaken within the Trust during the period April 1st 2020 to 31st March 2021.
- The report covers DATIX incident data on health and safety related incidents during 2020/21.
- The report is not an audit of all the Trust's health and safety systems and it does not seek to provide assurance on all health and safety duties that relate to the work activities of the Trust.
- The Trust aims to comply with its statutory duties in relation to health and safety at work and to minimise its losses due to risks encountered during operational activities

2.2. Summary

- COVID-19 impacted significantly on health and safety workload
- Upward trend in RIDDOR reportable incidents to the Health and Safety Executive
- Health and Safety Committee terms of reference were reviewed
- Substantial compliance achieved with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013

2.3. Conclusion

The Trust Board is asked to note the Trust's Annual Health and Safety Report

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

3. Health and Safety Annual Report

3.1 Introduction

The Health & Safety Executive (HSE) has memoranda of understanding with other regulatory bodies including the Care Quality Commission, General Medical Council and the Nursing and Midwifery Council, which set out roles and responsibilities and clarifies which regulator is likely to act in the event of a patient or member of staff suffering serious harm/death.

The HSE focus their investigations on systemic failure of management systems, which may include:

- Systemic failures to comply with statutory health and safety duties.
- The absence of or wholly inadequate arrangements for assessing risks to health and safety.
- Lack of suitable controls and inadequate monitoring and maintenance of the procedures or equipment needed to control the risks, resulting in serious harm or death.

The HSE may, dependant on the circumstances, investigate RIDDOR reportable incidents which include some needlestick injuries, work related injuries and serious injuries or ill-health caused by hazardous substances.

3.2 Health and Safety Arrangements

The Trust has a clearly defined structure for health and safety reporting:

The Chief Nurse retained Board-level responsibility for health and safety, with the Health and Safety Committee being chaired by the Director of Estates and Facilities. The Trust employed a 0.4 WTE Health and Safety Advisor to assist with compliance with the requirements of section 7(1) of the Management of Health and Safety Regulations 1999.

3.3 Fee for Intervention (FFI)

A fee for intervention is charged if the HSE identify a material breach of health and safety law. A material breach is something which an inspector considers serious enough that they need to formally write to the Trust requiring action to be taken to rectify the breach. The fee is currently £157 an hour (increasing to £160 in 2021/22) and the total charge will include the costs covering the HSE inspector's time during inspections, preparing reports, obtaining specialist advice and any costs associated with formal enforcement or prosecutions.

The Trust did not incur any fee for intervention costs in 2020/21

3.4 Health and Safety Management Systems

Organisations have a legal duty to put in place suitable arrangements to manage for health and safety.

The Health and Safety Executive provide a framework in the form of the document 'Managing for Health and Safety' (HSG65). This framework outlines the management arrangements and systems that organisations should have in place to manage their health and safety risks in a proactive manner. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

The ongoing response to the COVID-19 pandemic placed significant pressure on the Trust's health and safety resource and led to a mostly reactive approach, following ever-changing national guidance. It was challenging to adhere to the HSG65 Plan, Do, Check, Act model, particularly in the early stages of the pandemic response, however a summary of the activities related to the model are detailed below.

PLAN

The Health and Safety Committee continued to meet bi-monthly throughout the pandemic and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations,1977.

A Health and Safety Working Group, chaired by the Health and Safety Advisor, was established with a remit to manage operational level safety issues and to improve the safety culture of the Trust.

The Trust employed a 0.4 WTE Health and Safety Advisor to undertake the role of Competent Person as required by the Management of Health and Safety Regulations 1999. The provision was temporarily increased to 0.8 WTE for 6 months to assist with the pandemic response. The Health and Safety Advisor provision also incorporates the roles of Central Alerting System Liaison Officer and Medical Devices Safety Officer.

DO

COVID-19 specific risk assessments were carried out for all members of staff and all working areas.

The Health and Safety Committee met bi-monthly during 2020/21 and has monitored health and safety incidents, RIDDOR reported incidents, safety alerts and legislation changes.

The Health and Safety policy sets out the organisational duties of Trust employees and details the arrangements required to assist in the implementation of the health and safety policy.

Health and safety risk assessments were recorded in DATIX Risk module and monitored in accordance with the Trust's Risk Management Strategy.

The Health and Safety Working Group led on resolving operational level health and safety issues.

CHECK

Due to COVID-19 restrictions, health and safety inspections by Staffside union safety representatives were not able to be carried out.

COVID-19 risk assessment compliance audits and regular site walkarounds were carried out to ensure that social distancing was being maintained and national guidance adhered to.

The Trust has a comprehensive incident reporting system in operation. The DATIX database is utilised to record all staff, patient and visitor health and safety related incidents. Fire, security and violence and aggression incidents are reported to the health and safety committee via regular Estates reports.

The charts below show the number of DATIX health and safety incidents reported by sub-category during 2020/21.

ACT

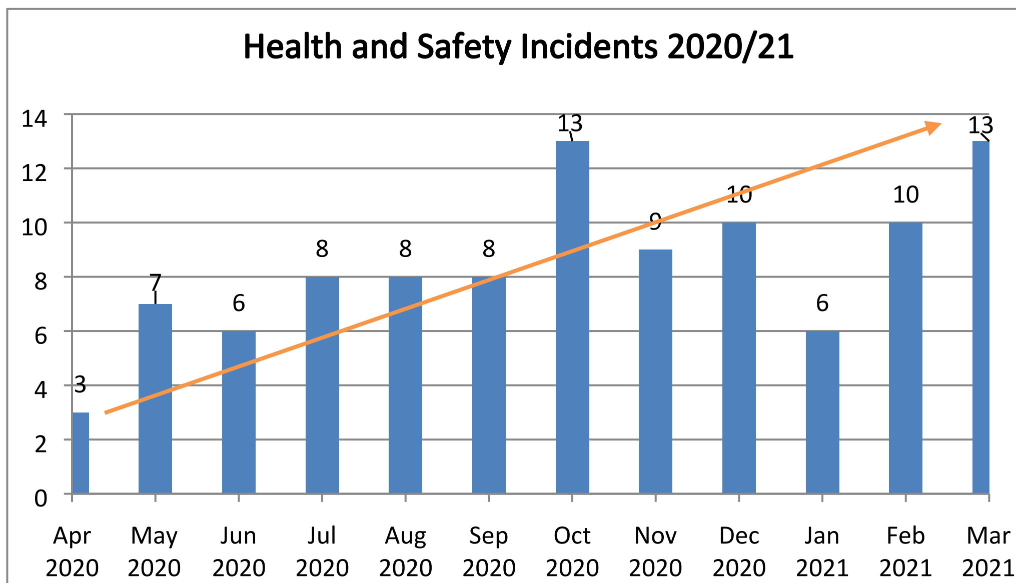
Non-compliance with COVID-19 requirements relating to social distancing were addressed when identified during audits and walkarounds.

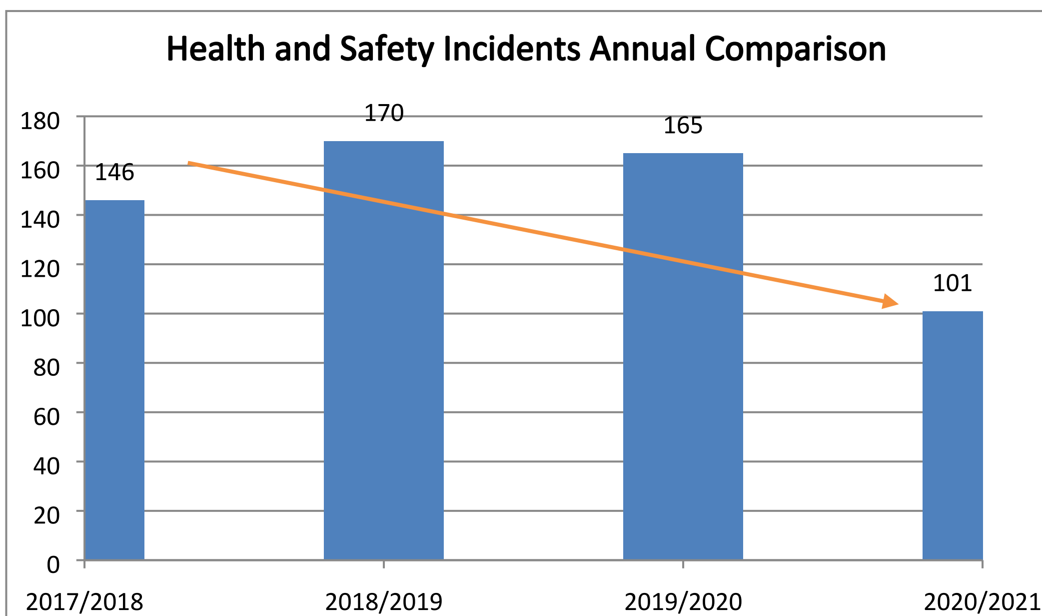
Incidents reported to the Health and Safety Executive as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) were jointly investigated by the Health and Safety Advisor and Staffside Union Safety Representatives.

Non-compliances relating to safer sharps were actively addressed by the Health and Safety Working Group.

3.5 DATIX Incident Reporting (Trends and Analysis)

A total of 101 health and safety incidents were reported during the 2020-21 financial year.



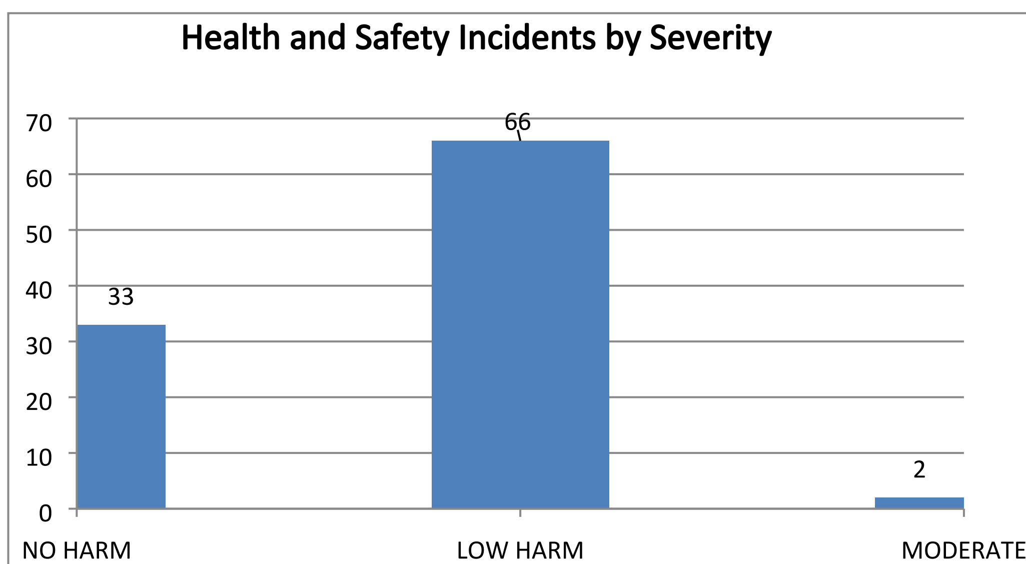


The reduction in health and safety incidents must be viewed in the context of significantly reduced activity due to the ongoing pandemic.

The top 5 sub-categories related to health and safety are shown in the table below:

Category	Number of Incidents
Near Miss - Safety	13
Contact with a sharp surface/object	10
Manual Handling	8
Staff slips or trips	7
Contact with hot liquid	7

Severity of incidents



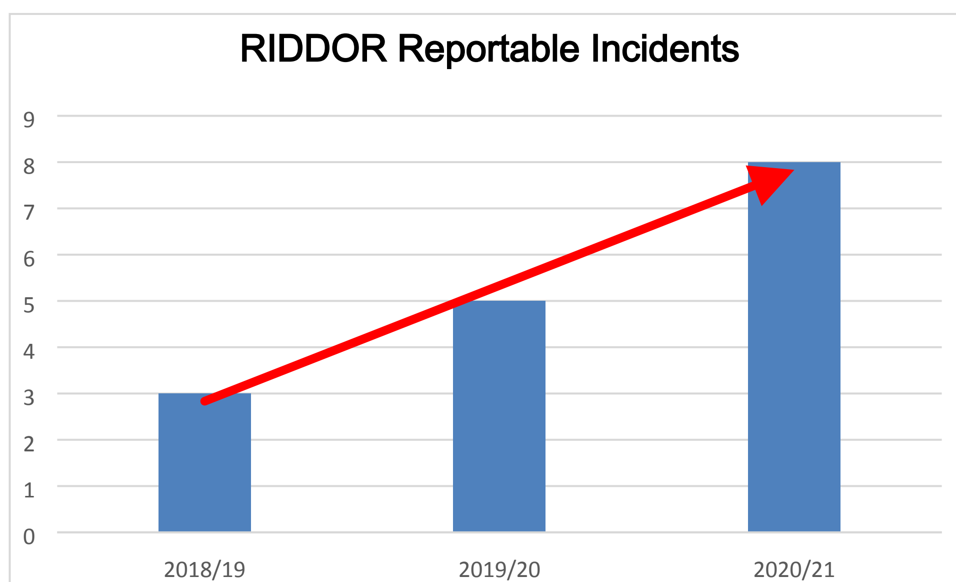
3.6 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

The Health and Safety Advisor ensured that any incident meeting the criteria of the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2015 (RIDDOR) was appropriately reported to the Health and Safety Executive (HSE). It must be noted however that there was no process in place to ensure the reporting requirement was met during periods when the Health and Safety advisor was absent due to leave or outside of the Advisor's 0.4 WTE working hours.

There were eight RIDDOR reportable incidents in 2020/21, six of which resulted in staff sickness absence of more than seven days. Two reports were as a result of COVID-19 outbreaks on wards. No enforcement action was taken as a result of the incidents.

3.6.1 RIDDOR Trend Analysis

There are a relatively low number of RIDDOR reportable incidents in the Trust, but there is a clear upward trend which may be indicative of the current level of health and safety resource.



If the COVID-19 outbreaks are excluded, Slips, trips and falls have accounted for the majority of RIDDOR incidents this financial year. A number of serious injuries have been sustained by staff including a fractured elbow, a fractured shoulder and a significant head injury.

All incidents have involved members of staff, no patients, visitors or other site users have been injured.

All of the incidents were recorded on DATIX and investigated by the Health and Safety Advisor in conjunction with Staffside Safety Representatives in accordance with the Safety Representatives and Safety Committees Regulations 1977.

Estates and Facilities have taken action to mitigate the effects of adverse weather with the following:

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

- Formalised the gritting/snow clearing contractor arrangements;
- Implemented the use of 'man-down' alarms for lone working Estates staff;
- Introduced an Estates and Facilities 'adverse weather' procedure;
- Reviewed the winter personal protective equipment provided to Estates staff, including trialling anti-slip boot covers;
- Placed orders for improved gritting equipment for use Trust staff ;
- Reviewed the response to medical emergency calls.

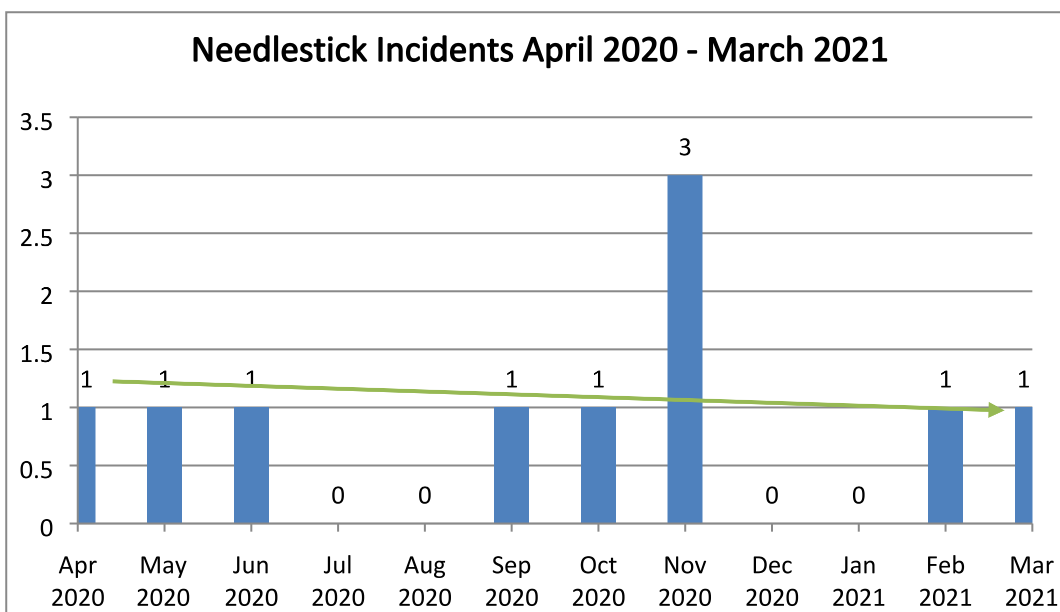
Further work is planned to improve slips, trips and falls awareness across the site.

3.7 Safer sharps

Following a review by the Health and Safety Advisor, it was recognised that the Trust was non-compliant with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013. There were a range of sharp instruments in use around the Trust where safer alternative devices may have been more appropriate.

A safer sharps working group was established and a sharps management procedure was approved. The pandemic response workload pressures delayed efforts to return the Trust to full compliance in a timely manner, but by year-end substantial compliance had been achieved.

Needlestick injuries remain at a low level and work is ongoing to ensure that safer sharps become the default devices of choice wherever reasonably practicable.



3.8 Health and Safety Committee

The terms of reference were reviewed to better reflect the assurance and escalation purpose of the Committee. A Health and Safety Working Group was established to manage operational level issues. The membership of the Committee was refreshed with the Chair being transferred from the Chief Nurse to the Director of Estates and Facilities.

The Health and Safety Committee met bi-monthly and included health and safety representatives from staffside unions in compliance with the Safety Representatives and Safety Committees Regulations,1977.

Health and Safety Committee Attendance 2020/21					
	May 2020	July 2020	Sep 2020	Dec 2020	Feb 2021
Chair/Deputy Chair	✓	✓	✓	✓	✓
Health and Safety Advisor	✓	✓	✓	✓	✓
Governance Representation	✓	✓	X	X	X
Estates/Facilities Representation	✓	✓	✓	✓	X
Clinical Representation	X	✓	✓	✓	✓
People Services /Training Business Partner	✓	✓	✓	✓	✓
Staffside Representation	✓	✓	✓	✓	✓
Manual Handling Coordinator	X	X	✓	✓	✓
Quorate	✓	✓	✓	✓	✓

3.9 Central Alerting System Safety Alerts

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Alerts that are distributed include Estates Safety Alerts, Chief Medical Officer Messages, MHRA Drug Alerts, and Medical Device Alerts.

The Health and Safety Advisor undertakes the role of CAS Liaison Officer and Medical Devices Safety Officer within the 0.4 WTE provision and is responsible for overall management of the CAS process. The pandemic response led to alerts being received out of normal core hours and assistance in administering the alerts was received from the COVID-19 mailbox team. The Divisional Governance Lead (Surgery & Theatres) gave valuable assistance in administering safety alerts throughout the year, allowing the Health and Safety Advisor to perform other essential duties.

Progress towards completion of alert actions was monitored by relevant Committees and overall progress was monitored by the Health and Safety Committee. A formal process has been developed and Executive approval is sought before the Health and Safety Advisor formally signs alerts off via the web portal.

The Trust received a total of 135 safety alerts through CAS in 2020/21, all of which were actioned within their respective deadlines.

A significant number of Field Safety Notices (FSN) were also received, these were sent either directly to the Trust by manufacturers or suppliers or by NHS Supply Chain and are not captured through the central alerting system.

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

The Medical Devices Safety Officer manages the distribution of FSNs and monitors action completion. All required actions were taken, and confirmation returned to manufacturers where requested.

3.10 Estates Premises Assurance Model (PAM)

The NHS Constitution contains two pledges that relate to the premises in which healthcare is delivered:

- Services are provided in clean and safe environments that are fit for purpose, based on national best practice.
- Continuous improvement in the quality of services users receive, identifying and sharing best practice in quality of care and treatments.

The NHS Premises Assurance Model (PAM) identifies those areas of premises where the NHS Constitution needs to be considered and where assurance is required. Changes to the national reporting requirements for PAM audits required current data to be submitted before the usual PAM annual assessment date and resulted in a requirement to complete a high level half yearly interim PAM audit.

With Covid pressures affecting the ratings, a true reflection of progress could not be ascertained. Some areas, such as patient experience, were fundamentally affected by the requirement to adjust working practices, thereby disproportionately affecting results and penalising the Trust within the revised scoring mechanism.

One domain has been downgraded to requires minimal improvement, ‘Lifts, Hoists and Conveyance Systems’, which was downgraded as the Trust does not currently comply with the requirement have an Authorising Engineer; the risk was mitigated however by a third party accredited Inspector.

An action plan has been created to address all issues. This is being undertaken by relevant parties and audited through the Health and Safety Working Group and Committee.

It is considered that the PAM process has led to significant improvements in health and safety in the Estates and Facilities department and all services that they provide to the Trust.

3.11 COVID-19

The Health and Safety Advisor worked closely with colleagues in Infection Prevention & Control and Estates and Facilities departments to advise and support on the response to the rapidly developing pandemic.

A large-scale face-fit testing programme was rapidly introduced to ensure that all at-risk staff were correctly fitted for close-fitting FFP3 protective facemasks. Over 1000 face fit tests were completed by the end of March with an ongoing process, supported by a Department of Health team, in place to ensure that all relevant staff would be tested.

The Health and Safety Advisor also assisted the implementation of lateral flow test kit distribution to all staff and supported the project team with the establishment of the RJAH vaccination centre.

4.0 Conclusion

The Committee is asked to note the content of the annual report.

Appendix 1: Acronyms

CAS	Central Alerting System
HSE	Health and Safety Executive
PAM	Premises Assurance Model
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Chair's Assurance Report
People Committee – 7th October 2021

0. Reference Information

Author:	Mary Bardsley Assistant Trust Secretary	Paper date:	25 November 2021
Executive Sponsor:	Paul Kingston, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the People Committee on 7th October 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the oversight of the Trust's system of internal control to the People Committee. This Committee is responsible for seeking assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. It seeks these assurances in order that, in turn, it may provide appropriate assurance to the Board.

2.2 Summary

- The meeting was well attended and noted as quorate
- The members of the meeting discussed the way forward for the freedom to speak up initiative
- An update was received on the Trusts' Consultant recruitment plans
- The Committee were informed of the increased patient contact which will be jointly monitored by the Quality and Safety Committee
- The Committee received the standard agenda items, Performance Report and Board Assurance Framework for consideration and approval before onward presentation at the Board
- Chair's assurance reports were provided

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 7th October 2021. The meeting was quorate with 3 Non-Executive Director and 5 Senior Leaders in attendance. The full list of attendees is listed below:

Attendance:	
Paul Kingston	Non-Executive Director (Chair)
Harry Turner	Non-Executive Director
Chris Beacock	Non-Executive Director
Hilary Pepler	Trust Board Advisor
Sarah Sheppard	Chief People Officer
Stacey-Lea Keegan	Interim CEO
Kerry Robinson	Chief Performance Improvement and OD Officer
Ruth Longfellow	Chief Medical Officer
Sara Ellis Anderson	Chief Nurse and Patient Safety Officer
Shelley Ramtuhul	Trust Secretary
Sue Pryce	Head of People Services
Liz Hammond	Freedom to Speak Up Guardian
Alex Yashchik	Consultant Anaesthetist and Wellbeing Guardian
Sarah Thomas	Learning & Development Manager
David Low	Improvement and OD Manager
Donna St John	MSK Unit Matron
Jo Banks	MSK Unit Managing Director
Rob Freeman	Consultant Orthopaedic Surgeon
Amber Scott	Minute Secretary
Apologies:	
None	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declarations of Interest		
None to note	N/A	
Freedom to Speak Up (verbal)		
The Committee noted the report. It was noted more work is to be completed to support the freedom to speak up process and service. The Committee were assured a plan was in place to address the gaps and improve the current service.	Partial	People Committee to receive a monthly update on the service and monitor the process as well as review the policy
Performance Report		
The Committee noted the performance report. Assurance was requested on length of visa the new recruits have and whether this will become an issue soon for	Yes	

retaining them. Although the visa is limited, there are no foreseen issues with these being extended, also adding that this is a process that is the same across all job roles, and that People Services are confident in the process with no issues arising to date.		
Deep Dive Update		
The Committee noted the update. The deep dives will be incorporated into the People workplan. The Committee welcomed for the first report.	Yes	
Board Assurance Framework		
The Committee approved the framework – no concerns have been raised	Yes	
Consultant Recruitment Plan		
The Committee noted the recruitment plan and agreed for a presentation to be given to Board next month.	Yes	
Doctor Wellbeing Audit		
The Committee noted the audit and requested information as to if the report has been aligned to the GMC guidance.	Yes	
Increase in patient telephone calls (verbal)		
A verbal update was received by the Committee with an assurance paper being provided to the Quality and Safety Committee this month. There has been an increased number of incidents recorded relating to distressed patients telephoning staff. Further training is being provided to support staff.	Yes	Awaiting the assurance report to be presented to the QS Committee.
Nursing workforce update		
The Committee noted the report. The Committee were assured with the detailed report.	Yes	
Training MCSI progress report		
The Committee noted the progress report. The business case for the cleanliness technician has been approved however this requires further approval from the system. An update was provided on the 2 actions which had not yet commenced due to the Trust waiting for external information.	Yes	
System People Plan and Action Plan		
The Committee noted the plan and action plan. Concerns were raised in relation to no planned completion dates being recorded. It was suggested that the document is aligned to the BAF. The Committee agreed for an assurance column to be incorporated within future reports.	Yes	An assurance column to be incorporated into the action plan.
Uniform Policy		
The Committee approved the policy. It was suggested that one policy per quarter was audited and reviewed by the aligned Committee.	Yes	
Professional Learning and Development or CPD Policy		
The Committee approved the policy. A review of the policy has been requested in approx. 2 months due to the noted simplification of the document.	Yes	
Chair Reports		
Staff Experience Committee The Committee noted the Chair's report.	Yes	
Trust Performance and Operational Committee The Committee noted the Chair's report.	Yes	

Chair's Assurance Report
People Committee – 7th October 2021

ED&I Committee The Committee noted the Chair's report.	Yes	
Staff Survey (to note)		
The Committee noted the survey.		
Risk Register (to note)		
The Committee noted the register.		
Committee workplan (to note)		
The Committee noted the workplan.		
Any Other Business		
The Committee a review on the dates recorded on the Committee workplan/board portal and diary invites	N/A	

3.4 Approvals

Approval Sought	Outcome
Professional Learning and Development or CPD Policy. Uniform Policy	Approved Approved

3.5 Risks to be Escalated

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

3.6 Conclusion

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

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