The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 29.04.2021

MEETING
29 April 2021 09:30

PUBLISHED
28 April 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	29/04/21		09:30

1. Part One - Public Meeting		
1.1. Minutes of the Previous Meeting	Chair	09:30
1.2. Matters Arising	Chair	
1.3. Declarations of Interest	Chair	
1.4. Civility and Behaviours in Theatre's Presentation	Chief Medical Officer	09:35
1.5. Professor Richardson Memorial Garden Film	Chief Executive	09:50
2. Chief Executive Update (verbal)	Chief Executive	09:55
3. Quality & Safety		
3.1. Chair Report: Quality and Safety Committee	Non Executive Director	10:05
3.2. Learning From Deaths	Chief Medical Officer	10:10
3.3. Infection Control Report	Chief Nurse	10:15
4. People Update		
4.1. Chair Report: People Committee	Non Executive Director	10:20
4.2. Guardian of Safe Working	Chief Medical Officer	10:25

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams	29/04/21		09:30
5. Performance & Governance			
5.1. Chair Report: Risk Management Committee		Non Executive Director	10:30
5.2. Chair Report: Finance, Planning and Digital Committee		Non Executive Director	10:35
5.3. Performance Report M12		Chief Performance, Improvement and OD Office	10:40
5.4. Board Assurance Framework and Corporate Objectives		Trust Secretary	10:50
5.5. Governors Update (verbal)		Trust Secretary	10:55
6. To Note			
6.1. Chair Report: Quality and Safety Committee March			
6.2. Chair Report: Finance, Planning and Digital Committee March			
6.3. Chair Report: Extra Ordinary People Committee March			
7. Any Other Business		All	11:00
7.1. Questions from the Public			
8. Next meeting: 27th May 2021			

Contents

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC BOARD
25 MARCH 2021

MINUTES OF MEETING

Present:

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

In Attendance:

Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Chief of People	SS
Hilary Pepler	Board Adviser	HP
Nia Jones	Managing Director for Specialist Services	NJ
Laura Peill	Managing Director for Support Services	LP
Jo Banks	Managing Director for Clinical Support Services	JB
Richard Potter	Clinical Chair for MSK	RP
Ruth Longfellow	Associate Medical Director	RL

FC welcomed everyone to the meeting and in particular RL who will shortly be joining the Board as Chief Medical Officer

FC commented on SW's retirement at the end of the month the virtual farewell held a few days ago. FC acknowledged SW's exemplary tenure as Medical Director / Chief Medical Officer and wished to place on record his thanks for his commitment to the role. The Board wished SW all the very best for his retirement. SW commented that his role as Medical Director has been a great experience for him watching the Trust improve and progress.

FC also welcomed Mr Dheerendra, Clinical Lead for Spinal Disorders, who was observing the meeting and presenting later in the agenda.

MINUTE NO	TITLE
25/03/1.0	**APOLOGIES** David Gilburt, Non-Executive Director
25/03/2.0	**MINUTES OF PREVIOUS MEETING** The minutes of the previous meeting were accepted as an accurate record of the meeting held subject to the following amendment: Page 5 the reference to students taking on substantive roles should be third year students not first year students.
25/03/3.0	**MATTERS ARISING** None
25/03/4.0	**DECLARATIONS OF INTEREST**

	FC confirmed that Vernacare Group Ltd, a company that he Chairs, has acquired Robinsons Healthcare Ltd who manufacture and supply medical devices and consumables to NHS hospitals, other NHS and social care centres. FC confirmed that in the unlikely event there were discussions or decisions involving this company he would appropriately withdraw. The Board ***noted*** the declaration of interest.
25/03/5.0	**PATIENT STORY – MRS ELIZABETH WEDLEY** SLK introduced the story of Mrs Wedley who has been treated under the Spinal Team at the Trust. Mrs Wedley provided the Board with the following outline of her experience: • She had woken up one morning in pain and attended Wrexham Maelor Hospital. • She was transferred to the care of Mr Munigangaiah, Consultant Spinal Surgeon and a degenerative disc disease was diagnosed. • Her surgery was postponed due to pandemic when the Trust took on trauma work and this had an effect on her mental and physical health and she went back to the Trust and was kept in for longer to control the pain. • She reached out again to the Trust and surgery was scheduled for November. • Following the surgery she had a little infection which was treated by the Trust and three months down the line she is back to work and pain free. • She made observation about the paperwork being passed around the hospital • She also commented on the distance that she had to walk to and from the Orthotics porta cabin due to the one way entry and exit system in the hospital. She felt that whilst this was not a big deal for her it could be to someone else. FC commented on the emotional and mental wellbeing side of her condition and invited comments from the Board. CB recalled the issue of paperwork being passed around from a previous patient story and sought assurance that this has been dealt with. SLK confirmed that improvements have been made with the screening process and paperwork and that both patient stories were from about the same time and therefore pre-dated these improvements. FC asked SLK to extend the Board's thanks to the patient. The Board ***noted*** the patient story.
25/03/6.0	**CHIEF EXECUTIVE UPDATE** MB provided an update on the following: • MB extended his thanks to SW for the support he has given to both him and the team. He wished SW and his family a long, happy and fruitful retirement • The final cohort of staff are being welcomed back to the Trust from SaTH, MB reminded the Board that a good number of staff have been over in SaTH since January providing them with support. MB thanked staff for the support they have provided to SaTH but also thanked those who have been doing different jobs in the organisation or perhaps have not changed jobs and have kept doing what they do. This has been a challenging time for staff and they have shown resilience and commitment. • The Covid position locally is much improved and it is important that the Trust continues to play its part. The Trust is starting to welcome visitors back and MB confirmed he was grateful to Board members and governors for staying away from the site. It is important to take all measures to continue to prevent infection. • MB highlighted that attentions have turned to restarting services and the Trust is beginning to do that in order to return to more normal methods of operating. MB

	confirmed there is still 2-4 weeks of work to do and that alongside this opportunities for improvement are being worked in as well as the different ways in which the ongoing impact of Covid on the ways of working. The Trust is also beginning to look at the recovery stage. Historically, waiting times have been managed by treating patients in date order, however, clinical prioritisation is now the key with clinicians having to clinically assess all patients to ensure those most clinically urgent are treated first. The Trust is one of the top performers in that work and this work will continue. This is, however, challenging because the Trust's systems and processes are designed to prevent waiting and these therefore have to be adapted. • MB commented on the privilege he had last week of watching Mr Balain, Consultant Spinal Surgeon, undertaking an endoscopic spinal procedure to remove part of her disc. This was fascinating to watch and what was obvious was that the procedure was more complex due to the time that she had been waiting. This will be a consideration for the Trust going forward and how the outcomes delivered for patients will be impacted. It also links back to the patient story. • The Trust is looking at what world class patient communication looks like to ensure patients are kept informed and supported whilst they are waiting. • The Trust's improvement work has not stopped and the outpatient flow is currently being looked at. • MB was grateful to Stuart Hay, Consultant Surgeon, on the work he has done to enable the Trust to offer 8 medical students a 4th year placement in June and July. • The work on an electronic patient record work is underway and is an exciting development for the Trust. • The planning application for the Veteran's Centre has been submitted. • A Vaccine Centre has been set up on the Trust's site at the request of the wider system. The small unit has seen over 25,000 patients and has supported almost all staff to be vaccinated. The unit is now working through second doses. MB commented that this was a team of all talents with the HR team supporting the recruitment and senior consultants working in the centre. • Rebecca Warren, was the Health Hero for the month following nominations received from patients. FC commented that Rebecca Warren and her colleagues should be invited to attend the Board to share their experience. **ACTION: Vaccination Centre staff to be invited to share their experience with the Board** The Board ***noted*** the update.
25/03/7.0	**ICS DEVELOPMENT UPDATE** MB presented an update on the ICS Development and confirmed the following: • ST&W approved as an integrated care system, this is subject to the white paper becoming a bill. • A new organisation will be formed April 2022 overseen by an NHS organisation and Health and Care Partnership Board. • MB is currently the interim CEO Lead for the system which is working to deliver what is needed. • It is expected that the bill will passed over the summer with some more guidance on process issued in the autumn. • It is recognised that this is a difficult time for colleagues in the CCG which will cease next year as a result of the changes. FC commented on the importance of representation in the system but recognised the additional pressures this brings. He is chairing the ICS Financial Sustainability Committee

	which is focussing on stabilising system finances over the next 12 months and then bringing about financial balance in the subsequent years. The Board ***noted*** the update.
25/03/8.0	**CHAIR'S REPORT QUALITY AND SAFETY COMMITTEE** CB presented a verbal Chair's Report and highlighted the following: • The meeting was well attended and quorate. • The agenda is presented due to meeting only taking place seven days earlier. • The Committee spent time considering serious incident investigations and in particular the process for disseminating learning from this. • The management of patients waiting was considered with a focus on harms reviews. There is not yet clear line of sight on how many have been conducted or the outcomes so this is work in progress and therefore only partial assurance was gained. • There was one unexpected death noted and this will be covered later in the meeting. The Board ***noted*** the report.
25/03/9.0	**NHS FOOD REPORT** LP introduced Sara Ellis-Anderson (SE) as Chair of the Nutrition and Hydration Group and Sian Langford (SL), Deputy Facilities Manager. SE highlighted that the Trust has a good track record on the quality of its food and this is reflected in the CQC's findings and the Inpatient Survey. Consequently, the Trust has been asked to participate in the exemplar programme being run by NHS England. SE introduced a video that Pru Leith, Advisor for Improving Hospital Food, had prepared for the Trust. Pru Leith's video highlighted the following: • Eight recommendations have been made with regard to improving hospital food • The Governance has approved these recommendations and allocated funding to support the work • Congratulations were extended to the Trust for coming top in the country for its catering standards for 14 out of the last 15 years • The Trust is an exemplar hospital committed to helping others improve standards of catering. FC commented on signposting for Trusts interested in our work and confirmed that a link will be shared relating to a press release. **ACTION: Link for press release to be shared** SE advised the Board that the recommendations are yet to be published for hospitals but are understood to focus on areas such as the communication of allergens, the monitoring of nutritionally vulnerable patients. A checklist has been devised for catering managers and SE handed over to SL to talk through this: SL highlighted the following: • The Nutrition and Hydration Group has undertaken a gap analysis and can demonstrate compliance with 16/18 actions. • This reinforces the Trusts place as an exemplar. • There are eight areas of further work, some of these will be relatively quick to implement such as including updates on the Board agenda and supplier visits but others will require a little bit of development work. Examples given were extending the out of hours menu and communal dining for patients.

	• The Nutrition and Hydration Group will use this gap analysis as a road map for full compliance. FC congratulated the team for their work and noted that this area of success could be easily taken for granted as the Trust has always performed so well but it is important to work on maintaining and improving the standards. The Board ***noted*** the report.
25/03/10.0	**STAFF SURVEY** SS presented an overview of the staff survey results and highlighted the following: • The survey took place in the autumn during a really challenging time. • 57% of staff responded. • In the context of when the survey took place the results are encouraging. • A strong improvement can be seen in managers taking an interest in health and wellbeing and relationships with immediate managers and morale of staff has also improved. • There is a small deterioration in some areas and areas of focus are being discussed with managers. • There are challenges around engagement and communication with senior managers and there is further work being undertaken to understand what this means. • The paper sets out a new approach to previous years and thanks to David Low, Improvement and Organisational Development Manager and Sue Pryce, Head of People Services for their work on this. • The paper sets out the Trust's story, what it will do and continue to do so that progress can be seen and measured. • The work will complement the work already being undertaken on the people plan and will be a regular item at the People Committee. HT commented on the impressive results and the fact that making any comparisons to previous years is challenging due to the impact of Covid and the new management structure. He asked whether any benchmarking work had been undertaken and SS explained the difficulties with this due to last year being so unusual. SS confirmed that the team are working with information colleagues and triangulating the information with other data available so it is not a case of looking at the staff survey in isolation. There continues to be a focus on health and wellbeing and staff are feeling better looked after as the importance of this across the NHS has been well recognised due to recent events. FC considered that the benchmarking will be possible at some point when things settle but until then it will be an apple and pear comparison. CB commented on the great results but questions whether conclusions can be drawn from such small changes without any statistical analysis as there is potential for natural variation. FC agreed and SS confirmed that the other information available suggests that small but steady improvement is being made and therefore these are not looked at in isolation. The staff survey is one of several indicators but it shows positive rather than negative movement. MB commented that given the last year a set of results which were broadly similar to previous years should be seen as positive. He recognised that there are one or two of the specific areas that need further understanding and focus on the detail of what these questions mean. There remains a huge expectation on staff in terms of the level of recovery and are already dealing with upset patients who have been waiting a long time and there therefore needs to be continued support for staff.

	FC agreed regarding the challenges ahead and the leadership needed to navigate these. The Board ***noted*** the report.
25/03/11.0	**CHAIR'S REPORT FOR POLICY COMMITTEE** SR presented the Chair's Report for Policy Committee in the absence of David Gilburt. SR highlighted the policies that had been approved. FC asked about the continuation of the Policy Committee and PK confirmed that the Committee is starting to refer the policies to the other committees to restore business as usual around the management of policies. It was felt that the Committee could be removed in 3-4 months time. FC agreed that it had been established to address the backlog and this should be reviewed in the future. **ACTION: Review of Policy Committee in 3 months time** The Board ***noted*** the report.
25/03/12.0	**CHAIR'S REPORT FOR FINANCE PLANNING AND DIGITAL COMMITTEE** RH presented a verbal Chair's Report and highlighted the following: • The Committee received the Veterans' Centre business case which was well written and approved on behalf of the Board. The next step is to go to the System for review. The Committee asked for a check point after the first phase. • The Committee received the Performance Report and note that KR is going to make some revisions to the way performance is monitored next year. It was recognised that, along with most other Trusts, the Trust is not going to achieve the standard targets. • A briefing was received from the Restoration Committee. • The Financial Planning Report was received and considered and whilst assurance could be provided on the process it was too early to provide assurance on the actual numbers. • The Committee received an update on EPR procurement and is expecting a full business case in September. It was recognised that System socialisation was required between now and then The Board ***noted*** the report.
25/03/13.0	**CHAIR'S REPORT FOR RISK MANAGEMENT COMMITTEE** CB invited questions on the Chair's Report and the Board confirmed there were no questions. The Board ***noted*** the report.
25/03/14.0	**STRATEGY BOARD UPDATE** KR presented a summary of the Board Strategy session which took place in February and highlighted the following: • The overarching theme of the discussion was around caring for staff as the Trust recovers and renews and this was looked at in context of staff absence and vacancy rates • The complexity of patients and the impact of this on services was considered • There was extensive debate around the restart work and the Board went through numerous models and looked at the sustainable state. • Workforce modelling was presented and considered. • It was agreed that work needed was needed on the strategic case to look at workforce and a sustainable model. The Board ***noted*** the summary.

25/03/15.0	**PERFORMANCE REPORT MONTH 11** KR highlighted the changes to the performance report to reflect the current environment and confirmed that this will launch in April and be presented in May. KR also highlighted that elective care for month 11 was significantly reduced due to the mutual aid being offered to SaTH meaning the Trust is only operating on Priority 2 patients. *Caring for Staff* SS highlighted the following: • Sickness absence has not increased. There is still a lot of work ongoing to support staff and the levels of absence are encouraging. FC asked if there were still hotspots being looked at and SS confirmed that the team continue to keep a close eye on the detailed data to address any hotspots. *Caring for Patients* SLK highlighted the following: There was one serious incident reported in February which related to a patient who deteriorated during surgery and required transfer out. The investigation is currently ongoing although some immediate improvement actions have been taken and Quality and Safety Committee will be presented with the report. SW highlighted the following: There was one unexpected death in February which related to rehabilitation patient transferred to the Trust following surgery for a severe spinal injury. The patient was found unresponsive and despite resuscitation died. The case was referred to the Coroner due to the unexpected nature of the death however no lapses in care have been identified. The Quality and Safety Committee were fully briefed and a further update briefing was provided to the Chair of the committee. JB highlighted the following: • Five out of six cancer targets were met for January (reported one month in arrears); the 62 day target was missed and has been reported through Quality and Safety Committee. • The 18 week wait target was below target at 54.53%, this is a further deterioration due to the pause on P3 and P4 elective operating with P2 patients continuing to be prioritised. The clinical prioritisation is being done for the system and reviewed weekly. • Over 52 week English waiters have increased to 1334, an increase of 358 since January. This is expected to continue to grow based on planned activity. This was discussed in the Restoration Committee and the Trust continues to prioritise the most urgent patients i.e. patients who clinically need to be seen within 4 weeks. The current clearance rate for these patients is 3.4 weeks which is a favourable picture across the region. • Over 52 week Welsh waiters have increased to 798. • For all over 52 week waiters the Trust continues to work on validating patients and assessing any potential for patient harm. • With regard to diagnostic targets the English 6 week waits and Welsh 8 week waits continue to be below target at 83.3% for English patients and 94% for Welsh patients but improvement is being seen. The Trust is back to the level of performance seen in September and there is an action plan for further improvement. • Activity was less than plan at 26% of pre-Covid levels of activity and continues into March at lower levels. • Bed occupancy was down at 63.7% and Powys and Kenyon wards remain closed. • Outpatient activity for February was at 77.15% of 2019/20 levels which was an improvement to the previous month. • The DNA rate was high at 6.34% but has reduced since the previous month.

	• Elective spells were forecast at 34% of pre-Covid levels for March but delivery is at 50%. Outpatients are forecast at 68% of adjusted activity levels, 94% of actual March 2020 levels. Diagnostics activity is at 79% adjusted for MRI, 73% for CT and 73% for Ultrasound, all above March 2020 levels. MB commented that the plan was set on a number of assumptions and did not include the number of staff that were sent to SaTH and the second pause in elective activity. Taking this into account the Trust has done well in terms of what it has been able to deliver. It would be good to show this in the review of the year at the next Board. FC agreed it would be good to have that contextual statement around why February dipped by comparison to January. FC commented that the reclamation of the pre-Covid position is going to be a long and challenging time for all organisations. *Caring for Finances* CM highlighted the following: • February was a good financial month and there continues to be protection from the interim funding programme so currently there is no negative impact. • The financial position includes a partial repayment to Wales • A break even position is required and the Trust is currently on track to deliver this. FC confirmed the Board is aware of the financial envelope the Trust is operating within The Board ***noted*** the report.
25/03/17.0	**SPINAL DISORDERS GIRFT REVIEW** Mr Dheerendra, Clinical Lead for Spinal Disorders attended the Board to present an overview of the recent GIRFT review of Spinal Disorders. Mr Dheerendra highlighted the following: • An overview of a number of exciting projects the Spinal Disorders Unit are pursuing such as further work on paediatric spinal disorders and day case surgery. • A history of the unit. • Introduction to the team. • An overview of some of the complex work they do • Examples of how they are leading the way with spinal surgery • National comparisons which show high performance • Good Friends and Family Test results • The challenges on the unit such as the emergency on call service and the impact of this on surgery cancellations and waiting times • With regard to waiting times there are a number of initiatives underway such as looking at the allocation of work, new roles. • Leading the way in governance with 100% compliance with the Spinal Registry • Engagement with the Clinical Effectiveness Committee • 100% of cases passing through the MDT for scrutiny and consensus • An overview of research and education in the unit. FC noted the recommendations from GIRFT acknowledge the good work but there are one or two areas of improvement which are not overly concerning and don't require material changes. CB was encouraged by the work of the unit and was particularly interested in the detailed outcome measures. He asked if there were plans to share that outcome data more widely with the organisation and patients. Mr Dheerendra explained that the Spinal Registry has only been running for the last seven years and they are seeking the release of the data with a view to obtaining Trust level data for the Chief Medical Officer.

	MB commented that excellent services have excellent leadership and he referenced Mr Dheerendra's leadership since taking over the unit. PK commented on the recruitment requirements and how the People Committee can support this. Mr Dheerendra confirmed that there is a business case for recruitment in progress and the plan is to have a least one tumour nurse and two specialist spinal nurses, he felt this would help work to improve the length of stay for patients and he welcomed the People Committee's support with this plan. The Board ***noted*** the presentation.
25/03/18.0	**BOARD ASSURANCE FRAMEWORK** SR presented the Board Assurance Framework and highlighted the changes that had been made since its last presentation the Board; these were noted in blue in the report for ease of reference. The Board ***noted*** the Board Assurance Framework.
25/03/19.0	**CORPORATE OBJECTIVES 2021/22** SR presented the Corporate Objectives which had been approved by the Senior Leadership Group and circulated to Board members for comment. SR confirmed that if approved would commence to align the Board Assurance Framework to these new objectives. The Board ***approved*** the Corporate Objectives.
25/03/19.0	**BOARD WORK PLAN** The Board received and ***approved*** the work plan for 2021/22.
25/03/20.0	**OCKENDON REPORT** MB advised the paper highlights some of the themes of the review that will be put on the agendas of the next People and Quality and Safety Committees. The Board ***noted*** the report.
25/03/21.0	**GOVERNORS UPDATE** SR confirmed that there were still restriction on the Governors attending site but the Trust is looking at ways this can be done remotely. The Governor Elections will commence shortly and further detail of these will be provided at the Council of Governors. The Trust will shortly be embarking on recruitment of a new Non-Executive Director which will require the involvement of the Governors. The Board noted the update.
25/03/22.0	**ITEMS TO NOTE** The Board was presented with written reports of the Quality and Safety Committee, People Committee and the Finance, Planning and Digital Committee in relation to meetings held in February as there had not been opportunity to present the reports since the meetings had taken place. The Board ***noted*** the reports.
25/03/23.0	**QUESTIONS FROM THE PUBLIC** None
	DATE OF NEXT MEETING IN PUBLIC: Thursday 29 April 2021 9.30 via Teams
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

25 MARCH 2021

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	**Lead Responsibility**	**Progress**
28/01/13.0 GUARDIAN OF SAFE WORKING HOURS Invite Rob Banerjee and a Registrar to a future Board	Trust Secretary	Invitation issued for May Board
Actions from Last Meeting	**Lead Responsibility**	**Progress**
25/03/6.0 CHIEF EXECUTIVE UPDATE Vaccination Centre staff to be invited to share their experience with the Board	Trust Secretary	Planned for May Board
25/03/9.0 NHS FOOD REPORT Link for press release to be shared	Communications Team	Completed
25/03/11.0 CHAIR'S REPORT FOR POLICY COMMITTEE Review of Policy Committee in 3 months time	Trust Secretary	Scheduled for July 2021

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

Human Factors: why is civility important?

Dr Sophie Shapter
Consultant Anaesthetist & Lead for Human Factors
April 2021




Why is civility important?

Civil work environments matter because they reduce errors, reduce stress and foster excellence.

NHS

The NHS Long Term Plan

NHS

WE ARE THE NHS:
People Plan 2020/21 -

NHS

Supporting our staff

A toolkit to promote cultures of civility and respect

Cost implications

£2.3 billion/yr cost to NHS (Kline & Lewis 2018)

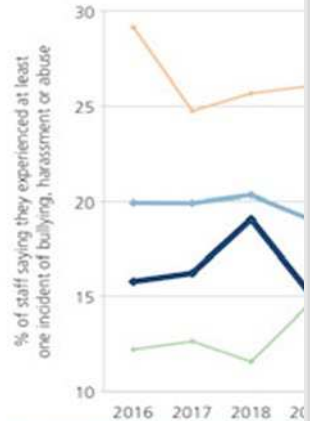
- sickness absence
- covering sickness
- employee turnover
- reduced productivity
- compensation & litigation

NHS Staff Survey

Survey Coordination Centre

Q13a

In the last 12 months h
times have you personally
harassment, bullying or at
from patients / service u
relatives or other members



Worst	29.2%	24.8%	25.7%	26
Your org	15.8%	16.2%	19.1%	15
Average	19.9%	19.9%	20.3%	19
Best	12.2%	12.6%	11.6%	14

2020 NHS Staff Survey Results > Theme results > Detailed

Survey Coordination Centre

2020 NHS Staff Survey Results > Question results > Your job
> Q4j > I receive the respect I deserve from my colleagues at work

NHS England

	2018	2019	2020
Best	77.9%	76.3%	75.9%
Your org	70.9%	73.5%	72.7%
Average	73.7%	73.6%	72.4%
Worst	69.6%	69.3%	68.4%
Responses	656	947	894

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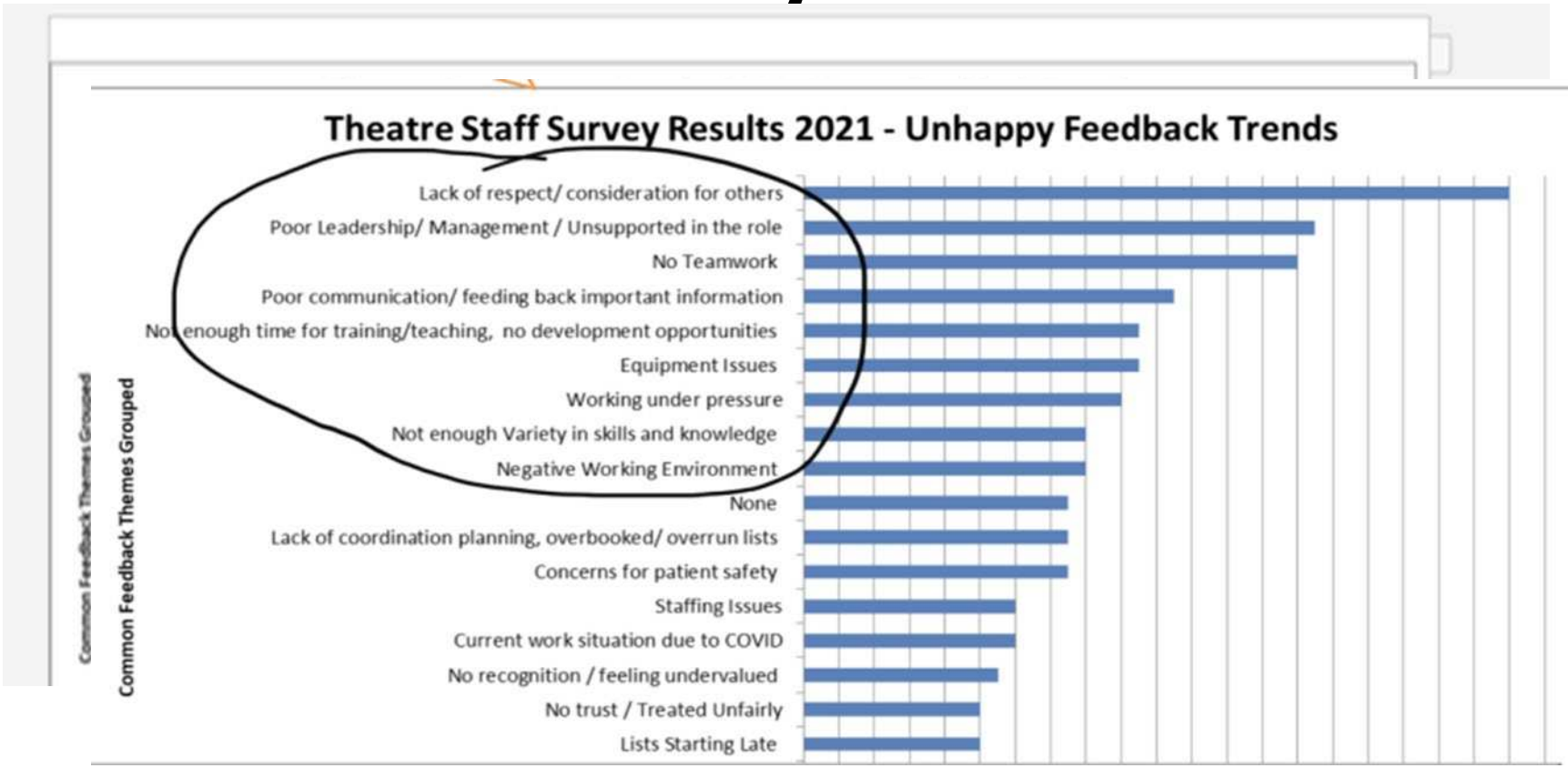
Aspiring to deliver world class patient care

Theatres Staff Survey



Human Factors: teamskills

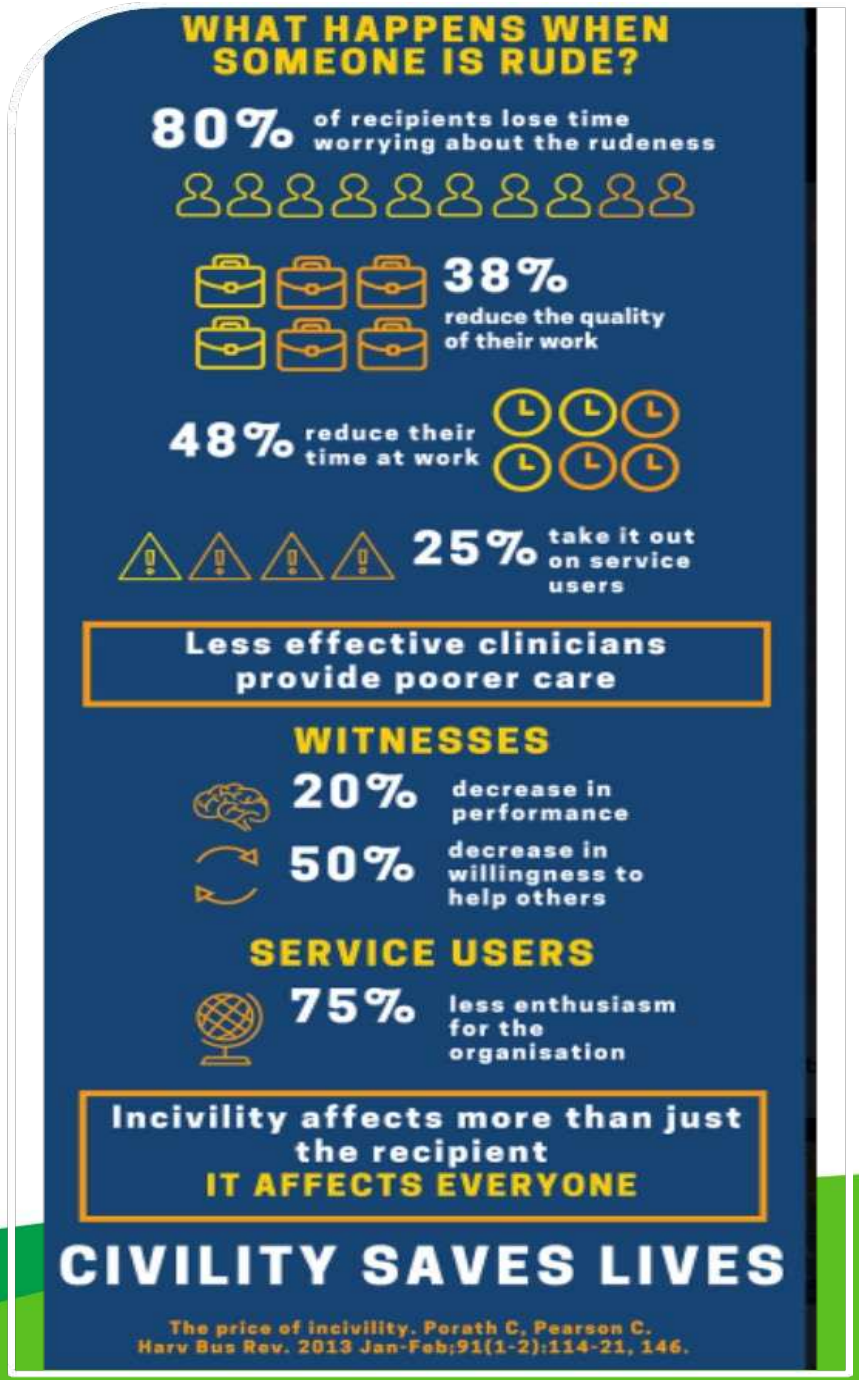
Briefing The effective briefing will be operationally thorough, interesting and will address co-ordination, planning and potential problems.	**Leadership / Followership / Concern for the Task** The extent to which appropriate leadership and followership are practiced..
Communication and Decision Reflects the extent to which free and open communication is practiced. Active participation in decisions encouraged.	**Interpersonal Relationships / Group Climate** Reflects the quality of relationships among the team, the overall climate in the workplace
Team Self Feedback The extent to which a team recognises the need to give and receive feedback.	**Preparation / Planning / Vigilance** Reflects the extent to which teams plan ahead, maintain situation awareness and anticipate contingencies.
Enquiry / Advocacy / Assertion Team members advocate, with appropriate persistence, the course of action they feel is best, even if it involves disagreement.	**Workload / Distractions** This is a rating of time and workload management. It reflects how the team distributes tasks, avoids overload and distractions.

Psychological security

- Interpersonal relationships
- Group climate
- Authority gradient
- Communication
- Performance

Does it make a difference?

http://www.youtube.com/watch?v=Jck6brLL0Go



Incivility: the facts

How can we do better?

- Strategy to support our staff
- Peer support, second messenger
- Resilience


Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice.
Civility between team members creates that sense of safety and is a key ingredient of great teams.
Incivility robs teams of their potential.

Chair Report
Quality and Safety Committee
15th April 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29th April 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 15th April 2021. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1 Context

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

2.2 Summary

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

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	15/04/21		14:00
1. Introduction			14:00
1.1. Apologies		All	14:01
1.2. Minutes from the previous meeting		Chris Beacock	14:02
1.3. Action Log / Matters Arising		Chris Beacock	14:04
1.4. Declaration of Interests		All	14:06
2. Caring for Patients			
2.1. Serious Incidents, Never Events & Learning from Incidents		Shelley Ramtuhul	14:07
2.2. Harms Reviews			
2.2.1. Harms Reviews Data and Governance		Sara Ellis	14:12
2.2.2. Harms Policy		SR/SK/RL	14:17
2.2.3. Harms Review Audit		Shelley Ramtuhul	14:22
2.3. Legal Claims Update - Q4		Shelley Ramtuhul	14:27
2.4. Health Inequalities (To Follow)		Shelley Ramtuhul/Stacey Keegan	14:32
2.5. Learning from Deaths Report - Q4		Ruth Longfellow	14:37
3. Committee Management			
3.1. Specialist Unit Quality Report		Nia Jones	14:42
3.2. Board Assurance Framework & Corporate Objectives		Shelley Ramtuhul	14:52
3.3. Integrated Performance Report - Verbal (Paper to follow next month)		Stacey Keegan	14:57
3.4. CIP Quality Impact Assessment Update - Q4		Stacey Keegan	15:02

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	15/04/21		14:00

4. Items to Note:		
4.1. Chair Report from Research Committee	Jo Banks	15:07
4.2. Chair Report from Patient Safety Committee	Stacey Keegan	15:08
4.3. Chair Report from Trust Performance & Operational Improvement Board	Stacey Keegan	15:09
4.3.1. March 2021		
4.3.2. April 2021		
4.4. Review of the Workplan	Chris Beacock	15:10
4.5. Attendance Matrix	Chris Beacock	15:12
4.6. Top Risks	All	15:13
5. Any Other Business		15:14
5.1. Next Meeting: Thursday 20th May 2021 at 2pm		

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	29th April 2021
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

Learning from Deaths summary report to the Board of Directors.

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

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

Deaths are reported through the Board of Directors.

They are also reported and 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.

2. Executive Summary

2.1. Context

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

2.2. Summary

See Numbers Below.

2.3. Conclusion

No Concerns identified.

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	Actions
December 2020	0	0	0	0	No theme	None required
January 2021	1	0	0	0	No theme	None required
February 2021	2	2	0	0	No theme	None required
March 2021	0	0	0	0	No theme	None required

3.3. Associated Risks

Two deaths COVID positive. One on admission, and one on review swab after 6 days. Thus both deemed acquired outside of RJAH using PHE scoring methods.

3.4. Next Steps

Discussions on progress with SATH concerning a link with their Medical Examiner system.

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

Plan to involve more reviewers as the SJR plus system is better tailored for MDT reviews.

September post-death process has learning for us in that it was performed and documented very well. I will summarise this and present it at next MDCAM.

3.5. Conclusion

January death still awaiting coroner's investigation due to cause of initial injury, well before admission to RJAH.

No concerns identified.

Appendix 1: Acronyms

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

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

0. Reference Information

Author:	Sue Sayles Sian Langford	Paper date:	29/04/2021
Executive Sponsor:	Stacey- Lea Keegan; Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Infection Control Committee	Paper Ref:	
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board are asked to note the quarterly report against the annual plan for Infection Prevention Control and Cleanliness.

2. 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 (Chief Nurse and Patient Safety Officer). 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**
Jan	0	0	0	0
Feb	0	0	0	0
March	0	0	0	0
Quarter total	0	0	0	**0**

The increased flu vaccination uptake of 82.96% (excluding staff opt outs) from 68.17% during 2019/20 against a target of 75% demonstrates the hard work of our lead Practice Nurse Facilitator to raise awareness of the benefits of the flu vaccination whilst working alongside Team Prevent and additional nurse vaccinators, improving the accessibility and availability of the flu vaccine to all staff.

The trust continued to react and implement changes in response to COVID-19. There were two outbreaks of COVID-19 during January 2021. Outbreak meetings are undertaken with the DIPC, CCG and PHE to establish the root causes, lessons learned and the findings shared.

2.3. Conclusion

The Board of Directors are asked to note the Infection Prevention Control and Cleanliness quarter 4 report.
Summary in the main report shows current performance in cleanliness and infection control against the work plan.

3. The Main Report

3.1.1. Introduction

This report provides an update on progress made within quarter 4, 2020/21 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 Control Committee

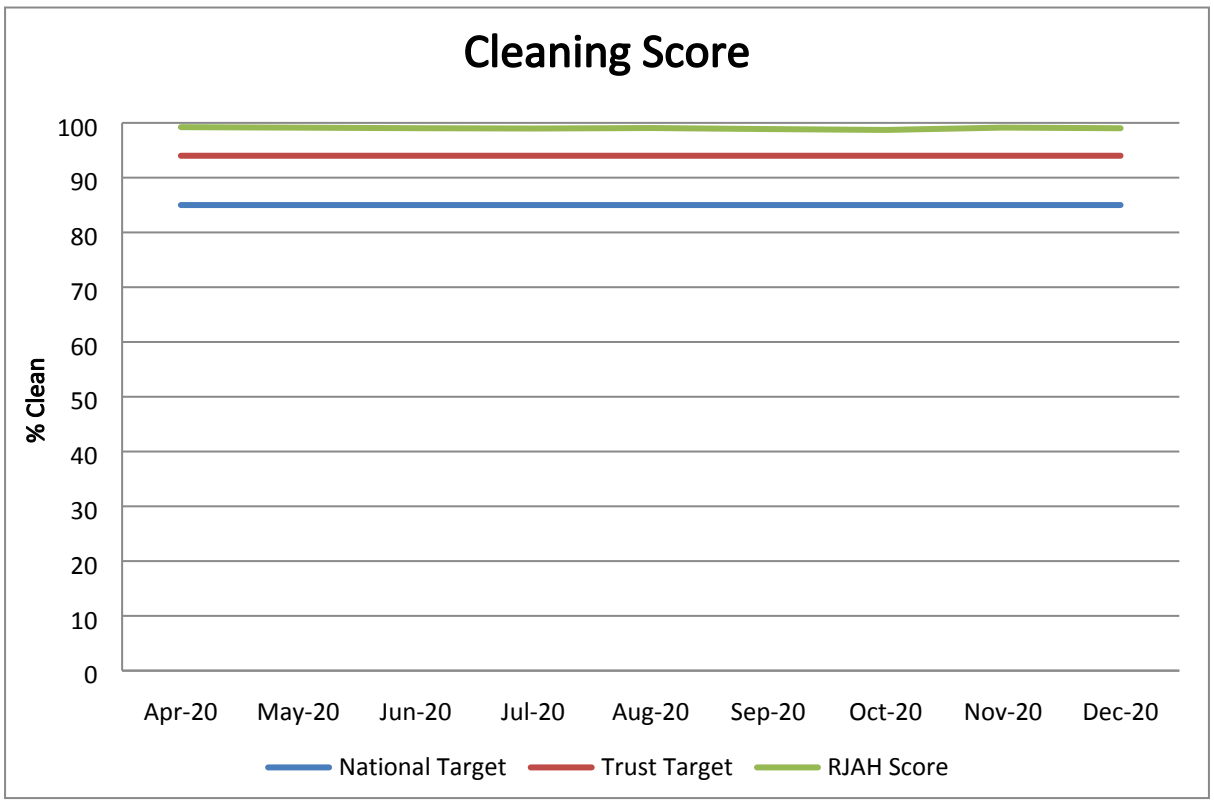
The IPC Programme of Work 2018 – 21, which has been developed in line with the Shropshire and Telford Health and Social Care Strategy, has been agreed at the Infection Control Committee in July 2018 and progress is reported quarterly.

3.2. Cleanliness

Measured cleanliness has been maintained above the National calculated target (85.0%) and Trust target (94.0%) over the most recent quarter, achieving an overall average for the quarter of 98.95% which is consistent with recent reporting periods.

3.2.1. Cleanliness

By average, all functional areas have achieved their national specification for cleanliness target audit scores across the quarter.



Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

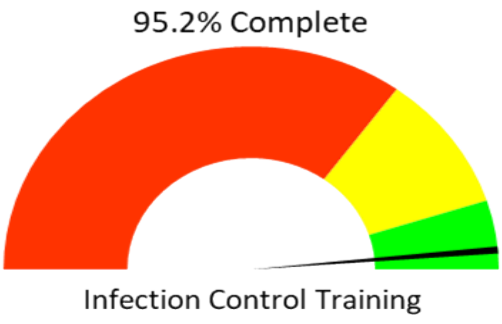
Over the quarter, 12 instances were reported where an individual area didn't meet its risk based target for an individual audit. Actions identified through this process continue to be raised via action sheets to the relevant team – before and after photos such as those shown below, are not only useful to demonstrate action completion, but are also an important learning tool for the wider team. Auditing in very high risk areas continues to be undertaken in conjunction with the operational team so that any concerns or support required are escalated on day of audit.

Recognising the importance of in depth, accurate auditing, the team has recently been strengthened, with additional staff members trained in cleanliness auditing, and refresher training for those already undertaking this role. This included a series of management audits and review meetings with departmental managers.

Work has also been undertaken to work more closely with the estates operational team, so that fails identified under this domain can be better prioritised based on risk.

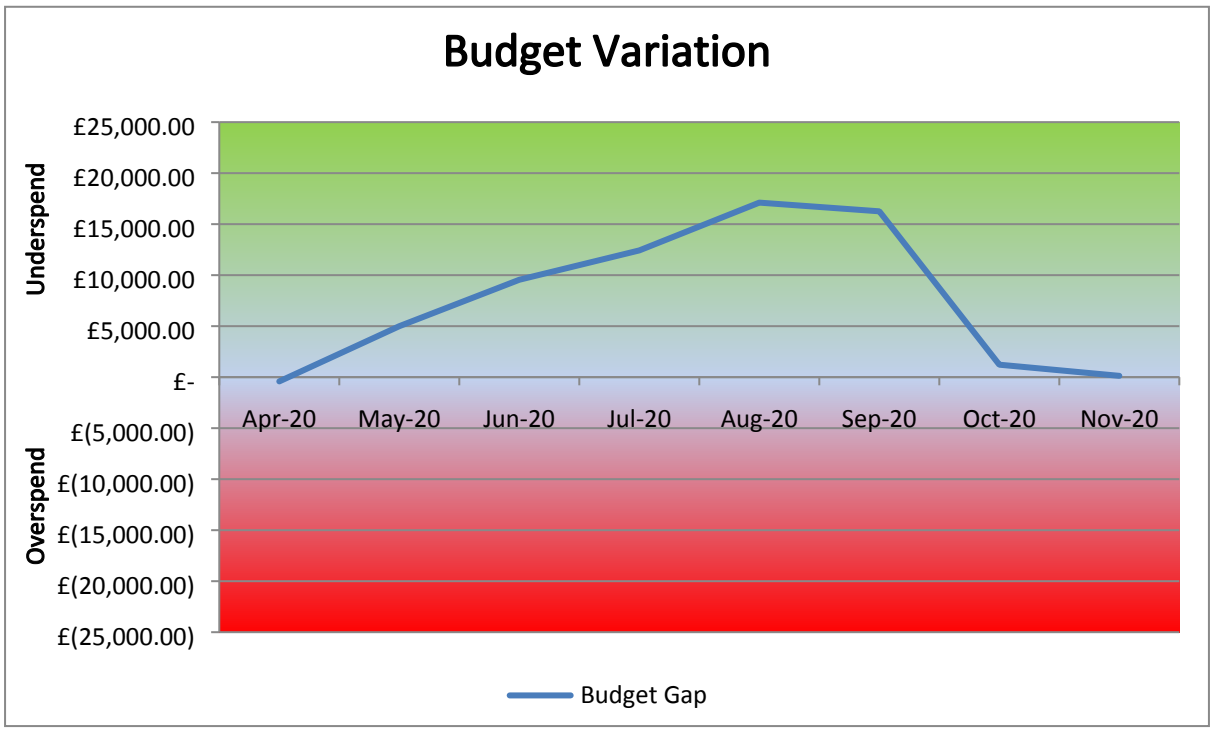
3.2.2. Cleanliness – Staff Competency

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 March 2021 is shown



3.2.3. Cleanliness – Spend on Cleanliness

The below chart demonstrates the position at end of November 2020. 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.

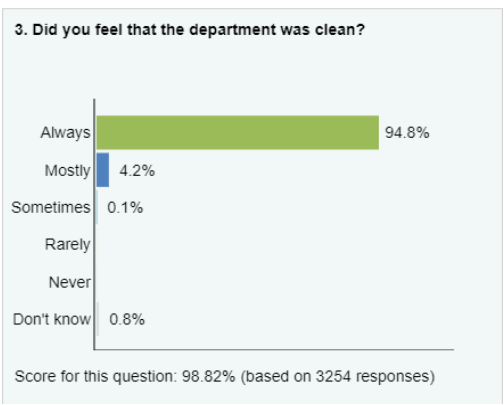


3.2.4. Cleanliness – Patient Satisfaction

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

Of the 11 low scoring comments (Sometimes, rarely, never) reported below, 1 patient provided an accompanying comment. The patient queried mandatory use of the car park machines for payment which were not wiped between uses. Assurance was given that additional touch point cleaning of these machines is in place, which along with provision of hand gel and wash facilities at the Trust entrance meets the current infection control guidance.

Outpatients



Inpatients

3.2.5. Specific Cleaning

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.

No HPV fogging has been undertaken on site this quarter.

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, this has included:

MCSI

Following both IPC and Facilities audits, concerns were raised over the standards on MCSI. Working with the ward, consideration was made for actions using a risk based approach. This included a thorough deep clean, deploying the PEAT team to support cleanliness technicians, and replacement of floors in MCSI OPD as shown below. Ongoing work is considering a change of cleaning service hours to better fit the service requirement of the ward and improve access, and a redecoration programme including protective coverings to prevent further damage.

MCSI OPD Before

MCSI OPD After

Cleaning Cupboards

An external IPC audit of DAART noted a requirement for hand wash sinks in cleaning cupboards where a sluice hopper is in place. A review of all cleaning cupboard was undertaken and 7 further areas identified as requiring a sink. The Estates team procured appropriate facilities and these are now being installed.

Lime scale Build Up

Following IPC spot checks, several taps were identified and having scale build up. The PEAT team audited each outlet on site, identifying those which could be descaled and completing and providing the Estates team with a detailed list of those which require replacement. A rolling programme of replacement is now underway

3.2.6. Compliance Update - Facilities

National Standards of Healthcare Cleanliness

The Trust awaits final publication of the updated National Cleanliness Standards

PLACE

Following confirmation that the National PLACE collection would not take place in 2020, and further detail received in March advising of no current plans for a National collection in 2021. Trusts are being encouraged to undertake internal assessments, as an example of good practice and continuous improvement, which are supported by the appropriate PLACE-lite audit tool. A programme of audits has been developed, covering all wards and departments usually assessed by the National model, with representation from Estates, Facilities and clinical teams undertaking the assessments.

Ward/Dept Name	Audit Date	Cleanliness	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	Movement from Previous Audit
Sheldon	30/10/19	100.00%	100.00%	100.00%	81.48%	73.33%	↑
Sheldon	30/03/21	100.00%	100.00%	100.00%	100.00%	100.00%	↑

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

On Sheldon ward, particular praise was given by the inspection team in regards to the work undertaken to reduce clutter in corridors and noticeboards, which enhanced the overall organised and calm feel of the ward. Whilst no actions were identified through the PLACE domains, recommendations made to the ward included:

- Purchase of clip frames from bathrooms to avoid potters being blue tacked to walls/equipment
- Ensure spare paper products are not stored in patient areas (bathrooms)

Going forward, actions 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.

Clinical Waste Management

As part of the Shropshire Wide Consortium, the Trust has taken part in a tender exercise for clinical waste management.

The new contractor has worked with the operational team over the quarter to ensure a service is maintained through handover on April 1st, which has included receiving relevant registration permit information, including contingency plans focused on ensuring clinical waste continues to be removed from site.

The consortium has procured an external Duty of Care Audit to comply with hazardous waste regulations.

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

COVID-19 Documentation & Response

As previously reported, Estates & Facilities continues to support the wider Trusts COVID response, both through operational enhancements and evidence based assurances. This includes:

- 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.
- Daily submission to NHS England, escalating any waste management issues on site is available, and the Trust continues to link in 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.
- 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 installation of a new sluice on MCSI OPD, partitions between bays in theatres, access door control, physiotherapy gym partitioning.

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	10/12/2020→ 01/03/2021
Legionella	31
Pseudomonas	71
Hydropool water quality	12
Z Bacteria	1

As is standard practice all out of parameter results are followed up and resolved.

The Trust Appointed Authorising Engineer (Water) audited the Trust in December 2020 and recently issued Estates & Facilities with a report and action plan, which is being completed and will be reported through Water Safety Group.

Projects

The main water storage tank replacement scheme is now complete.

Training

Training for cleanliness technicians has been completed to bolster knowledge and skills regarding flushing and the green 3 program.

Innovation

Estates & Facilities are currently reviewing water consumption to the site. As a Trust, we are an outlier amongst our peer Trusts on our water consumption, so we're looking at ways of reducing the amount of water we consume without compromising the service we provide to patients, visitors and staff. We're looking at:

- Urinal water consumption
- Flushing regimes
- Water tank chlorination (and the requirement to dump large volumes of water to drain)
- The cumulative effect of small leaks
- Our steam raising plant and traps, and how much 'condensate' we dump water to drain
- Removing infrequently used outlets (that have to be flushed), if they're no longer required
- The type of siphon we use for toilet cisterns

However, these initiatives do not come without risk of proliferation of bacterial growth, so we're remaining vigilant by continuing our routine monitoring throughout site.

3.2.7. Compliance Update – Estates

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' in order to validate the machines for safe use. All periodic testing due this quarter has been carried out; 100 weekly tests, 9 quarterly tests and 2 yearly tests. As is standard practice all out of parameter results are followed up and resolved.

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 Q4, 52 settle plate tests were carried out; no results breached the limits set out by Decontamination Group.

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. Menzies Procedure Room and Gladstone Isolation Room were revalidated this quarter. The formal reports are pending, but no major non-conformances were reported at the time and the work was supervised by the Trust appointed Authorised Person (Ventilation). It is noted that the Maternity Ward Labour Room critical air plant has not been revalidated due to repurposing for the Vaccination Hub. The plant will be revalidated prior to being put back into use.

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

All reverifications are audited by the Trust appointed Authorising Engineer (Ventilation).

3.3. Infection Prevention & Control

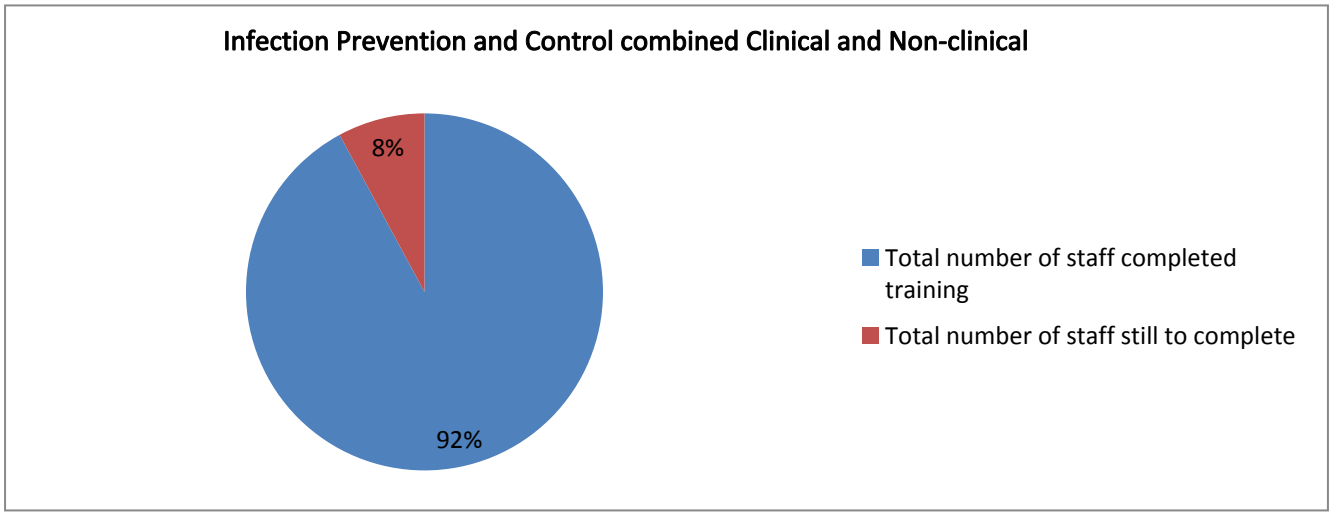
3.3.1. Training

Core Training Compliance - Infection Prevention & Control - 31/03/2021		Including Bank Staff			
Validity Period	Course Name	Total number of staff required to complete training	Total number of staff completed training	Total number of staff still to complete	Compliance Percentage
Annual	Infection Prevention & Control (Clinical Staff)	1001	901	100	90.01%
3 Yearly	Infection Prevention & Control (Non-clinical Staff)	635	606	29	95.43%
Annual/3 Yearly	Infection Prevention & Control combined Clinical and Non-clinical	1636	1507	129	92.11%

Infection Control Training Data as at 31 March 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
Clinical Services Unit	207	190	91.8%	93	90	96.8%	300	280	93.3%
MSK Delivery Unit	434	405	93.3%	55	54	98.2%	489	459	93.9%
Specialist Delivery Unit	257	225	87.5%	59	57	96.6%	316	282	89.2%
Support Services Unit	8	8	100.0%	322	314	97.5%	330	322	97.6%
TRUST WIDE TOTAL (Including Medical Staff)	**908**	**828**	**91.2%**	**594**	**576**	**97.0%**	**1502**	**1404**	**93.5%**
Bank Staff	93	73	78.5%	41	30	73.2%	134	103	76.9%
TRUST WIDE TOTAL (Including Medical and Bank Staff)	**1001**	**901**	**90.0%**	**635**	**606**	**95.4%**	**1636**	**1507**	**92.1%**

Key for Rag Rating for Training Compliance
>92%
<92%



Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

The graphs above 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 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.

A request was made to the training department for detail on areas that failed to undertake training. It was confirmed that the collection method for data was not set up to include this and therefore could not be provided.

3.3.2. Infection Control Link Meetings

Link meetings are held bi-monthly. Link nurses are required to disseminate infection prevention and control updates /information to their work colleagues. Agenda items in February included:-

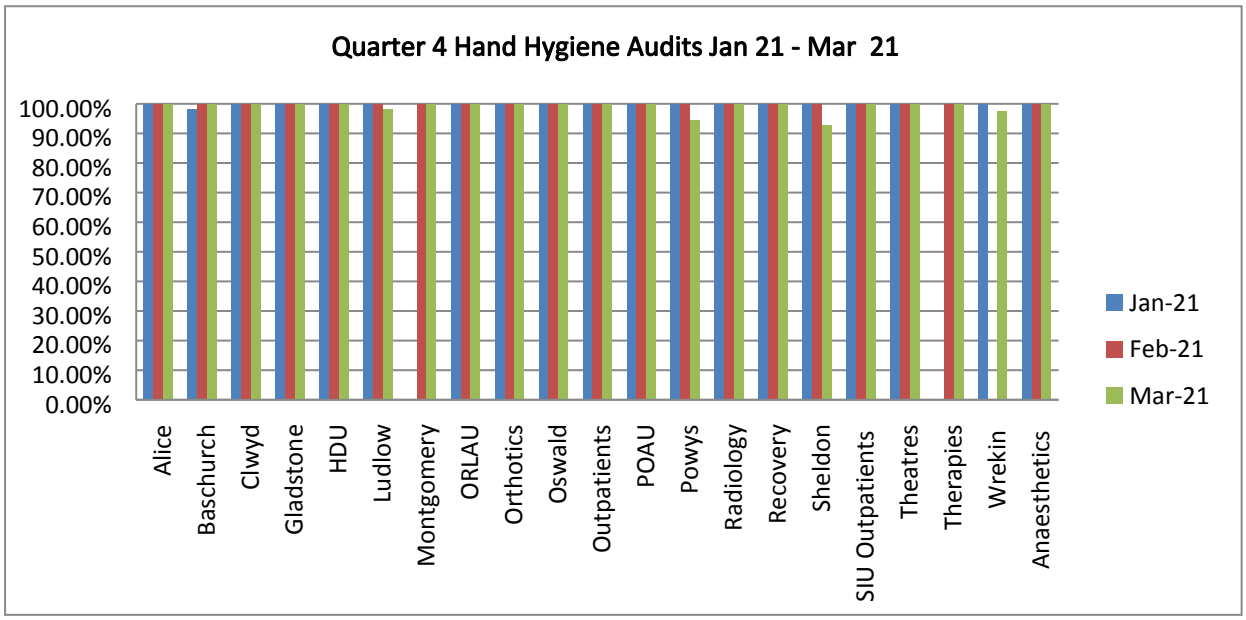
February 2021

- Covid 19 update and Natonal Guidance update
- Infection Control Team update
- Patient mask wearing flowchart
- Update on Outbreaks.
- Alert organisms
- Audit feedback and update.

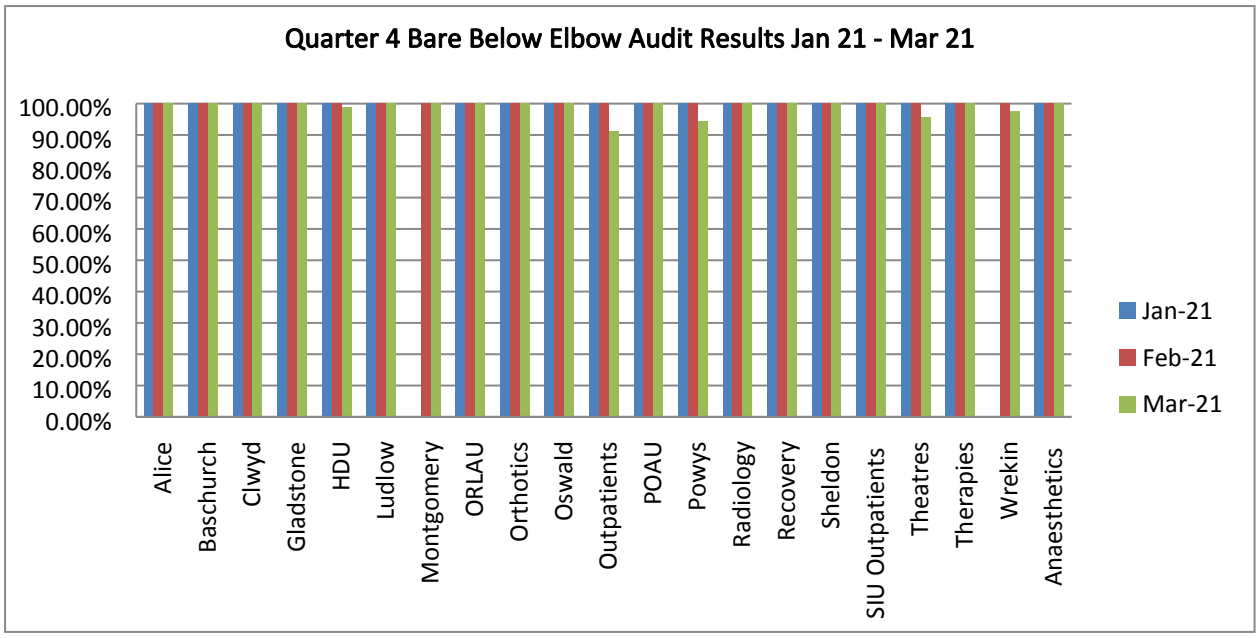
Going forward an infection control newsletter highlighting key infection control issues/themes for the month will be circulated to the link staff and disseminated with the wider ward/departmental teams.

3.3.3. Audit

3.3.3.1. Hand Hygiene

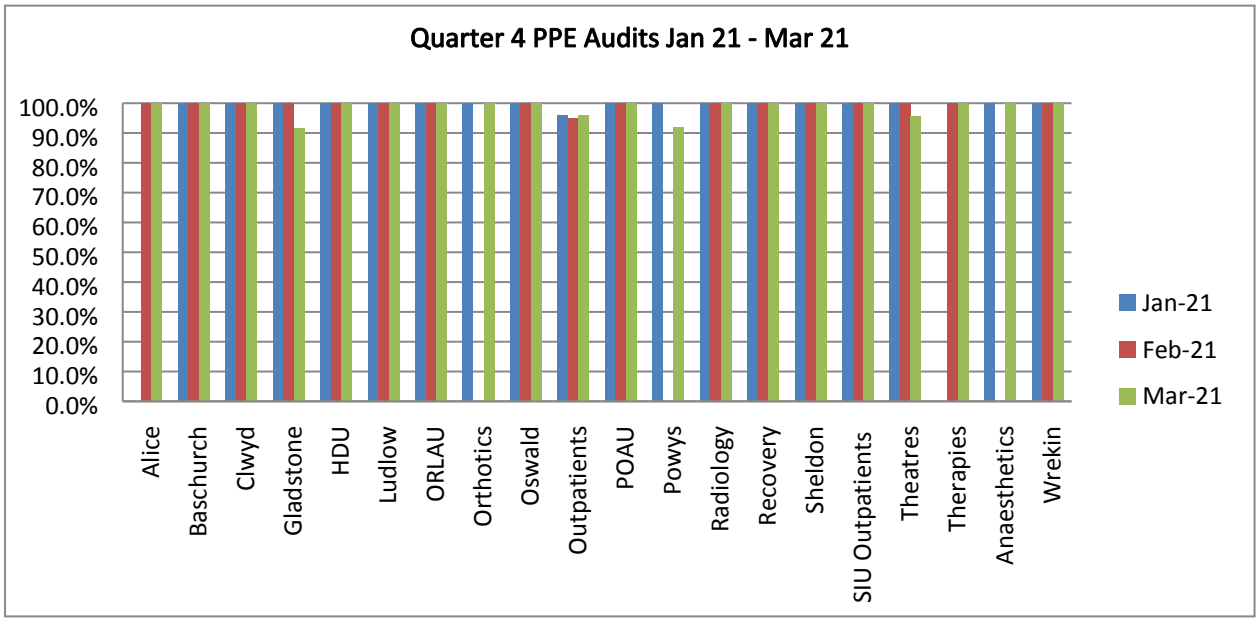


3.3.3.2. Bare Below



The above graphs demonstrate 99.6% compliance in Hand Hygiene and 99.8% compliance in Bare Below the Elbow. There was a notable decline in compliance for some wards in March. Feedback collected from the audit forms highlighted staff wearing watches and other forms of jewellery. The IPC team have agreed to undertake a uniform audit in all clinical areas to ensure principles of bare below the elbow are defined and enforced.

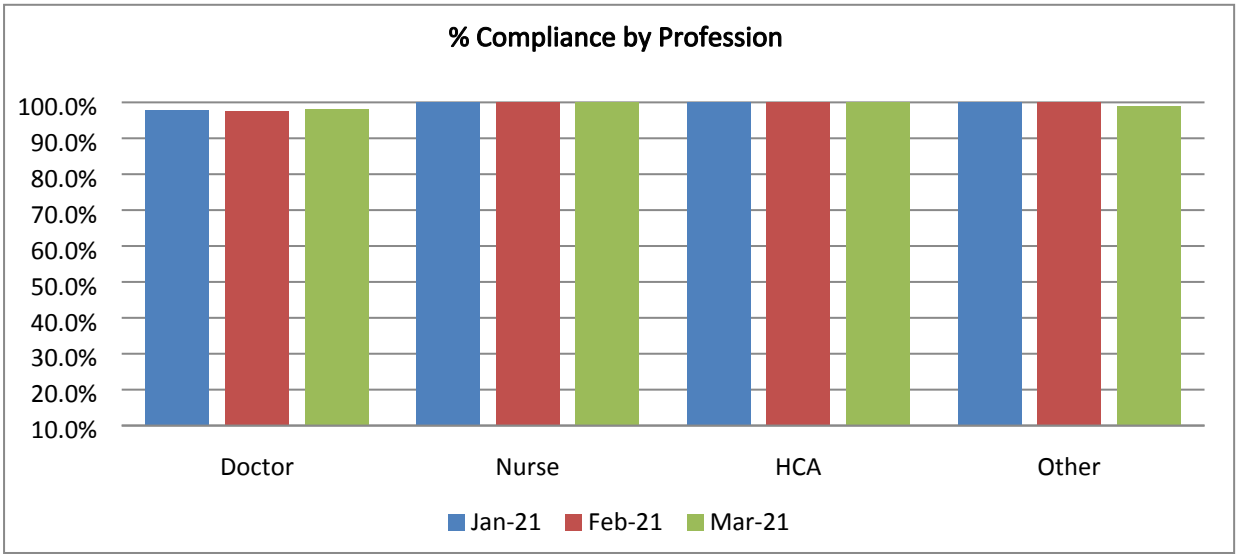
3.3.3.3. Personal Protective Equipment Audits (PPE)



The graph above demonstrates 99.4%. Results show that Outpatients continues to fall below the 95% target for this quarter.

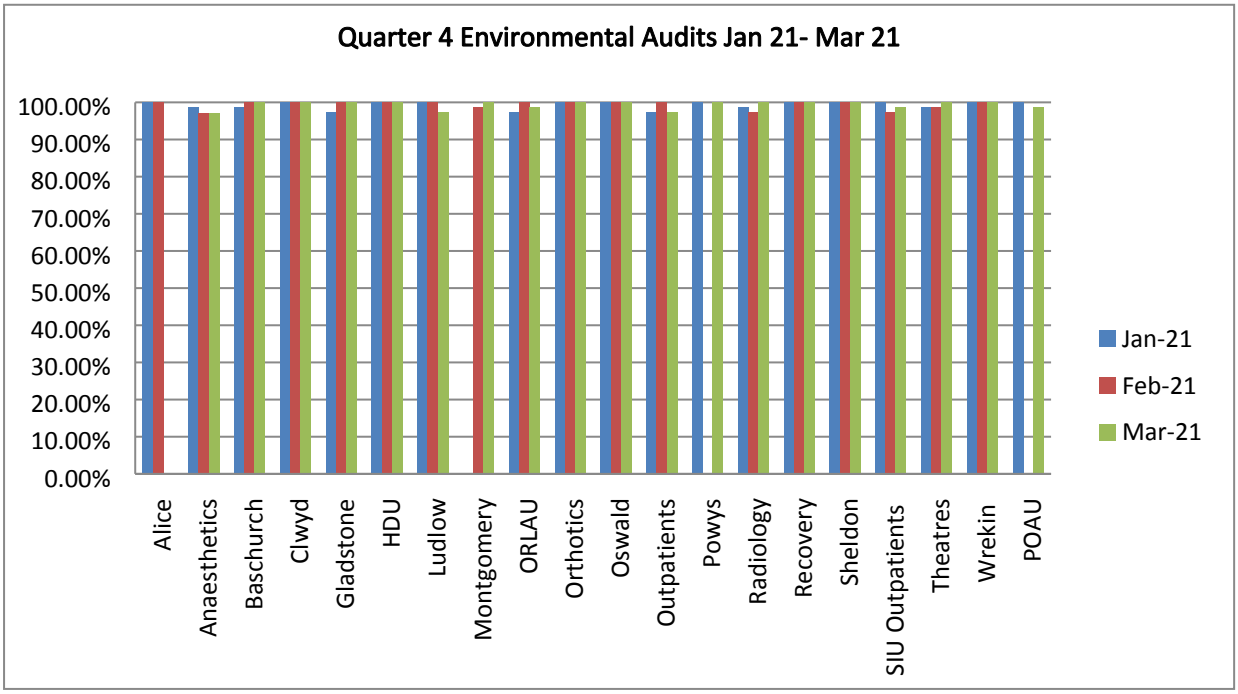
Main themes for poor compliance were issues relating to staff not being aware of the skin care documentation for mask wearing and some staff had not received training for donning and doffing of PPE. These scores correlated with the scores of COVID-19 audit checklist and actions have been undertaken to address these issues. These have been detailed in the

COVID-19 Checklist section of this report. The PPE Champions returned to the infection control department in January to provide additional donning and doffing training.



The above graphs demonstrate the PPE compliance for wards and departments and by individual staff groups. Staff have been encouraged to address any non-compliance at the time of the audit.

3.3.3.4. Environmental Audits



Analysis of environmental audits for quarter 4 highlighted two main themes for noncompliance. The table below shows details of these issues and a breakdown of where these failings were reported.

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

	Department	Date Reported
Floors clean & in good state of repair	Outpatients	Mar 21
	SIU Outpatients	Mar 21
	Anaesthetics	Mar 21
	Montgomery	Feb 21
Safer sharps devices are in use, or if not, a risk	ORLAU	Mar 21
	SIU Outpatients	Feb 21

The Trust is now substantially compliant with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.

A full list of sharps devices used in the Trust has been collated and safer sharps alternatives have been identified where available.

Work is ongoing to ensure that sharp instruments in use around the Trust continue to be assessed for safer alternative devices.

It is anticipated that audit scores will improve as safer sharps become further embedded within the Trust.

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

During Quarter 4 the infection control team undertook an additional audit across all wards and departments and the following themes were identified:

Common Themes

Lime scale build up on Cold Water Dispensers

Wards/Departments to observe build-up of lime scale on the cold water dispensers and to ensure that these are maintained ,including the emptying and cleaning of the overflow trays.

Lime scale on hot water drinks faucet

Facilities team have implemented a descaling programme across the trust.

Sticky residue in hand gel dispensers

Wards/Department Managers to ensure regular cleaning/maintenance regime is in place for the inside of hand gel dispensers and dani centres to prevent the formation of residue or dust.

Unclean/faulty macerators in the sluice

Ward/Department Managers to ensure macerators have a visible cleaning regime and rim of the macerator to be included in their daily clean. Staff to be aware of how to report faulty equipment via the Intranet to ensure appropriate channels are adhered to for their repair/replacement.

Cleaning regimes of equipment trolleys required

Regular spot checks are encouraged to ensure the cleaning regimes are being undertaken appropriately. Although cleaning regimes are in place for some Ward/Departments, it has been found that inside the drawers of trolleys and wheels were being missed.

Rust build up on equipment trolleys

Where there was build-up of rust on equipment, it is recommended that a replacement programme is put in place over a period of time to ensure that all equipment is repaired or replaced.

Insufficient storage

Ward/Department Managers to identify any storage solutions to move equipment and boxes off the floors in storage areas, and look into purchasing additional storage to keep floors clear.

Inappropriate items placed in sharps bins

Ward/Department Managers to disseminate to staff about the inappropriate disposal of some items into sharps bins. Awaiting annual audit of sharps bins across the trust by our (Sharps bins provider) Daniels.

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21

5-7th Day COVID-19 Screening Audit

In June 2020 NHS England & NHS Improvement released changes to guidance in relation to the 5-7 day screening of patients.

An audit was undertaken by the IPC department to assess compliance to this process and provide assurance wards were undertaking the 5-7 day screening in line with the guidance. Findings suggested that compliance to this process could be improved.
Analysis showed that although swabs were taken for most patients, not all were undertaken within the recommended 5-7th day target.

The audit also highlighted that patients had swabs taken on the 8th day which indicates there was confusion determining when the first day of the 5th - 7th day began. Therefore a joint decision was made by the Trust and Local Health Economy on the 25th February 2021 that day of admission would be counted as day zero.

Going forward the Infection control team will undertake quarterly audits to monitor compliance of this process.

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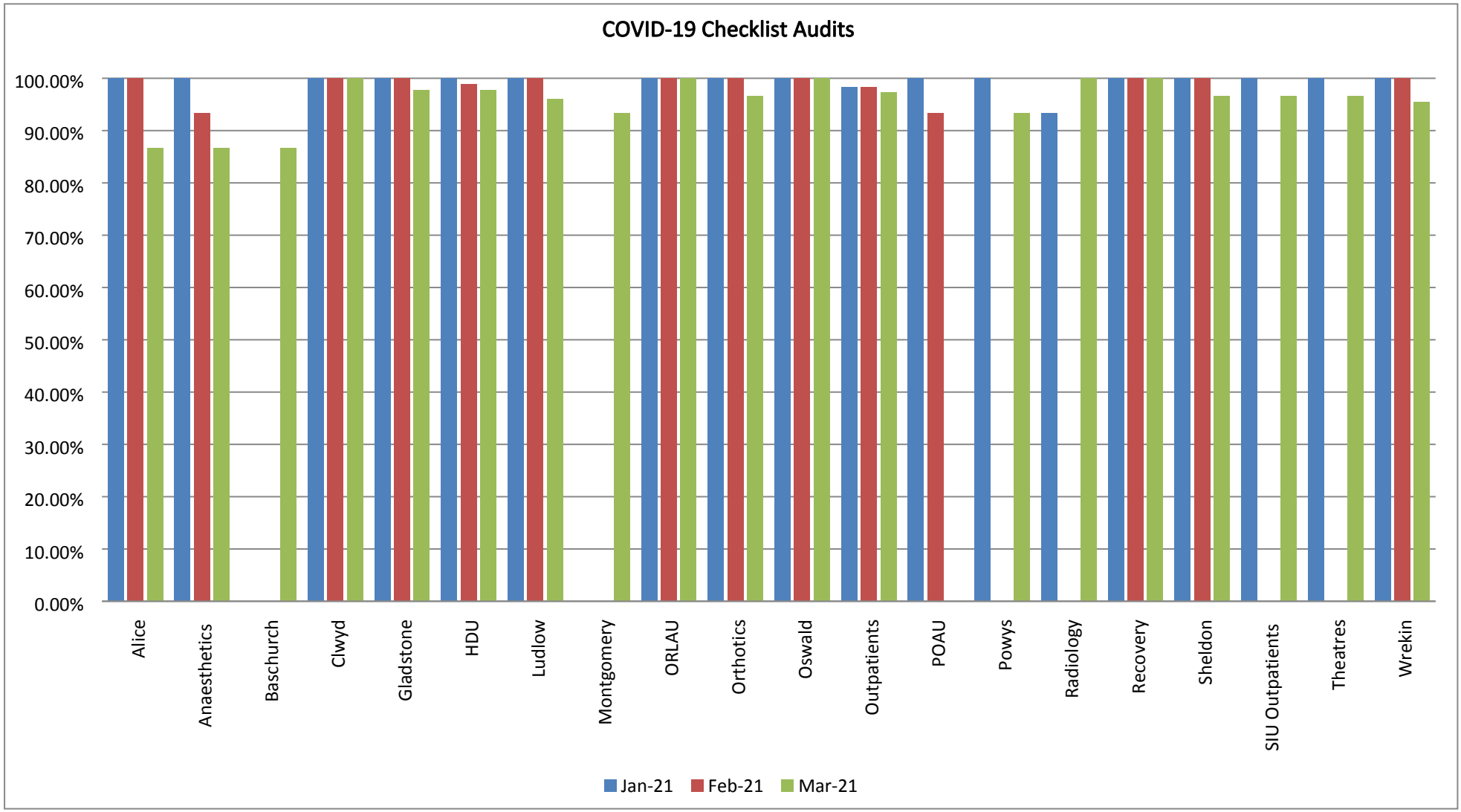
3.3.3.5 COVID-19 Personal Protective Equipment Checklist Observational Tool

An observational tool introduced in July 2020 to assess and address issues relating to PPE during COVID-19. Low scores received for PPE audits in March correlated with those of the COVID-19 Checklist audits and upon analysis the following themes for noncompliance were identified for quarter 4.

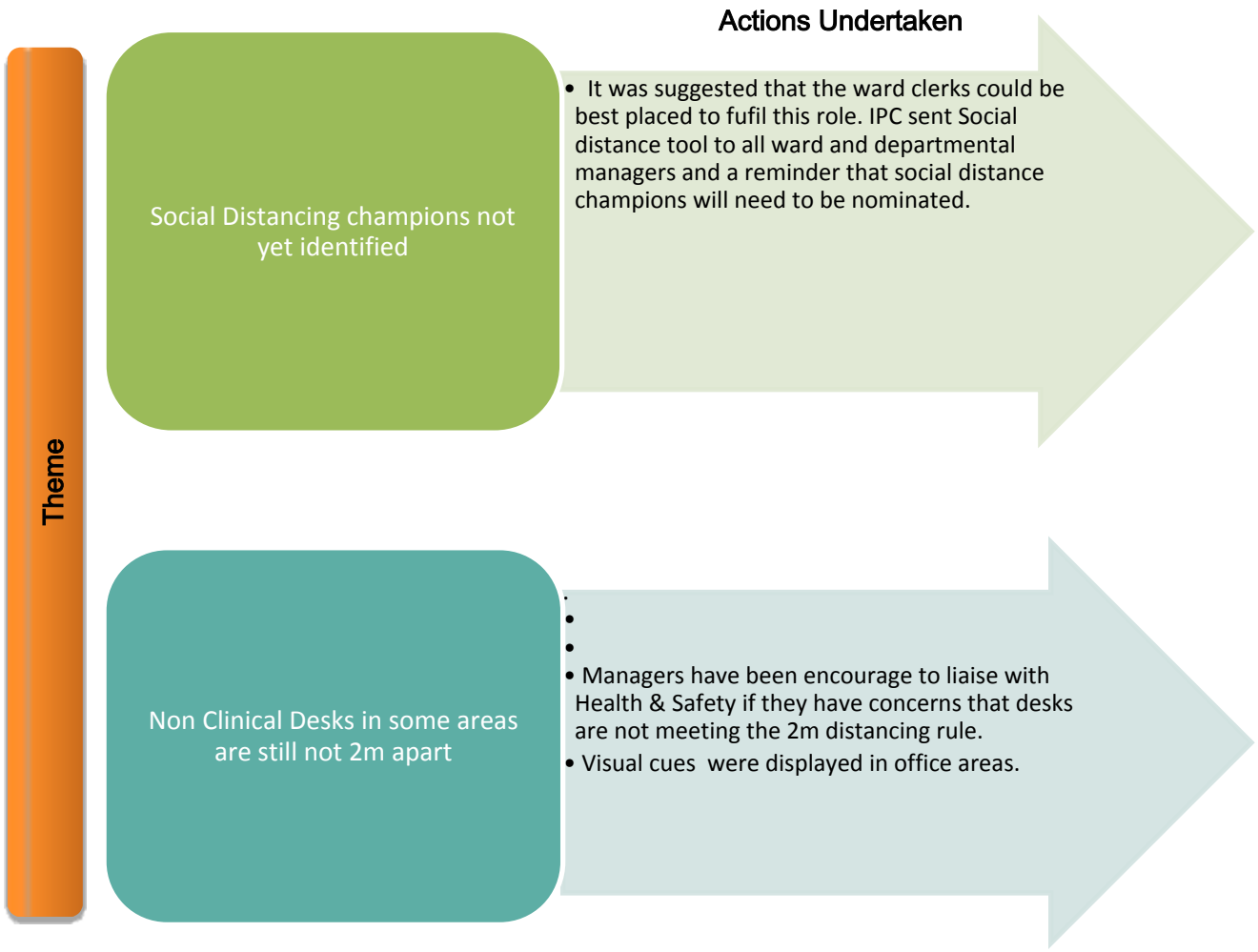
Theme	Actions Undertaken
Some staff members have not received donning and doffing training.	• PPE champions delivered a programme of training to areas identified. All areas were encouraged to contact the IPC team if further training was required. • Staff were reminded that the training video can be located on the Intranet or via the Coronavirus Portal. Managers are encouraged to keep a record for staff who have received training. • Positive feedback captured that PPE champions have been very supportive.
Some staff are not aware of the document: 'Helping prevent facial skin damage beneath PPE'	• Staff signposted to the COVID file kept in all areas. Updates and information will be emailed to all area managers when necessary.
Hand gel dispensers have a build-up of sticky residue.	• This issue was also highlighted during Infection Control audits undertaken in all areas by the IPC Team. Wards have been encouraged to report this issue and a local cleaning regime was recommended to keep on top of this.

Infection Prevention & Control & Cleanliness Quarter 4 Report 2020/21



3.3.3.6 Social Distance Checklist Observation Tool

The observational tool was introduced in July 2020 to assess and address issues relating to social distancing during COVID-19. The results are collected and analysed monthly and the following themes were identified during quarter 4.



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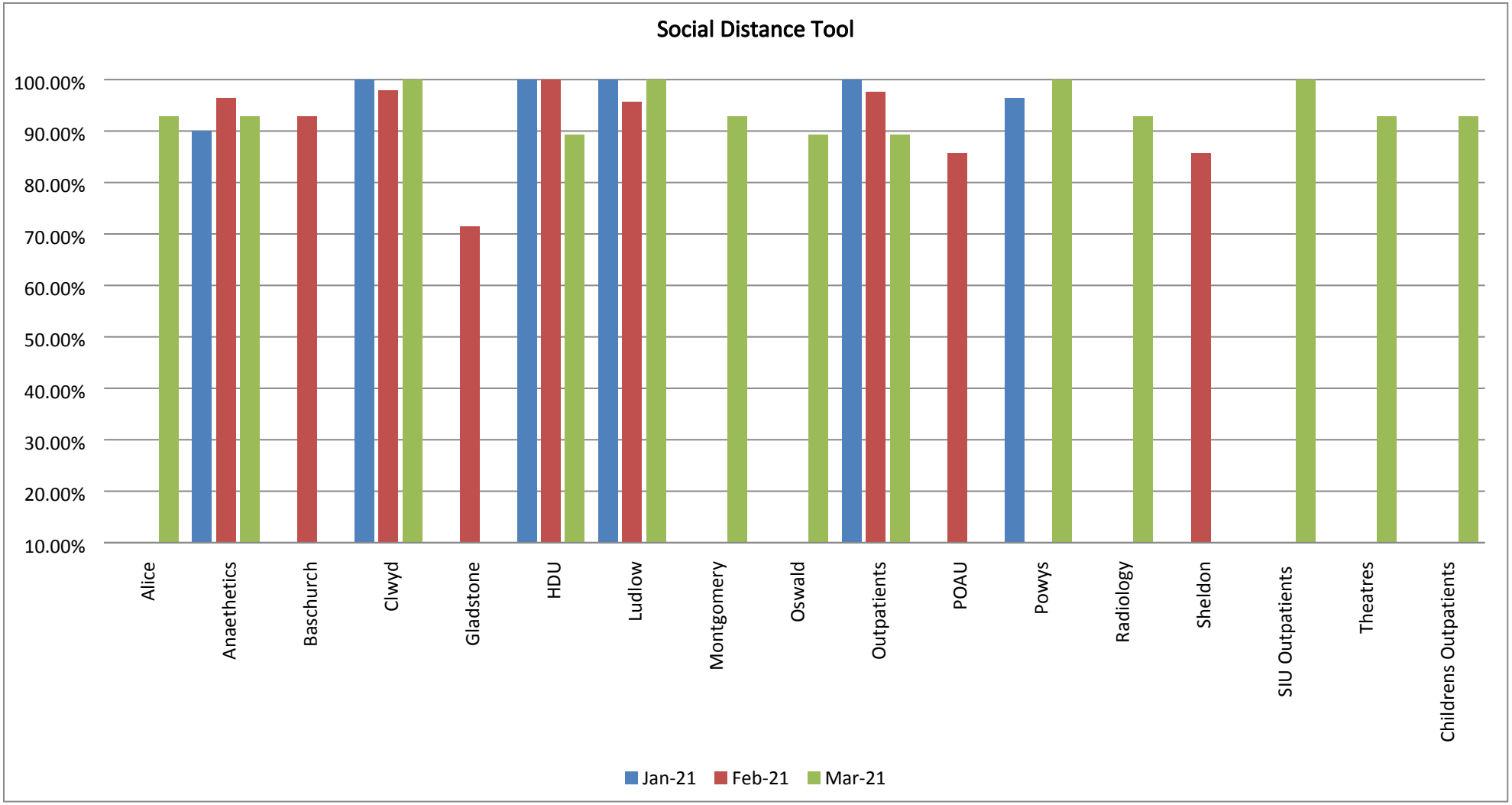
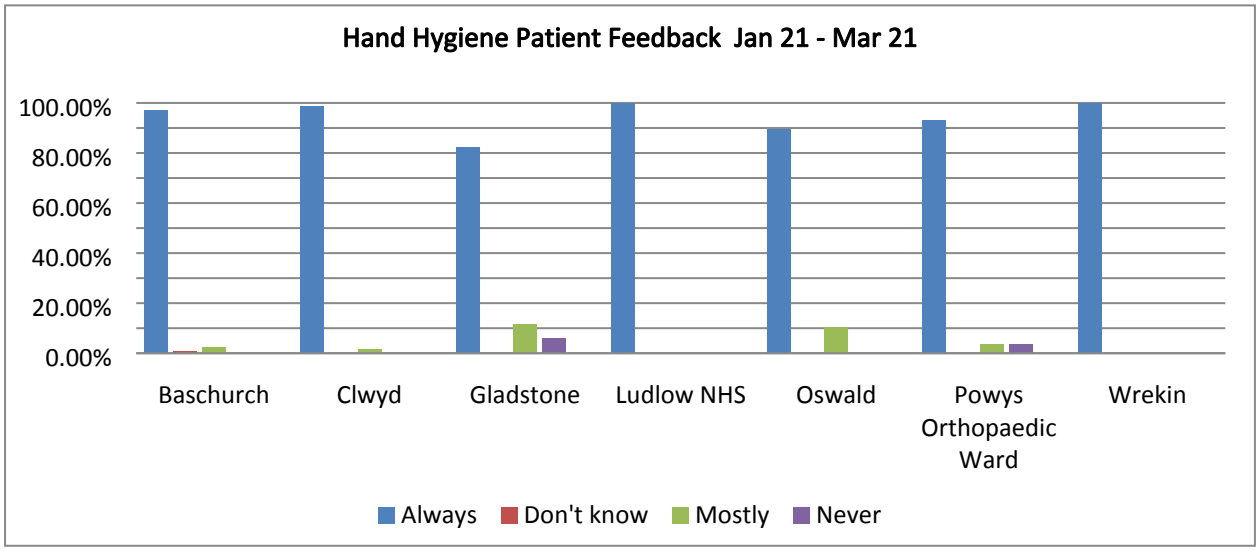


Hand Hygiene – Patient Feedback



Following the cessation of this service due to COVID-19, comment card feedback from patients was reintroduced by the Patient Advice & Liaison Service (PALS) at the end of December 2020. 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.

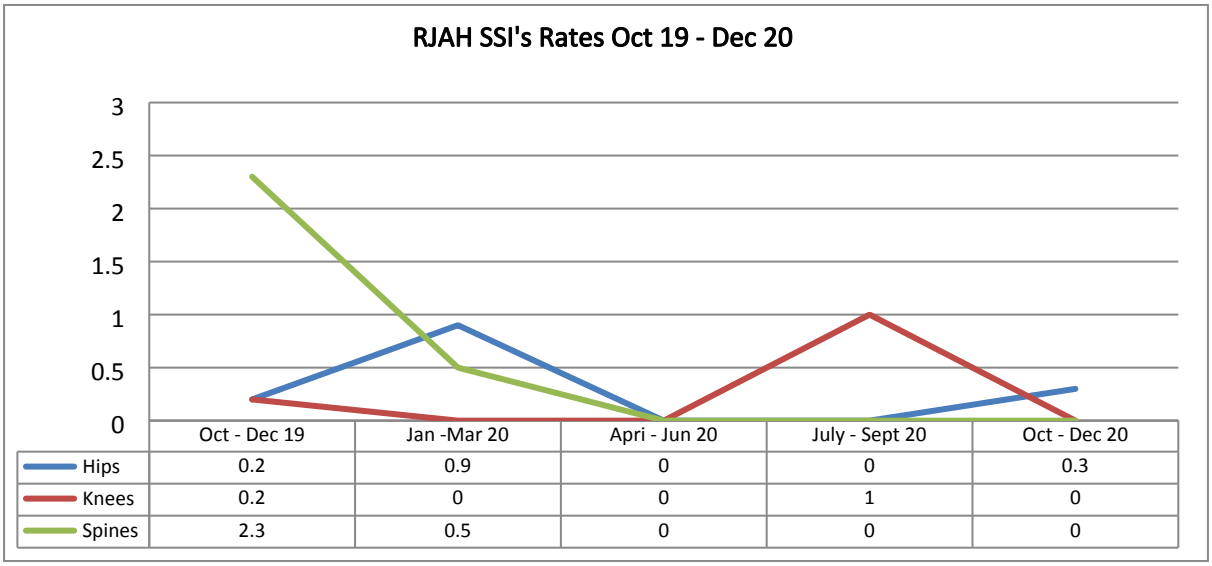
The Trust submits the maximum of all data, which is above the national requirement for one quarter of surveillance in one category of surgery per year. Year round surveillance is performed in total hip, total knee and spinal surgeries.

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

The data below shows the SSI rates for Oct-Dec 2020.

TKR	THR	Spines
0 infections from 232 procedures	1 infection from 297 procedures	0 infections from 115 procedures
0	0.3%	0.0
National Average 0.7 %	National Average 0.7 %	National Average 1.2%

The infection Control Nurse/ Surgical Site Surveillance Nurse liaise with the Consultants concerning wound infections. The data for Oct-Dec 20 has been verified and the results have been submitted to PHE and published on their web site. All of these infections were discussed and agreed at the infection Multi-Disciplinary Team meeting (MDT).



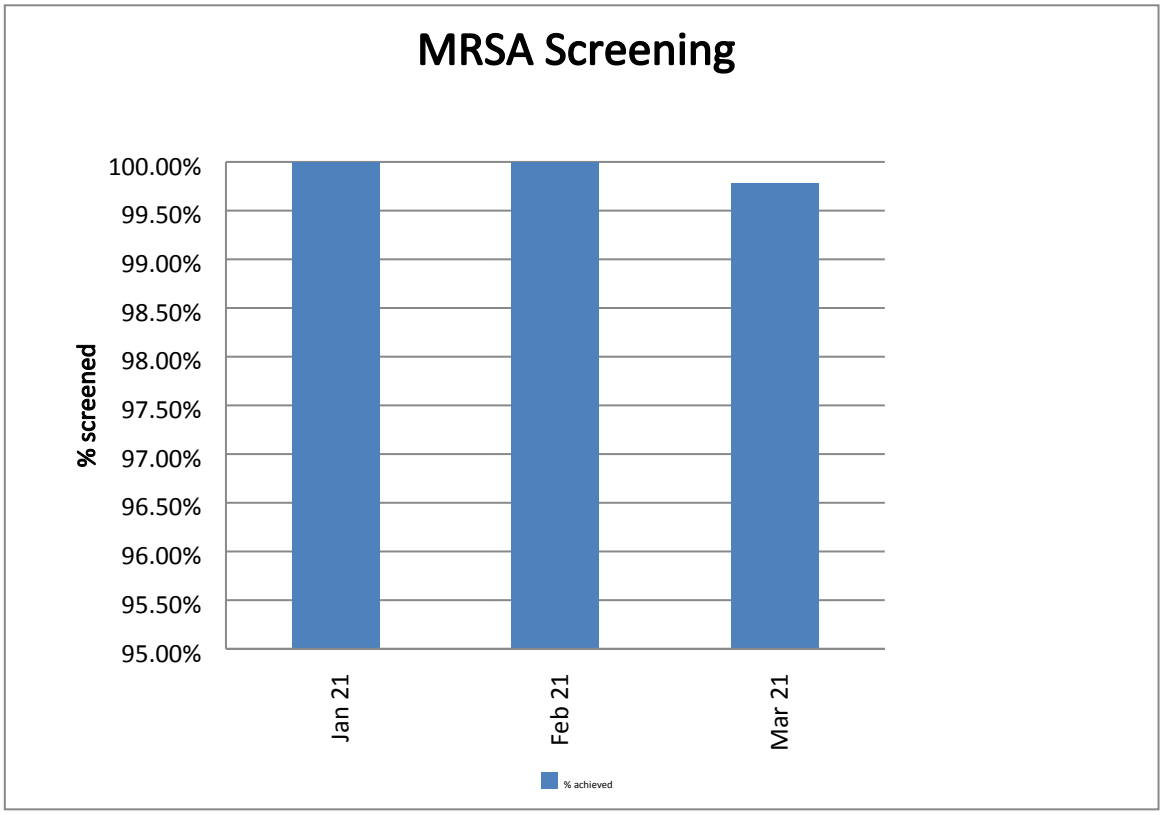
	Oct - Dec 19	Jan -Mar 20	Apri - Jun 20	July - Sept 20	Oct - Dec 20
Hips	0.2	0.9	0	0	0.3
Knees	0.2	0	0	1	0
Spines	2.3	0.5	0	0	0

The graph above shows RJAH Infection rates for the last 12 months. Rates for Hips (THR), knees (TKR) and spines fall below the national average for this quarter.

3.3.5. MRSA Swabbing & 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.

	Jan 21	Feb 21	Mar 21
Eligible patients	361	251	460
Screened for MRSA	361	251	459
% achieved	100%	100%	99.78
Target	100%	100%	100%



MRSA screening compliance remains high and above the target set by the commissioners.

3.3.6. Alert Organisms

3.3.6.1. C.*difficile*

There have been 0 cases of C.*difficile* to date against an annual target of no more than 3.

3.3.6.2. MSSA bacteraemia

There have been no cases of MSSA blood stream infections during Quarter 4. The MSSA blood stream infection that was reported in quarter 3 was a continuation of a blood stream infection from Royal Shrewsbury Hospital therefore a post infection review meeting was not required.

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

There have been no cases of E.coli / Gram negative blood stream infections during quarter 4.

There was an internal mis-reporting of an E.coli blood stream infection in the quarter 3 report. It was reported that there was one case of E.coli bacteraemia in quarter 3 but there were actually two cases in this quarter.

A post infection review (PIR) of this additional case was undertaken. The source of the bacteraemia could not be identified.

Lessons learnt:

- There was no documented evidence that the blood cultures had been taken
- There was no documentation around the venflon being inserted

Areas of good practice

- Evidence of VIP scoring
- Team recognised and escalated patient's deterioration within good time

Recommendations

- Share PIR findings at SNAHP meetings
- IPC to ensure new version of the blood culture policy is uploaded to the document centre
- Blood Cultures should be taken aseptically in line with updates to SaTH's Blood Culture Policy.

A post infection review meeting (PIR) was undertaken for the Klebsiella blood stream infection that occurred in December 2020. The most likely source was a catheter associated urinary tract infection (CAUTI)

Lessons learnt :

- Documentation of the need for the catheter was not completed
- Documentation for the insertion of venflons, blood cultures and VIP needs to be improved

Areas of Good Practice

- Team recognised and escalated patient's deterioration.
- First dose of antibiotics given appropriately.
- Sepsis 6 was initiated immediately.

Recommendations

- VIP scores will be recorded on the Vitalpac in the future
- Ensure that the insertion of any invasive devices are documented appropriately
- Any invasive devices from referring Trusts should be recorded on the Passport documentation.

3.3.6.4 COVID-19 Coronavirus

During quarter 4 the Trust continued to react and implement changes in response to COVID-19

The National guidance was updated in January to provide support for the maintenance of services. Changes included the extended use of facemasks across all pathways to include all patients; therefore an in-patient mask wearing flowchart was created by the IPC team and the compliance is monitored by the ward managers.

The Trust Coronavirus policy is regularly monitored and has been updated during quarter 4 to reflect the changes in the national guidance. Changes to the patient swabbing

requirements were made and a supporting document was created by the IPC team to support staff.

In January the IPC team were supported by two redeployed staff members from Theatres who have been the Trust's PPE champions. They have provided invaluable support to all members of staff across the Trust by providing PPE refresher training and an updated hand hygiene training video. They completed walk-around observations for all clinical areas and have provided reports to ward managers along with action plan templates.

The last COVID-19 positive case was on 27/1/2021 as part of the latest COVID-19 outbreak on the Midland Centre for Spinal Injuries.

The Trust has continued to restore elective services across the hospital in line with PHE guidance 'COVID-19: Guidance for maintaining services within health and care settings' in conjunction with updated NICE guidance that continues to support the management of patients on red, amber and green pathways

As the regional prevalence of COVID declined the trust reintroduced restricted visiting for the long stay patients in line with guidance published from NHS England. A visiting protocol was introduced by the IPC team and communicated across the Trust.

As of 31st March 2020 there have been 29 positive cases of COVID-19 in total within the trust since the start of the pandemic.

In line with national definitions for reporting, reviewing and Investigating Hospital-Onset COVID-19 cases

- 6 patients were Community-Onset
- 9 patients were Hospital-Onset Indeterminate Healthcare Associated
- 6 patients were Hospital-Onset Probable Healthcare Associated
- 8 patients were Hospital-Onset Definite Healthcare Associated

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 frameworks offers providers a way of 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, of which the Trust is in the majority, compliant of the standards required. An action plan has been produced to capture any areas of improvement that is required. Monitoring of this action plan, is undertaken through the IPC Committee.

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

During December 2020, the DIPC, IPC team and operational clinical staff met to review and update version 2 of the BAF to reflect changes in National Guidance and the Trusts systems, policies and processes to reflect the guidance. This was reported through the Trusts Quality and Safety Committee and Trust Board.

Version 3 of the BAF was released in February and is currently being updated.

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COVID-19 Pandemic Timeline

Jan 21

- Spinal injuries Covid-19 Outbreak
- Sheldon Ward Outbreak
- Updated IPC COVID-19 guidance from PHE
- A 7 day Covid -19 screening audit was undertaken
- PPE champions re-deployed to IPC team to support refresher training for staff

Feb 21

- RJAH joined IPCN forum; created to share lessons learned from outbreaks
- A programme of ward /departmental infection control environmental audits were commenced by the IPC team – results shared with ward managers and action plans devised
- Updates released to IPC Board Assurance Framework
- Update of roles and responsibilities of IPC link nurses
- Implemented a patient mask wearing flowchart

March 21

- Updated the Board Assurance framework
- Updated the Coronavirus Policy
- Updated visiting protocol for long stay patients
- Hand Hygiene video
- Approval to purchase an elite version of the Surewash device for hand hygiene training within the trust.

3.4 Outbreaks

There have been two COVID -19 outbreaks during quarter 4.

The Outbreaks were declared in January and investigated by the Outbreak Control Team which reviewed all the available evidence.

Lessons learned are shared with the ward/departmental team, SNAHP, and any areas of good practice/safety improvements are shared with other teams through the infection control working group and committee.

Dept	Date declared	How many involved (staff and pts)	Themes identified
MCSI	18/01/2021	8 patients 5 staff	• Staff member came into work while household member displayed Covid-19 symptoms • Some lapses in PPE usage by staff • Some environmental cleanliness and storage issues
Sheldon Ward	25/01/2021	2 patients	• Patients in same ward at referring Trust – possible transmission

Actions included:-

- Doors to be installed to close of the bays to enable cohorting
- To review the roles and responsibilities of the housekeepers
- To maintain a clean and clutter free environment
- Therapies team to introduce a regular cleaning regime for patient wheelchairs
- Patients to follow mask wearing guidance

3.5 Serious Incidents

There have been no Serious Incidents related to infection prevention or control reported during Quarter 4.

3.6 Conclusion

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

- No cases of MRSA bacteraemia.
- No cases of C.*difficille* against a target set at no more than three for 2020/21.

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 Board is asked to note the Infection Prevention Control and Cleanliness quarter 4 report.

Appendix 1: Acronyms

AHCP	Association of Healthcare Cleaning Professionals
BAF	Board Assurance Framework
C..diff	Clostridium *Difficile*
CAUTI	Catheter Associated Urinary Tract Infection
CQC	Care Quality Commission
E.coli	Escherichia. Coli
HCAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
TKR	Total Knee Replacement
THR	Total Hip Replacement
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessments of the Care Environment
PPE	Personal Protective Equipment
SSI	Surgical Site Infection
SCHT	Shropshire Community Health Trust
SATH	Shrewsbury and Telford Hospitals
SNAHP	Senior Nurse and Allied Health Professional
TSSU	Theatre Sterile Services Unit
UTI	Urinary Tract Infection
VIP Score	Visual Infusion Phlebitis

Glossary

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

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

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

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

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

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

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29th April 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 Trust Board and what input is required?

This paper presents an overview of the People Committee Briefing Meeting held on 30th March 2021 and is provided for assurance purposes.

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 following key points are as follows:

- good progress of actions from the previous meeting with all actions completed or updated
- Good progress was reported on the corporate risk register

The Trust agreed the importance of the following:

- To ensure the Trust is meeting it statutory and regulatory requirements in relation to workforce management
- To oversee the development and implementation of the People Plan and any related workforce plans
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'
- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.
- To assure and provide advice to the Board on any arising HR issues of significance

2.3. Conclusion

The Board is asked to note the Chair's Report following the meeting along with the assurance obtained.

3. The Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the People Committee which met on 30th April 2021. The meeting was quorate with three Non-Executive Directors and three Senior Leaders in attendance. A full list of the attendance is outlined below:

Attendance:	
Paul Kingston	Non-Executive Director (Chair)
Chris Beacock	Non-Executive Director
Sarah Sheppard	Chief People Officer
Kerry Robinson	Director of Performance, Improvement and OD
Hilary Pepler	Board Advisor
Steve White	Chief Medical Officer
Alexander Yashchik	Consultant Anaesthetist / Well Being Guardian
Sue Pryce	Head of People Services
Shelley Ramtuhul	Trust Secretary
Harry Turner	Non-Executive Director
Chris Marquis	Clinical Representation
Apologies:	
Craig Macbeth	Chief Finance Officer
Rob Freeman	Clinical Representation
Stacey Keegan	Chief Nurse and Patient Safety Officer

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. BAF and Corporate Risk Register		
The Committee were informed that the BAF and Corporate Risk Register were presented at Board last week and therefore have not yet been updated. There was a request from People Committee that a standalone risk on OJP be included within the Risk Register which has been agreed by	Y	
2. People Status Update		

The Committee were informed that staff absence continues to be well managed and is currently below the tolerance target. The Absence Line at the Trust will be stood down as of next week, in line with system, and the low number of reports being received. However, staffs are able to access a test if required, for either themselves or their family, via their line manager or through the System and via the Occupational Health Centre. 94% staffs have been vaccinated with many staff receiving their 2nd dose vaccine. The Non-Executive Directors raised concerns over unvaccinated staff being at risk in certain parts of the trust. It was agreed that all staff are required to be risk assessed.	Y	
3. Lead Employer Report – Vaccination Programme		
The Trust informed the committee that the data presented is now out of date and further recruitment has taken place since 10th March, with a further 600 members of staff recruited, with over 100 of those being 'bring back staff'. The programme was a powerful story of collaboration throughout the system, and highlighted this was not only collaboration within the NHS but successful collaboration working with Local Authorities and Volunteer groups, with some very valuable lessons learnt. The Trust explained that with the volume of staff within bank, the system has a big opportunity to create a system wide bank and to create a reservist set of staff. The System has supported two new posts, one of which is, Business Partner, to support the business management of this number of staff. Also, a post to work across the system to create a bank that can work across the system.	Y	
4. Recruitment Plan for Medical Staff		
The plan was shared with the Committee members for information. Members of the Trusts senior leader team have each been asked to plan, with growth, how many consultants will be required for each speciality, hence the data.	P	The committee agreed for a risk to be recorded relating to OJP and Sustainable Operating Model.

Following the discussions, the committee requested that a Risk is raised in regards to OJP and Sustainable Operating Model.		
5. WDES – 2019/20 and Plan 2021/21		
The following findings were presented to the Committee:, • 4.5% of staff consider themselves to have a disability. • 63.5% of staff consider themselves not to have a disability. • 31% of staff have not declared whether they have a disability or not. The Committee discussed the action plan and it was noted that there is an action to improve the questions asked within the staff survey to ensure all data is captured accurately. The action plan is to be presented with the Staff Experience group, as this would offer staff input rather than a leadership input, offering staff more opportunity to be involved in the various actions.	Y	
6. Policy Tracker		
It was noted there are a number of policies that require review currently and these are to be endorsed at the Joint Consultative Committee in April, to then be brought to Extra Ordinary People Committee in May.	Y	
7. Nursing Workforce – Projects and Development		
A summary of the work stream and progress to support the nursing workforce strategy was presented along with the action plan which offers assurance of the timeframe and progress made so far. The Committee were informed that there are elements of the plan which are being worked across the system, in particular the international recruitment. A concern of the link with the higher education institutes, and commented that the demand and capacity needs to be integrated into this. Following discussions, it was agreed by the committee that the Nursing Workforce would be brought to the committee monthly. The information is to incorporate the ICS connection and transforming the data into figures to provide further assurance to the Committee.	Y	
8. Subsistence Allowance Rates		
Following a request for approval, the Committee raised concerns on the allowance rates, with London Hotel rates expected to be higher following Covid. The Trust agreed to liaise with the Finance Department to ensure a compromise with the London	Y	

Hotels.		
9. People Committee – Proposed Sub Committee Structure		
Discussions took place over the structure, and concerns were raised over Training potentially being overlooked. It was requested for a fourth sub-committee to be created for Training. It was also requested for the terms of reference for each sub-committee to be presented at the next committee.	P	Further information to be presented to the Committee which include: • Training Committee • Terms of Reference for sub-committees
10. OD and Improvements Progress Update		
An updated wads presented for OD & Improvements, offering assurance to the committee of the progress being made and further progress to be made.	Y	
11. Work Plan Review		
The committee reviewed the Work Plan for 2021/22, it was agreed that further work is required on the work plan, to ensure this aligns with the current projects being undertaken within the Trust.	Y	
12. Terms of Reference		
The People Committee terms of reference were not approved, as they do not currently reflect the new Trust Structure. Discrepancies to be amended and to be submitted to next committee for approval.	N/A	

3.3 Risks to be Escalated

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

- OJP and Sustainable Operating Model.

3.4 Conclusion

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

Safe Working Hours: Doctors in Training Q4 2016-17

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	29th April 2021
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the Feb 2020 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

Work scheduling – junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work,

the working pattern, the service commitments and the training opportunities available during the post or placement.

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period March 2021(based on previous Jan figures) – *International training fellows not included*

Orthopaedics	Training posts	19
	Of which Doctors in training on 2016 contract	12
Rehabilitation/ Spinal Injuries	Training posts	1
	Of which Doctors in training on 2016 contract	1

3.2.2 Exception reports (with regard to working hours)

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

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

Currently there have been no exceptions reported to the Trust.

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

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

3.2.3 Work schedule reviews

None – please see above. Work schedule reviews are triggered by repeat exception reporting highlighting an issue with a position or rota. With no exception reports, no work schedule reviews should be expected.

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Please see Appendix 1

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Jan - 1

Feb - 0

Mar - 0

Vacant shifts

Jan - 8

Feb - 2

Mar - 0

Total cost - £4897.50

Safe Working Hours: Doctors in Training Q4 2016-17

Medicine

Number of Vacancies (12 posts)

Jan - None
Feb - None
Mar - None

Vacant shifts

Jan - 8
Feb - 20
Mar - 28
Total cost - £30240 (cover of paternity and long term sick leave)

MCSI

Number of Vacancies (9 posts)

Jan – 2
Feb – 3
Mar - 3

Vacant Shifts

Jan – 8
Feb – 16
Mar - 19
Total cost - £9477.80

Long Term Vacant Shifts

MCSI is consistently running with vacancies with an increase to three over the last quarter

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction was attended in February2021. During the pandemic Junior Doctor Forum has been reinstated virtually. Attendance was down from previous meetings.

3.3.2 Software System

Engagement with Allocate is still awaited.

Associated Risk

With the restart of elective activity, as previously discussed, appropriate focus on training needs to be ensured. Appreciation of the juniors working hours, with respect to evening or weekend work if it resumes, needs also to considered.

Next Steps

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

3.4. Conclusion

The Trust continues to see no exception reports or fines.

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

Christopher Marquis

Guardian of Safe Working

Appendix 1: Junior Doctor Agency and Locum usage and Rota Vacancy Report

Appendix removed for information governance purposes

Chair's Assurance Report
Risk Management Committee –7th April 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29th April 2021
Executive Sponsor:	Harry Turner, Non-Executive Director	Paper Category:	Governance and Quality
Paper Reviewed by:		Paper Ref:	
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Risk Management Committee Meeting held on 7th April 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

The Board of Directors has delegated responsibility for the implementation of the Trust's risk management systems and controls to the Risk Management Committee. This Committee is responsible for seeking assurance on the Trust's risk management in order that it may provide appropriate assurance to the Board.

2.2 Summary

Key points to highlight from the meeting

- The meeting was well attended
- There was good progress of actions from the previous meeting with most actions completed or updated
- The work plan was reviewed and agreed
- Deep Dives were presented from the CSU and SSU Units

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 Risk Management Committee which met on 7th April 2021. The meeting was quorate with one Non-Executive Director present. A full list of the attendance is outlined below:

Attendance:		
Membership:		
Harry Turner	Non Executive Director (Chair)	HT
Mark Brandreth	Chief Executive	MB
Stacey Keegan	Chief Nurse / Head of Patient Safety	SK
Craig Macbeth	Chief Finance and Planning Officer	CM
In Attendance:		
Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
Ashling Donohue	Governance Lead for SSU	AD
Part Meeting:		
Ian Gingell	Health and Safety Advisor	IG
Nicki Bellinger	Assistant Chief Nurse – SSU	NB
Sara Ellis Anderson	Assistant Chief of Professions	SEA
Laura Peill (part)	Managing Director for SSU	LP
Alyson Jordan	Head of Access	AJ
Dawn Forrest (part)	Managing Director for CSU	DF
Phil Davies (part)	Head of Estates and Facilities	PD
Minutes:		
Heather Pickering	Interim Trust PA	HP
Apologies: Chris Beackcok – Non Executive Director Rob Freeman – Clinical Representation Sarah Sheppard – Chief of People		

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
Corporate Risk Management Report		
The Committee received the Trust-wide report and noted	Y	

the following:- • 36 incidents overdue which is a normal level and this could be broken down as 14 incidents awaiting review, 14 incident still under investigation and 12 incident investigations completed and awaiting final approval • 36 risks overdue for review which are being chased by the Governance Team • 59 risks were closed and 38 risks were opened in Q4 • 1 serious incident reported where a patient aspirated under anaesthetic • 35 pressure sore incidents and the increase from 19 pressure sores reported in Q3 and 12 of the pressure sores are RJAH acquired. It was explained that there has been a drive in education around documentation and more focus in this area resulting in an increase in reporting. It was noted that pressure ulcer awareness was also a Quality priority for this year and it is positive reporting rather than any lapse in care. • An increase in Infection Control Incidents due to the Covid pandemic • A slight increase in patient slips, trips and falls • There were 707 live risks on the Trust's Risk Register which is an increase of 80 from the last report and these could be broken down as 264 risks which required treatment, 359 risks which have been mitigated and are being tolerated and 84 Covid related risks The Committee discussed the management of Covid risks and the need for this to be incorporated as business as usual going forward The Committee *noted* the report		
Board Assurance Framework / Corporate Objectives		
The Committee noted the new risk in relation to over-reliance on OJP. The Committee noted that the Trust had set new objectives and that the Board Assurance Framework (BAF) was being reworked to align to these, some risks may be carried forward. The Committee noted that by the end of Q1 there should be a clearer picture around Covid and Restoration and the System position and the BAF will look significantly different.	Y	

It was noted that the ICS BAF is still being devised and the Trust needs to link into that. The Committee noted that the ICS will be using a similar format with the objectives and risks incorporated into one document and felt that this helps discussion around what is trying to be achieved rather than looking at the risks in isolation. The Committee ***noted*** the BaF and Corporate Objectives		
Annual Reports		
Corporate Risk Register Annual Report The Committee received the report which highlighted the following:- • 18 current live risks with a rating of 15 or above - 17 are risks to be treated (1 on the Covid related risk register • In the last financial year 15 risks were added to the Corporate Risk Register, 9 of which were new risks and 6 were existing risks which were escalated to 15 or above • 4 risks remained on the register for the last 12 months – 2 risks have maintained the same rating – 2 risks have increased in rating The Committee considered the significant difference between the risks in the Specialist Unit and Clinical Service Unit against the other units and noted that they have the increased waiting times within Dexa and the services that have still been operating / have a large demand such as Spinal Disorders services. It was noted that there were no high risks for MSK and that risks around clinical prioritisation and the harms reviews sit as well as the pause in elective services needed to be considered. It was agreed that the four risks that have remained on the Corporate Risk Register for the last 12 months require a deep dive to understand why they have not moved or increased. The Committee considered the risks that have deteriorated:- • Cyber-attack has moved from amber to red and is stated as a Covid risk. It was noted that the risk	Partial	A deep dive around 12 month old risks to take place A further understanding of the cyber risk was required Responsiveness of reducing risks once mitigated – it was agreed this would be picked up by the Governance Team with the Units

was considered to be higher during Covid due to increased reliance on IT systems with homeworking but further understanding of this was required The risks around health and safety and tissue viability were considered and it was felt these could be de-escalated. There was a risk noted in relation to the age of the MRI scanner and this was deemed a relevant risk. A risk regarding therapeutic injection delivery was noted and the Committee was information that this was relating to Covid due to the amount of time taken to clean down in between appointments. The Committee was advised that the timings will be reviewed and hopefully time slots can be reduced to allow more patients through. The Committee *noted* the report.		
Committee Management (for noting)		
Terms of Reference The Committee received the Terms of Reference for review and noted that there had not been any significant changes. Minor changes had been made to job titles to align with the current structure. The plan to amalgamate the Risk and Audit Committees was considered and it was noted that the Terms of Reference for each committee would need to be reviewed. The Committee *approved* the Terms of Reference **Review of the Work Plan** The work plan was presented for the year ahead with the caveat that it might be decided to merge the meetings into Audit Committee and the impact will need to be considered on the Audit Committee Agenda and whether it needs to meet more frequently. The Committee considered the restoration and system work which is unknown at the present time. It was agreed that this may need to be added in as the System risk register and the System BAF is currently not in the work plan. It was agreed that once formulated these would be added in and looked at in conjunction with the Trust's. The Committee *noted* the work plan.	N/A N/A	

Safer Sharps Update The following was highlighted from the paper • The Trust is substantially compliant. • All non-safe sharps have been identified in the Trust • Safer sharps alternatives have been found. • More work is to be carried out in the labs but there are no concerns around this. Devices such as scalpels used in labs can be moved to safer alternatives. • In terms of regulatory compliance and actions from the HSE the Trust was felt to be compliant. The Committee considered what external assurance could be obtained and suggested an external assessment in 6 months' time to re-look at compliance and whether there is further work to be done. The Committee *noted* the update. **Chair Report Health and Safety Committee** The Committee was notified of a RIDDOR incident. A contractor was carrying out work on refrigeration plants and sustained a severe cold burn injury. The burns themselves are not RIDDOR reportable however it is classified as a dangerous occurrence. The Trust's requirement to report as controller of the premises was still being investigated given that it involved a non-employee. The Committee noted the non-assurance within the Chair's Report. • Manual handling concerns in TSSU being looked into with a report back to the Health and Safety Working Group and Committee • Fire Safety Training – The Trust Fire Trainer has retired and since the report was written a new company has been appointed to carry out fire safety training. This will provide more resilience as the new company has more trainers. 55% of new starters are not receiving local inductions – People Services consider this to be a paperwork issue and it is being investigated further. The Committee felt this should be referred to the People Committee. • Demographic Risk Assessment for Staff – Version 10 in now in place and therefore the version control issue has been resolved.	Y Partial	Additional assurances required around Occ. Health referrals and local inductions from People Services.

• Staff Referrals to Occupational Health – People Services are carrying out a piece of work to understand the timescales and again it was agreed this should be referred to the People Committee The Committee *noted* the changes within the Report and *accepted* the assurance contained within in. **Medical Devices Committee Report** The Committee received the report from the February Medical Devices Committee where good progress was noted against previously recorded actions. • KPIs at the meeting revolving around training and maintenance are well above the targets set. • A CAS alert brought to the meeting was noted as Closed in relation to Covid-related oxygen supply and associated fire risks. • Terms of Reference to go through the next meeting • Information Governance considerations of selling medical devices and the assurances required for this are being looked into. The Committee *noted* the Report.	Y	
Unit Deep Dives		
Clinical Support Unit The Committee noted the following :- • Since October CSU had 30 new risks opened and 23 closed – 4 have increased their rating and 17 have decreased. The reasons for the changes can be seen in Tables on page 5 and 6 of the report. • The Risk tracker focuses on the risks scoring 12 and above – several are related to work force, operational capacity, ageing equipment – particularly in radiology and IT systems. • The Orthotics risk has been reviewed and is now at 15 and not 20. The following three risks were highlighted to the Committee:- • Inadequate storage for the emergency drug cupboard – there have been several incidents relating to this in recent months. • Ongoing Health and Safety concerns with orthotic despatch. • The growing number of patients awaiting routine	Y	

RTT therapeutic injections. The Committee was advised that there is still further work to do within the unit :- • Focus on reviewing and closing the very low and low tolerated risks, Continuing to carry out the department Deep Dives for the governance meeting and • Raising awareness at department level of their top 3 risks and what actions are being taken in relation to this. The Managing Director for CSU confirmed that some risks seem to say the same thing and there are plans to 'cleanse' the register across the unit to ensure the risks are a) true risks and b) the risk is reflected in the description. The Committee *noted* the Report. **<u>Support Services Unit</u>** The Committee received an overview of the Deep Dive report for the Support Services Unit highlighting the changes to the risk register between October 2020 and March 2021. The paper also highlighted the improvement work within the unit around the risk management processes. • 0 overdue risks in March due to the rigour in place. • 270 lives risks – 226 within Estates and Facilities which is the usual distribution. • 7 risks are moderate. • 0 high risks. The key changes to risk since the last Deep Dive were noted as follows: • A number of additions to the digital risk following a number of review meetings with the Digital Director and the Chief Clinical Information Officer. • Several risks have been moved into the Assurance Team under the Director of Digital such as the cyber security risk. • The Group are meeting weekly to ensure the operational and strategic issues are joined up. • A number of moderate risks have been closed one of which was high due to securing additional funding. • Health and Safety Risk – there is ongoing discussion between the unit and the governance	Y	

team around how resilience can be increased in this area although the risk has decreased from 16 to 12. The Committee considered that in the coming years there will be challenges with investment capital and a number of the risks require investment. It considered how the risk register can be used to prioritise those risks e.g. Mortuary fridges, loss of telephony. Some of the risks will remain for a long time because of the lack of capital and which should be addressed first. It was noted that there is a Capital Management Group in place which uses the risk register to prioritise where backlog maintenance funding is used. The Committee noted the report.		
Any Other Business		
The Committee considered the issue of risks around the exit strategy as the Trust comes out of Covid and asked if a risk register should be created to be fully sighted on any risks. It was agreed that this needs to be thought through and requires a reframing of the Trust's Corporate Risks.		

3.4 Approvals

Approval Sought	Outcome
Terms of Reference	Approved

3.6 Risks to be Escalated

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

3.5 Conclusion

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

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

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29th April 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	Finance, Performance and Digital	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

A scaled down Finance Planning and Investment Committee was held on 27th April 2021. A verbal update will be provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

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

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
	27/04/21		14:00

1. Introduction		14:00
1.1. Apologies	Rachel Hopwood	
1.2. Minutes from the previous meeting	Rachel Hopwood	
1.3. Action log/Matters arising	All	
1.4. Declaration of interests	All	
2. Digital		
2.1. EPR Outline Business Case	Simon Adams	14:10
3. Performance		
3.1. Performance Overview Report	Kerry Robinson	14:30
3.2. Restoration & Financial Impact Committee Update (verbal)	David Gilburt	14:40
3.3. Finance Report	Mark Salisbury	14:45
4. Planning		
4.1. Financial Plan	Mark Salisbury	14:55
4.2. Capital Programme 21/22	Mark Salisbury	15:05
5. Committee Management		
5.1. Chair Report from MSK transformation programme	Craig Macbeth	15:15
5.2. Chair Report from Trust Performance and Operational Improvement Board	Kerry Robinson	15:20
5.3. Board Assurance Framework and Corporate Objectives	Shelley Ramtuhul	15:25
6. Governance		
6.1. Review of the Work Plan	Shelley Ramtuhul	15:35
6.2. Attendance Matrix	Shelley Ramtuhul	15:40

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
	27/04/21		14:00

7. Top Risks	Shelley Ramtuhul	15:45
8. Any Other Business	All	

9. Next meeting: Tuesday 25th May 2021

Month 12 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	29/04/2021
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 12 (March) 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.

During March 2021 the Trust began to repatriate staff that had been at a neighbouring provider to support them in their Covid response. March 2021 activity therefore remains low against the phase three national restoration targets. Trajectories and forecasts that are included in the IPR are based on activities before the system response was known. Furthermore, March 2020 baselines were impacted due to Covid. NHS EI have since released a Covid-adjusted baseline that is reflected in the slides and utilised in our phase three planning.

2.2. Summary – Month 12

In line with the Trust's Performance Framework, Board-level Key Performance Indicators (KPIs) which are considered to drive the overall performance of the Trust.

Areas of performance to highlight this month are as follows;

Caring for Staff;

- Sickness absence reported at 3.27% for March; remaining below 3.6% target for a second month. Overall position for the year reported below plan.

- Voluntary staff turnover remaining below 8% tolerance at 6.99%.

Caring for Patients;

- No RJAH acquired infections throughout March.
- One cancer waits standard remaining below target; Cancer 62 Days Consultant Upgrade.
- 18 weeks RTT open pathways performance remains well below target; 56.23% for March. Increase in list size from 11,315 to 12,027 due to reduced elective work and referrals continuing.
- The number of patients waiting 52 weeks and over continues to grow; now at 2,513 with 62% English patients.
- Both diagnostics standards remain below target with English reported at 90.53% and Welsh at 94.40%.

Caring for Finances;

- Total Elective activity was 438 in March; 338 spells behind the March 2020 levels (with working days adjustment) which was also impacted by COVID-19. NHS EI have made a covid adjustment to the March 20 baseline to reflect expected levels without the covid impact. The NHS EI adjusted baseline is 1,166, of which the Trust achieved 38%. Our phase 3 plan was originally aiming to restore 91% of the NHS EI adjusted baseline before the latest wave.
- Total Outpatient activity was 11,937 in March; 106 spells behind the March 2020 levels (with working days adjustment) which was also impacted by COVID-19. NHS EI have made a covid adjustment to the March 20 baseline to reflect expected levels without the covid impact. The NHS EI adjusted baseline is 16,885, of which the Trust achieved 71%. Our phase 3 plan was originally aiming to restore 79% of this NHS EI adjusted baseline.
- All finance measures green rated with exception of Expenditure.

2.3. Summary – Year End

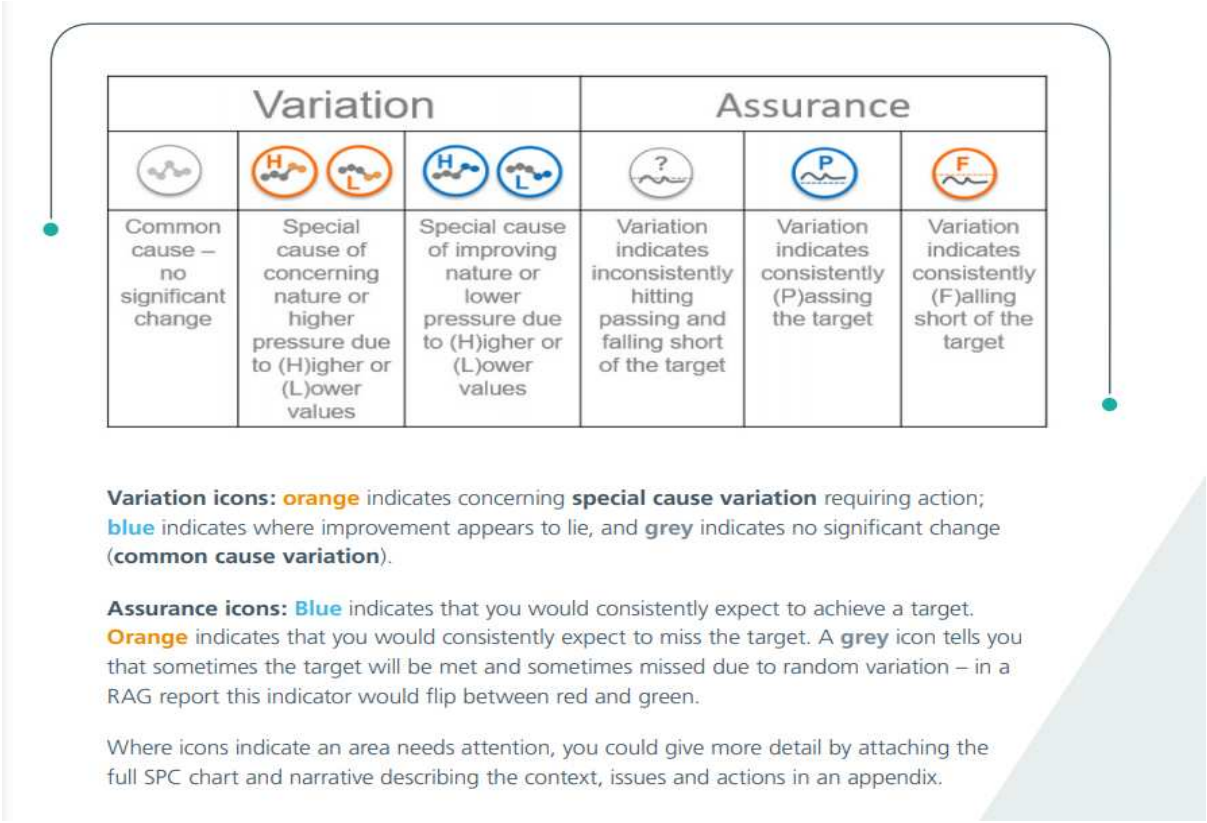
A review of the year-end position indicates the following measures did not meet year-end forecasts and will require focus throughout the new financial year:

Serious Incidents
RJAH Acquired E. Coli Bacteraemia
Unexpected Deaths
Cancer Plan 62 Days Standard (Tumour)
18 Weeks RTT Open Pathways
Patients Waiting Over 52 Weeks – English
Patients Waiting Over 52 Weeks – Welsh
6 Week Wait for Diagnostics - English Patients
8 Week Wait for Diagnostics - Welsh Patients
Bed Occupancy – All Wards – 2pm
Total Outpatient Activity
Total Elective Activity

In some cases, improvement has already begun in recent months. Monitoring within the new financial year will ensure these improvements are sustained and further improved where required.

2.4. IPR Format Change for 2021/2022

In line with the NHS EI recommended approach, the Trust will move away from RAG rating in 2021/2022 and instead adopt the summary icons, in conjunction with SPC graphs, as summarised below:



As the picture above demonstrates, the icons will summarise variation and assurance, assisting the Trust's performance monitoring where required.

2.5. Conclusion

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

Integrated Performance Report
March 2021 – Month 12

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

Aspiring to deliver world class patient care

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Thirteen-month heatmap view

Caring for Staff

	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Sickness Absence	4.37%	4.06%	3.98%	2.82%	2.77%	2.61%	2.79%	3.6%	4.45%	4.42%	4.4%	3.43%	3.27%	3.6%	3.6%	3.55%	G	Feb-20
Voluntary Staff Turnover - Headcount	7.32%	8.41%	7.96%	7.99%	8.14%	8.24%	8.34%	8.07%	8.2%	8.33%	7.97%	7.99%	6.9%	8%	8%	6.9%	G	Sep-19

Integrated Performance Report
March – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Caring for Patients

	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Serious Incidents	0	0	1	0	2	0	0	0	1	1	0	1	0	0	0	6	R	Apr-18
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Number of Complaints	7	2	7	5	3	2	4	8	10	4	9	7	10	8	96	71	G	May-18
RJAH Acquired C.Difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	G	Apr-18
RJAH Acquired E. Coli Bacteraemia	0	0	0	0	1	2	1	2	0	0	0	0	0	0	0	6	R	Jun-19
RJAH Acquired MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	G	Apr-18
Unexpected Deaths	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2	R	Apr-18
31 Days First Treatment (Tumour)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%			96%	96.77%	G	Nov-19
Cancer Plan 62 Days Standard (Tumour)*	100%	85.71%	50%	100%	100%	100%	50%	100%	0%	100%	100%	100%			85%	83.33%	R	
18 Weeks RTT Open Pathways	85.27%	78.77%	67.3%	50.6%	40.82%	42.93%	49.13%	52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	92%	92%	54.41%	R	
Patients Waiting Over 52 Weeks – English	0	12	33	68	123	198	306	418	540	687	976	1,334	1,551	0			R	Nov-19
Patients Waiting Over 52 Weeks – Welsh	3	15	40	77	135	199	299	385	453	528	639	798	840	0			R	Nov-19
6 Week Wait for Diagnostics - English Patients	90.2%	22.38%	20.24%	26.36%	28.66%	39.56%	72.35%	86.92%	88.7%	83.37%	78.24%	87.38%	90.53%	99%	99%	59%	R	
8 Week Wait for Diagnostics - Welsh Patients	90.57%	41.65%	21.04%	21.2%	20.66%	36.73%	74.93%	92.18%	87.99%	85.82%	83.58%	94%	94.4%	100%	100%	58.14%	R	

Integrated Performance Report
March – Month 12

Caring for Finances

	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Latest target	YTD plan	YTD actual	Year-end forecast	DQ rating
Total Elective Activity		35	35	81	132	153	491	605	693	779	377	263	438	776	11,943	4,082	R	
Bed Occupancy – All Wards – 2pm	80.53%	74.31%	70.96%	71.57%	74.43%	72.33%	72.86%	78.17%	75.14%	75.84%	73.37%	71.15%	73.63%	87%	87%	73.75%	R	Sep-19
Total Outpatient Activity		6,382	5,152	6,508	7,222	6,593	9,528	10,845	11,221	10,358	10,572	10,453	11,937	12,043	165,468	106,771	R	
Financial Control Total	1,107	0	0	0	0	0	0	462	463	137	272	-117	3,331	-630	0	4,548	G	
Income	10,633	8,783	8,756	8,716	8,962	8,656	9,306	9,387	10,058	9,138	8,988	9,380	14,180	9,502	110,752	114,309	G	
Expenditure	9,564	8,827	8,799	8,761	9,006	8,701	9,350	8,967	9,640	9,045	8,760	9,542	10,769	10,176	111,283	110,167	G	
Efficiencies Delivery	303	46	57	61	155	152	200	88	79	137	118	113	140	92	565	678	G	
Cash Balance	8,250	15,380	17,150	17,270	18,140	18,880	18,850	18,740	19,100	19,510	20,402	21,278	16,137	6,390	6,390	16,137	G	
Capital Expenditure	2,451	72	167	267	308	183	770	694	935	307	97	463	1,188	1,064	8,886	5,451	G	
Use of Resources (UOR)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	G	

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Sickness Absence

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

3.27% against **3.6%** target

Within target green rated

Exec Lead:
Director of People

Integrated Performance Report

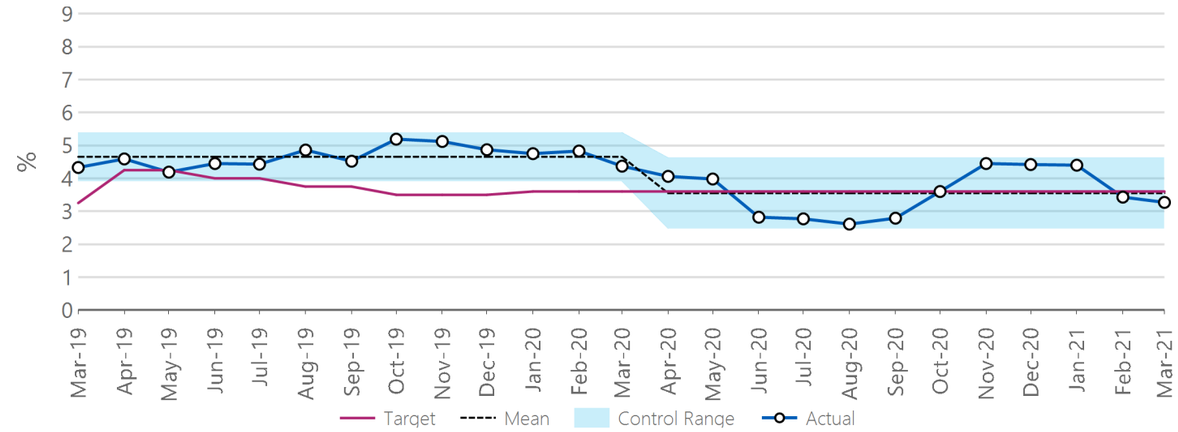
Narrative

The sickness rate for March is reported at 3.27%, a reduction from the February rate of 3.43%. Rate is within tolerance. Highest individual reason for absence was anxiety/stress/depression/other psychiatric illnesses, remaining static at a rate of 0.94%. Specialist unit sickness rates are above threshold at 4.02% due to long term absence.

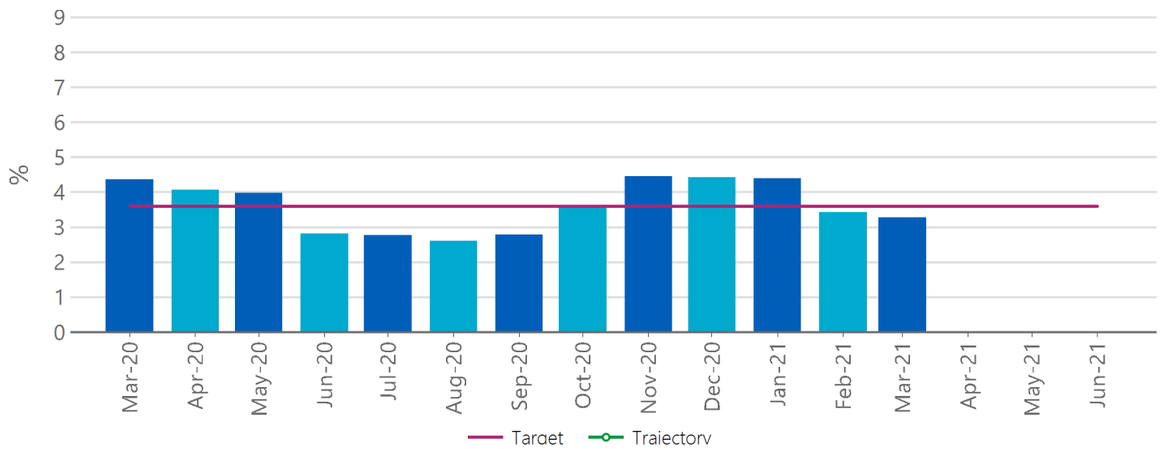
A unit breakdown is:
- MSK Unit 3.64% overall with 1.81% short term and 1.83% long term
- Specialist Unit 4.02% overall with 1.44% short term and 2.58% long term
- Clinical Services Unit 2.81% overall with 1.09% short term and 1.72% long term
- Support Services Unit 2.97% overall with 1.12% short term and 1.84% long term
- Assurance and Standards Team 1.24% overall with 0.06% short term and 1.18% long term

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Sustain: Continuing with local supportive actions for wellbeing.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
4.33%	4.59%	4.19%	4.45%	4.43%	4.86%	4.52%	5.19%	5.12%	4.87%	4.75%	4.83%	4.37%	4.06%	3.98%	2.82%	2.77%	2.61%	2.79%	3.6%	4.45%	4.42%	4.4%	3.43%	3.27%	3.55%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Voluntary Staff Turnover - Headcount

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

6.9% against **8%** target

Within target green rated

Exec Lead:
Director of People

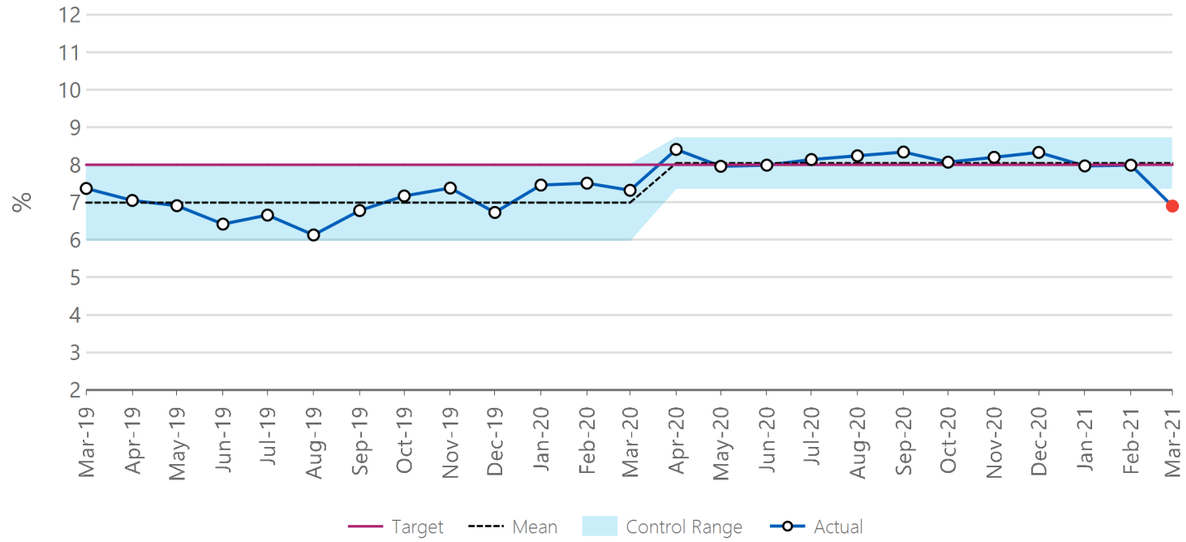
Integrated Performance Report

Narrative

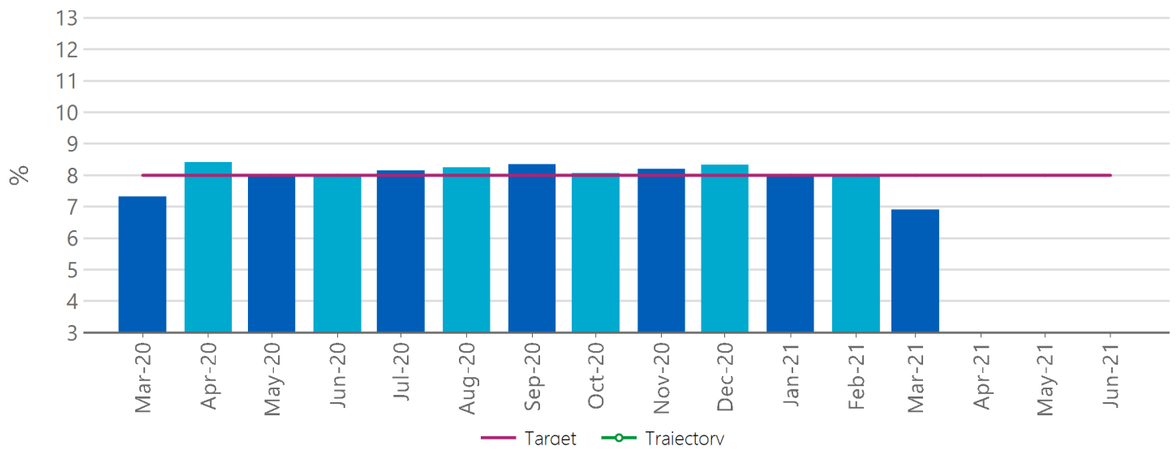
The voluntary staff turnover rate is reported below tolerance at 6.90%, remaining within target for a third consecutive month.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Sustain: Continuing with local supportive actions for wellbeing, particularly through the period of restoration.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
7.37%	7.05%	6.91%	6.42%	6.66%	6.13%	6.78%	7.17%	7.38%	6.73%	7.46%	7.51%	7.32%	8.41%	7.96%	7.99%	8.14%	8.24%	8.34%	8.07%	8.2%	8.33%	7.97%	7.99%	6.9%	6.9%

Serious Incidents

Number of Serious Incidents reported in month

0 against 0 target

On target green rated

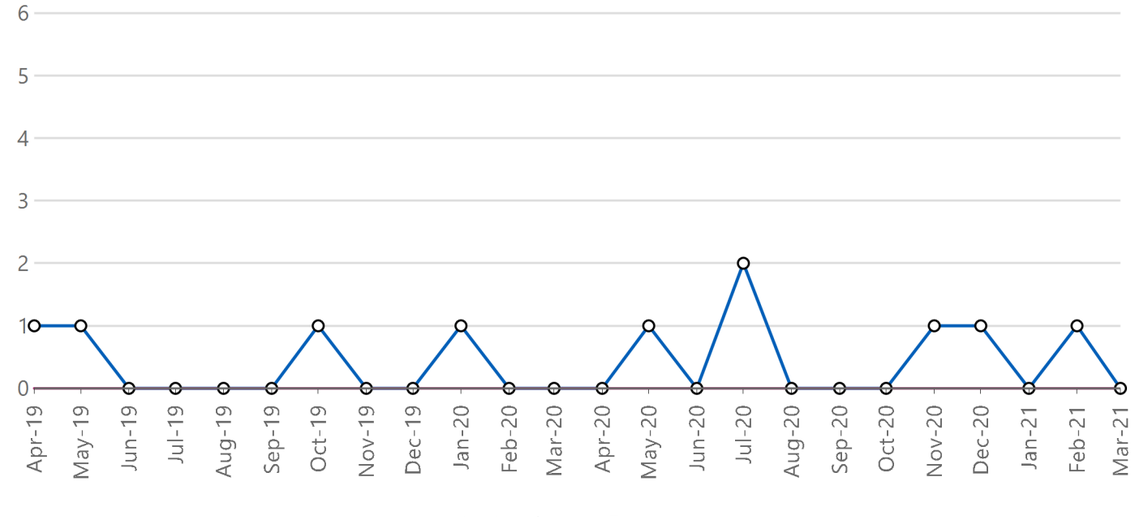
Exec Lead:
Director of Nursing

Integrated Performance Report

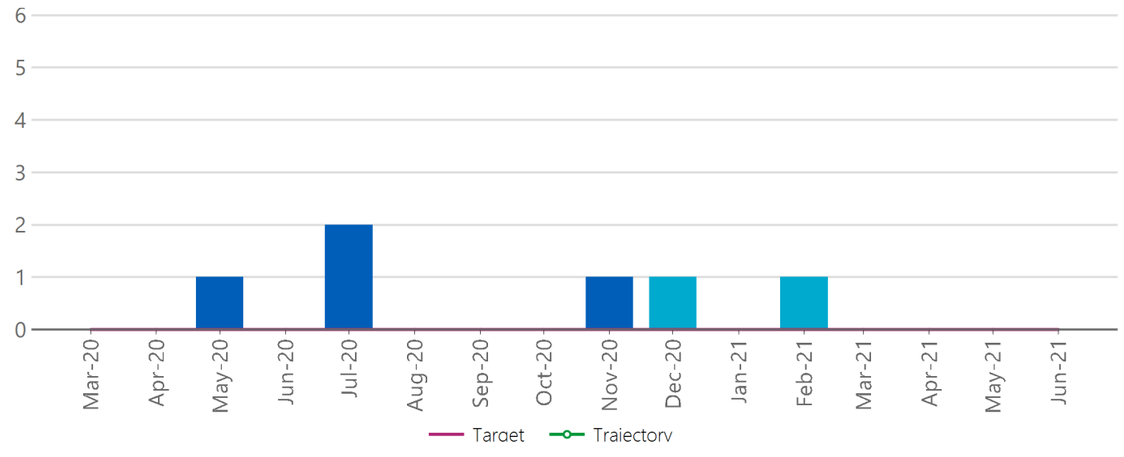
Narrative

There were no serious incidents reported in March.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Never Events

Number of Never Events Reported in Month

0 against 0 target

On target green rated

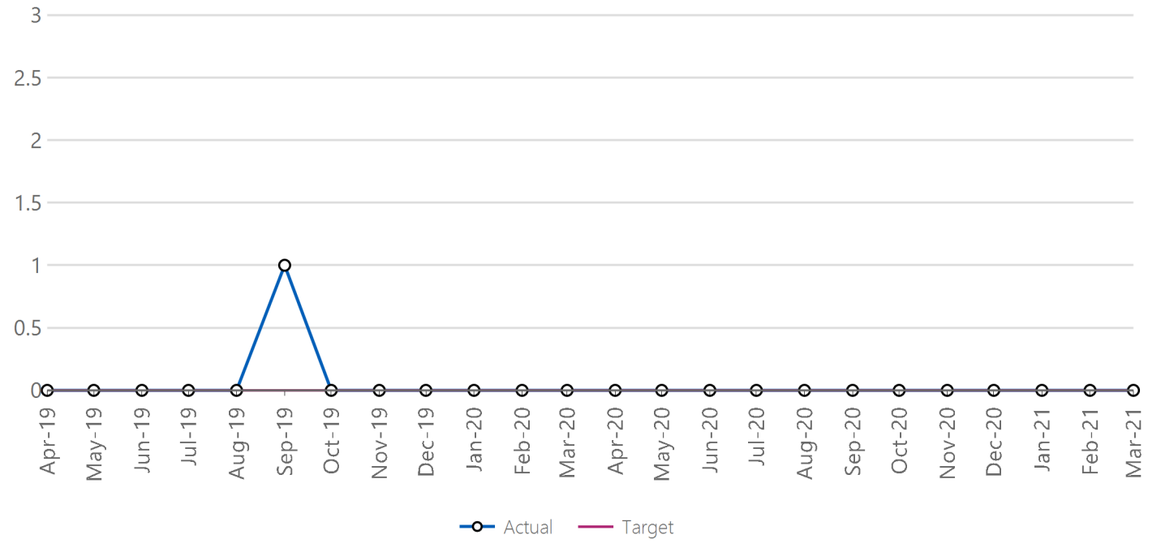
Exec Lead:
Director of Nursing

Integrated Performance Report

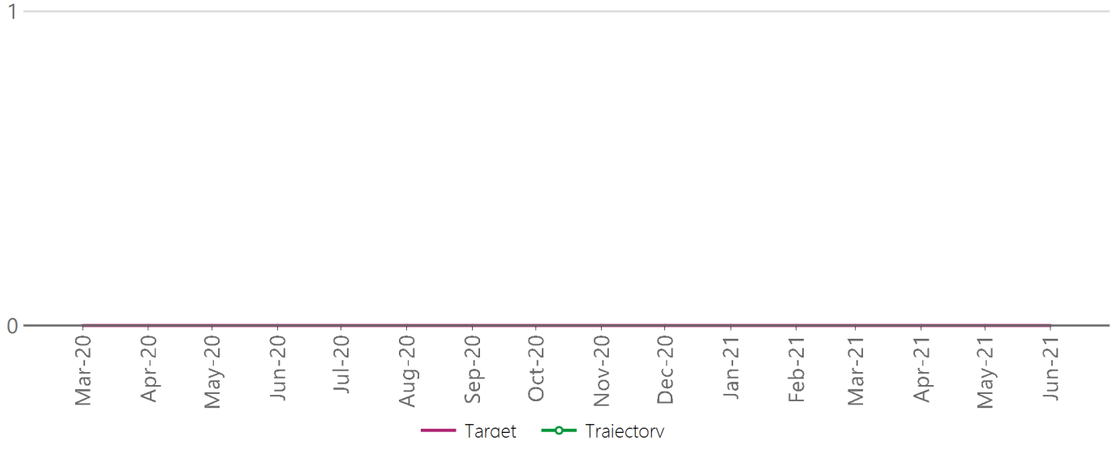
Narrative

There were no never events reported in March.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Number of Complaints

Number of complaints received in month

10 against 8 target

Breaching target red rated

Exec Lead:
Director of Nursing

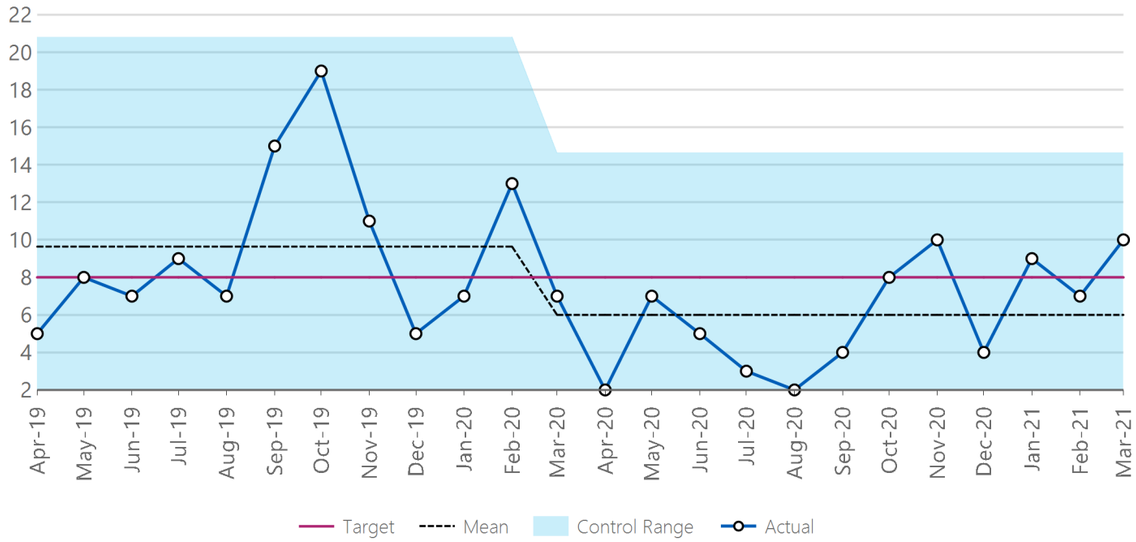
Integrated Performance Report

Narrative

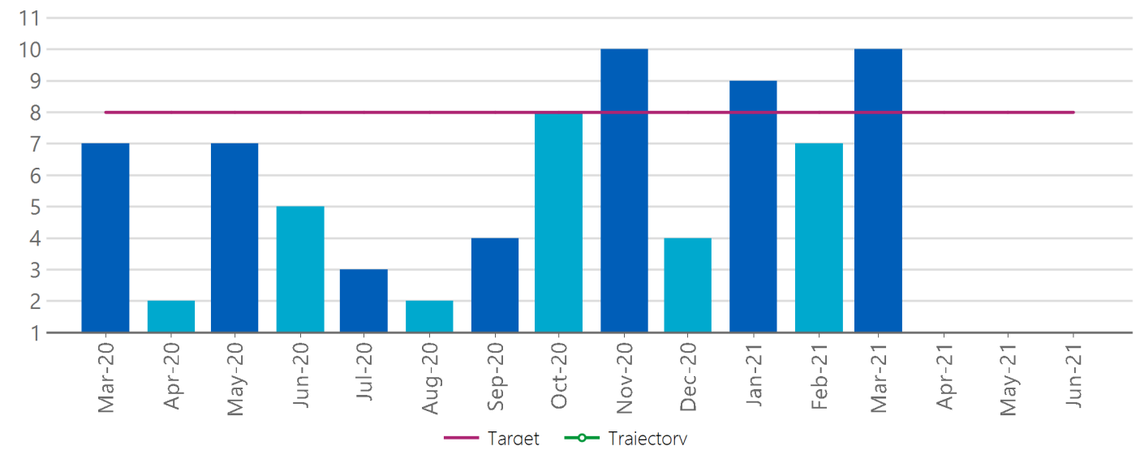
There were ten complaints received in March, above the Trust's tolerance of eight. Three complaints related to quality with reasons associated with transfer from paediatric to adult care (1), lack of follow up (1) and treatment and language used by radiologist (1) . There were seven operational complaints with reasons relating to waiting times for surgery (3), advice given (1), delivery method of outpatient appointment by telephone (1), issues re entry and wearing of face mask (1) and telephone calls not answered (1).

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: The complaints received in March have not been closed yet so it is too early to identify specific learning and actions but the Clinical Governance leads will progress these following closure of each case. The volume received in March is currently within common variation control limits.

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
5	8	7	9	7	15	19	11	5	7	13	7	2	7	5	3	2	4	8	10	4	9	7	10	71

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired C.Difficile

Number of cases of C.Difficile in Month

0 against 0 target

On target green rated

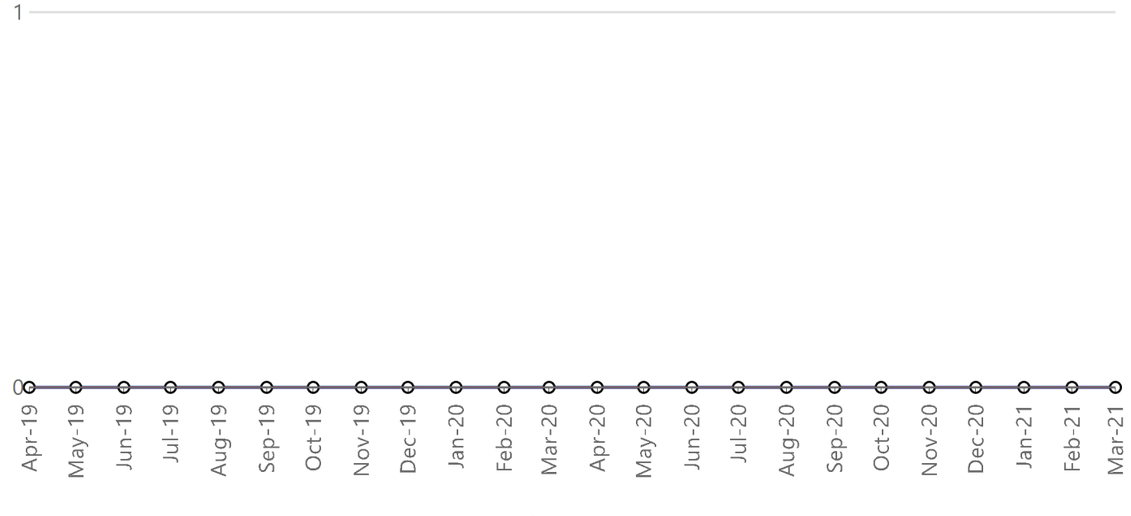
Exec Lead:
Director of Nursing

Integrated Performance Report

Narrative

There were no incidents reported in March.

Performance over 24 months –



Trajectory

Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired E. Coli Bacteraemia

Number of cases of E. Coli Bacteraemia in Month.

0 against 0 target

On target green rated

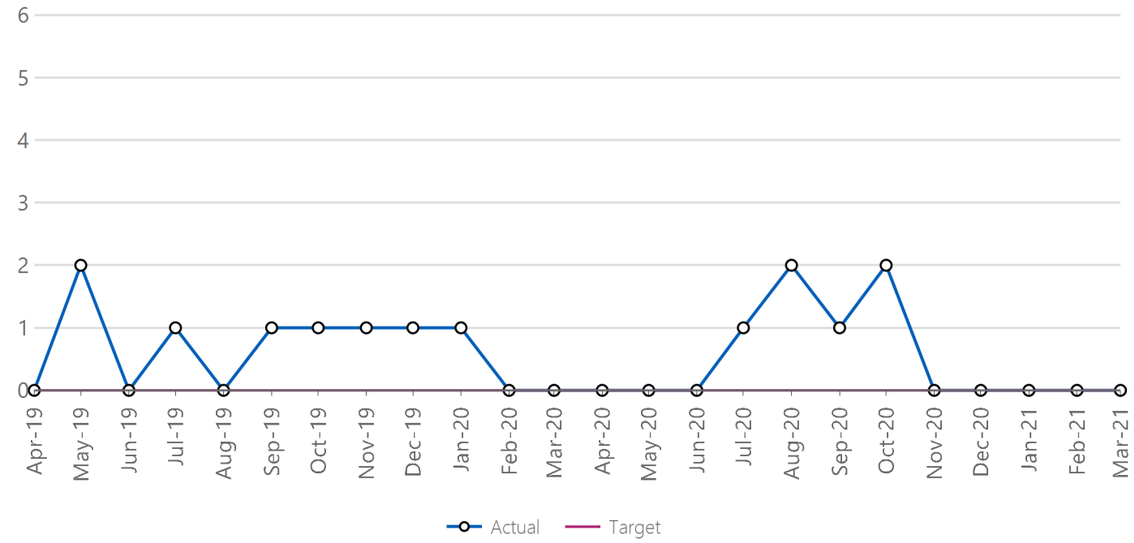
Exec Lead:
Director of Nursing

Integrated Performance Report

Narrative

There were no incidents of E.Coli Bacteraemia reported in March.

Performance over 24 months –



Trajectory

Actions

Heatmap performance over 24 months

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Acquired MRSA Bacteraemia

Number of cases of MRSA bacteraemia in month

0 against 0 target

On target green rated

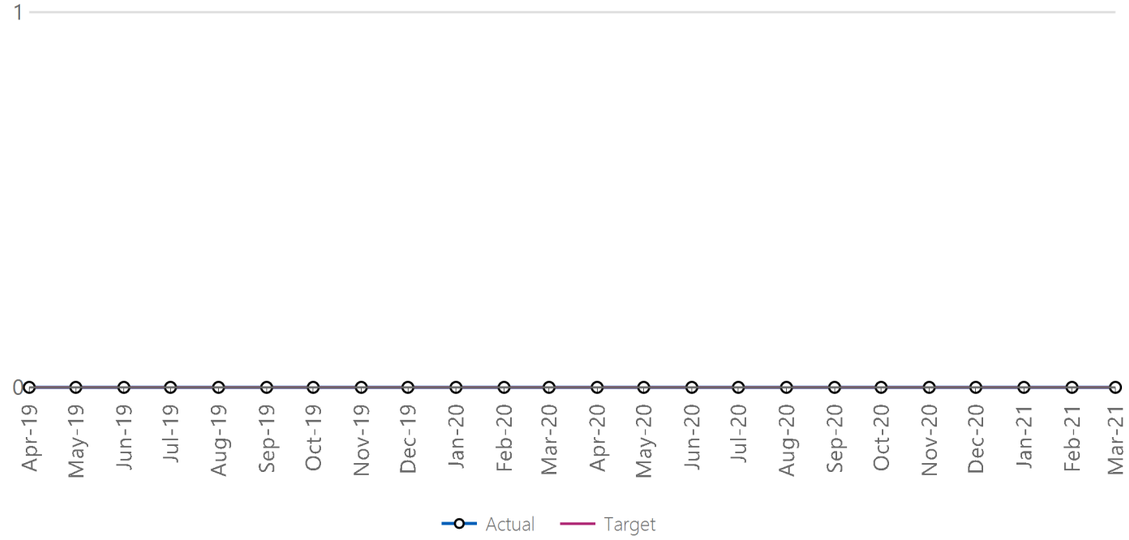
Exec Lead:
Director of Nursing

Integrated Performance Report

Narrative

There were no incidents reported in March.

Performance over 24 months –



Trajectory

Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Unexpected Deaths

Number of Unexpected Deaths in Month

0 against 0 target

On target green rated

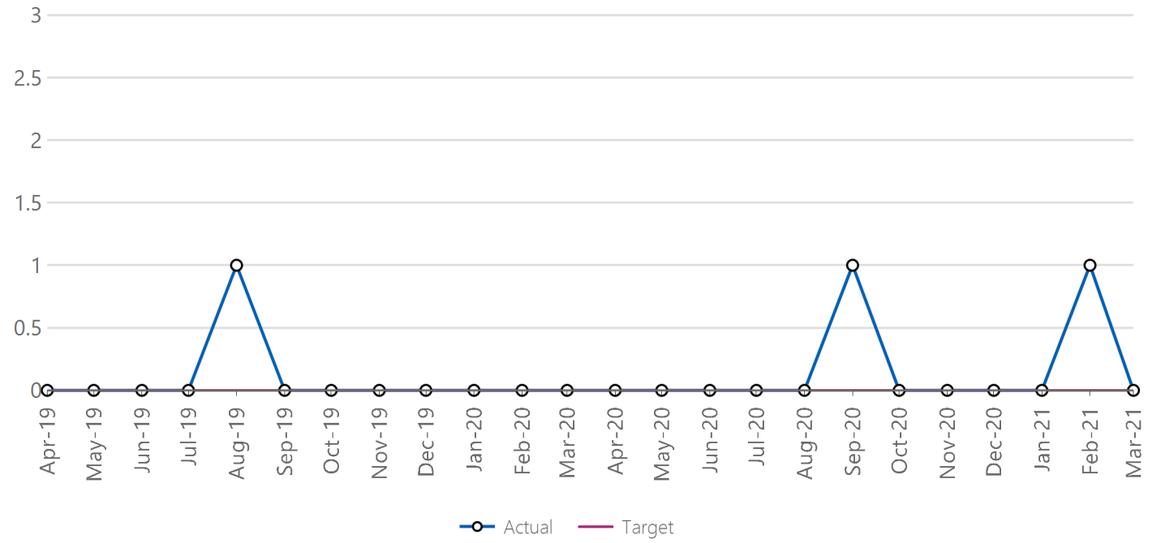
Exec Lead:
Medical Director

Integrated Performance Report

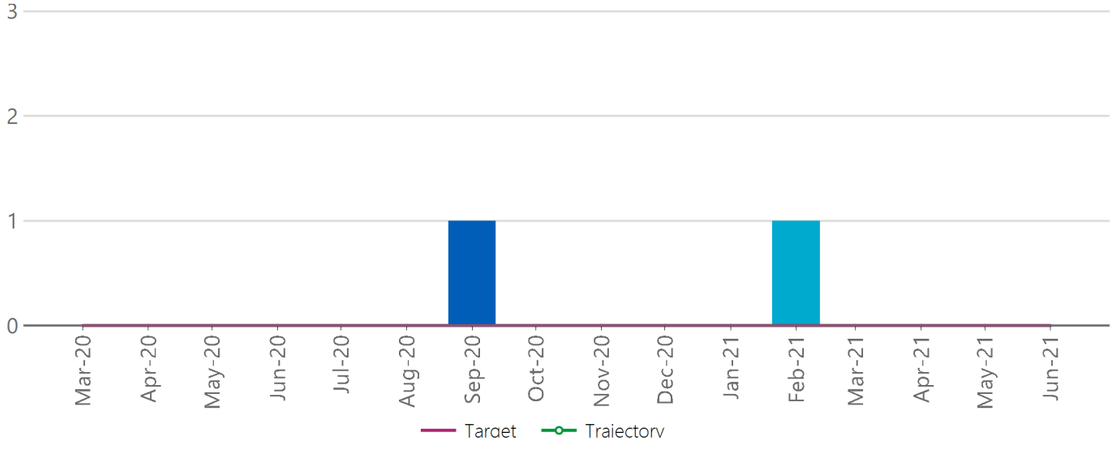
Narrative

There were no deaths throughout the Trust in March.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	2

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

31 Days First Treatment (Tumour)*

% of cancer patients treated within 31 days of decision to treat (*Reported one month in arrears)

100% against 96% target

green rated

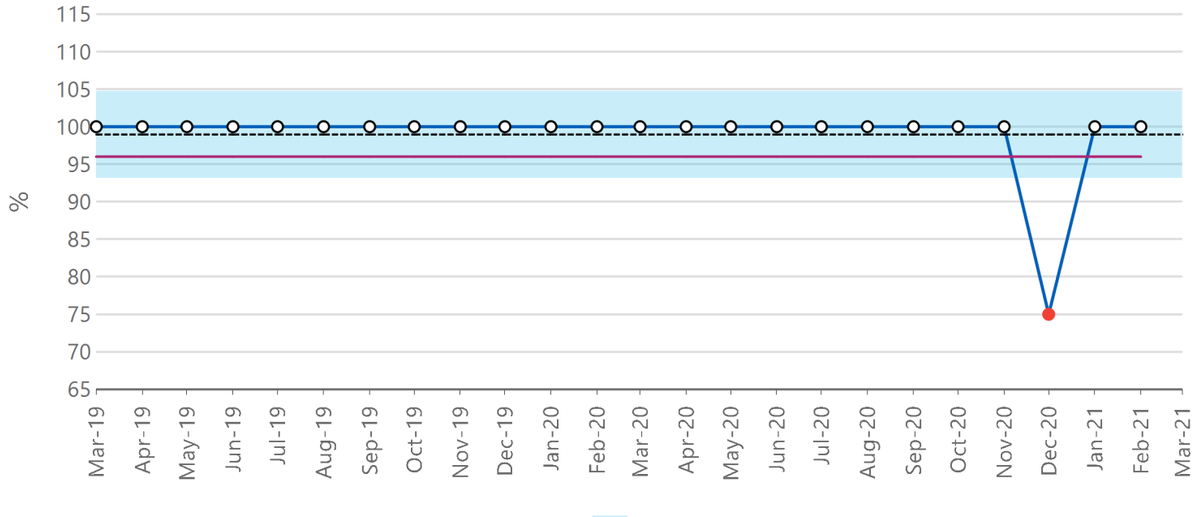
Exec Lead:
Specialist Services Unit

Integrated Performance Report

Narrative

The Cancer 31 day first treatment standard was achieved in February and indicative data for March shows achievement of the standard will continue.

Performance over 24 months – SPC



Trajectory

Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%		96.77%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cancer Plan 62 Days Standard (Tumour)*

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

100% against 85% target

green rated

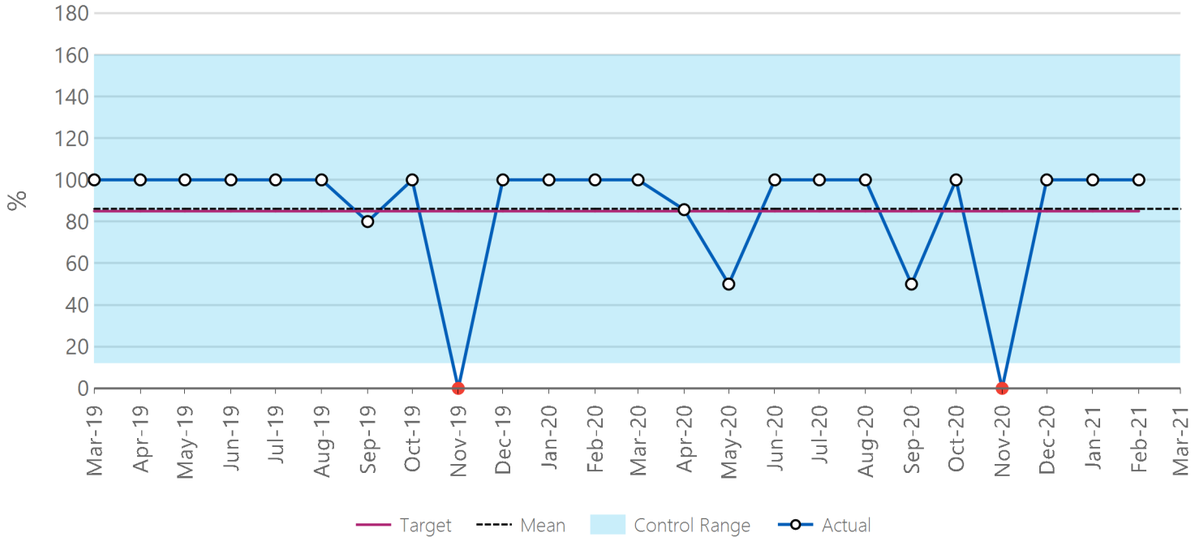
Exec Lead:
Specialist Services Unit

Integrated Performance Report

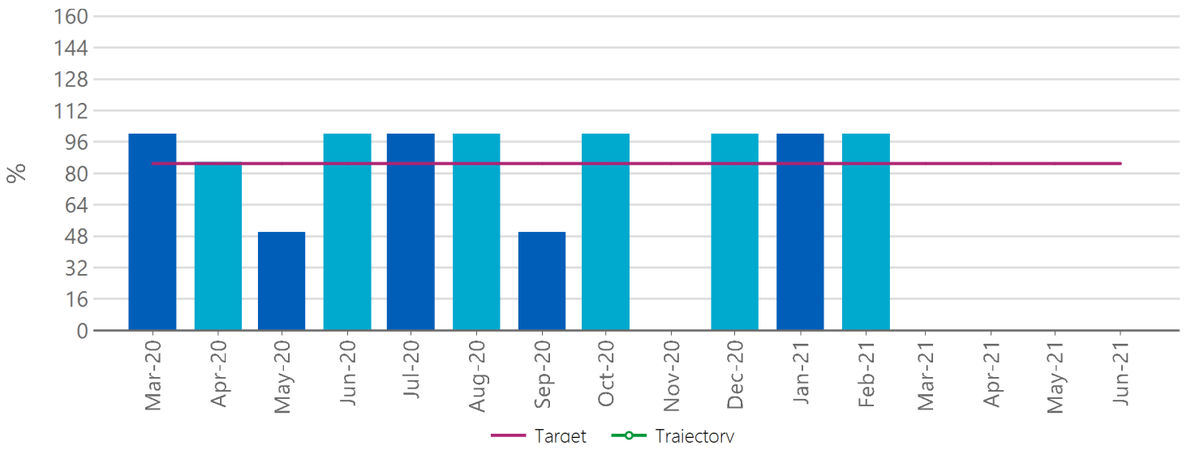
Narrative

The Cancer 62 Day standard was met in February. A breach will be reported in March.

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
100%	100%	100%	100%	100%	100%	80%	100%	0%	100%	100%	100%	100%	85.71%	50%	100%	100%	100%	50%	100%	0%	100%	100%	100%		83.33%

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

18 Weeks RTT Open Pathways

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

56.23% against **92%** target

Below target red rated

Exec Lead:
Support Services Unit

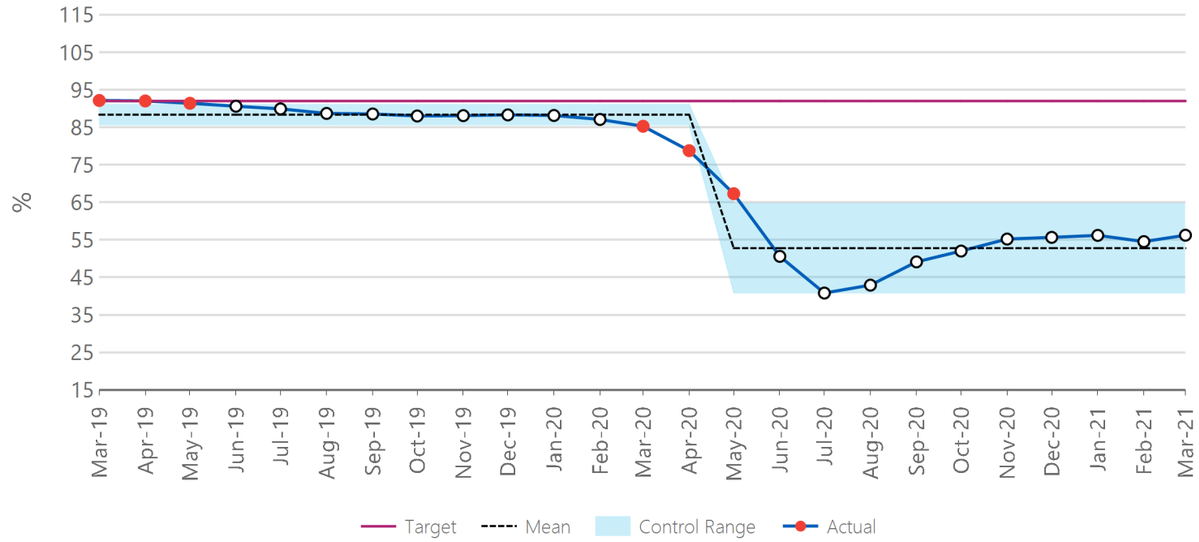
Integrated Performance Report

Narrative

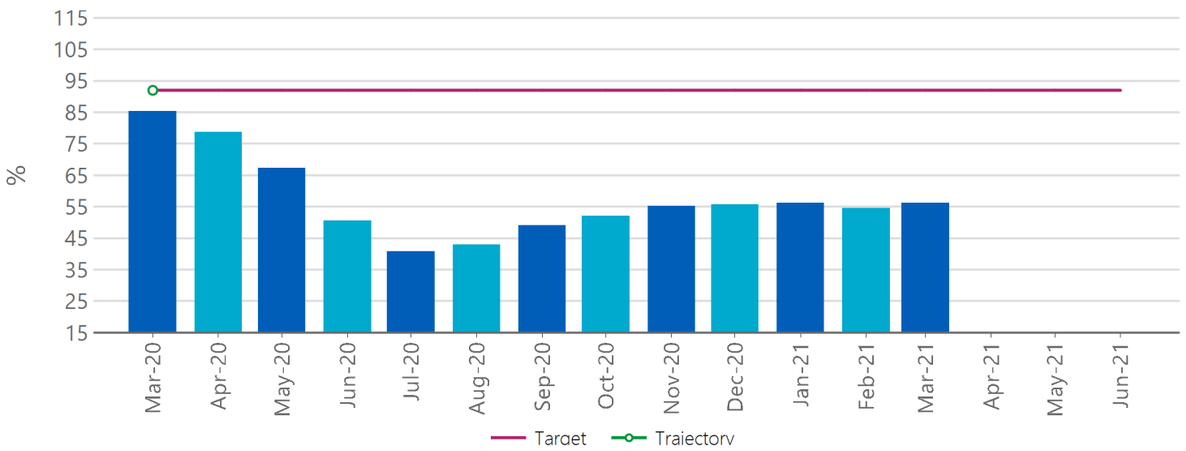
Our March performance was 56.23% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The total number of breaches has increased by 119, increasing from 5145 at the end of February to 5264 at the end of March. The performance breakdown by milestone is as follows: MS1 - 6687 patients waiting of which 1745 are breaches, MS2 - 1137 patients waiting of which 702 are breaches, MS3 - 4203 patients waiting of which 2817 are breaches.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: The Trust has been asked to rapidly draw up plans for the highest possible levels of activity across elective services. Utilisation of this capacity will need to be balanced between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
92.14%	92.01%	91.4%	90.61%	89.9%	88.69%	88.54%	88.01%	88.1%	88.3%	88.15%	87.08%	85.27%	78.77%	67.3%	50.6%	40.82%	42.93%	49.13%	52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	54.41%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – English

Number of English RTT patients currently waiting 52 weeks or more

1,551 against **0** target

Breaching target red rated

Exec Lead:
Specialist Services Unit

Integrated Performance Report

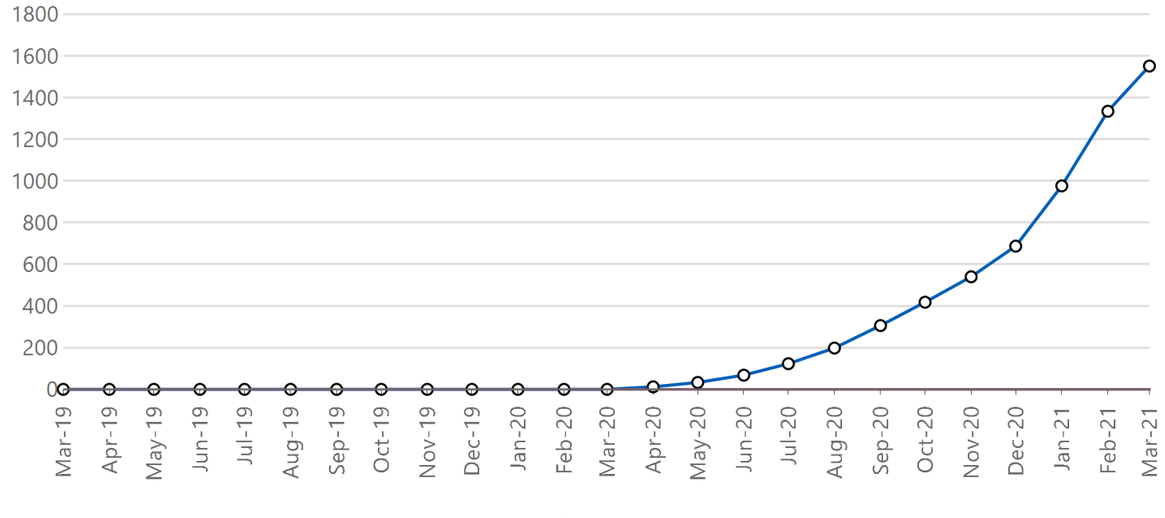
Narrative

At the end of March there were 1551 English patients waiting over 52 weeks. This is above our trajectory figure of 698.

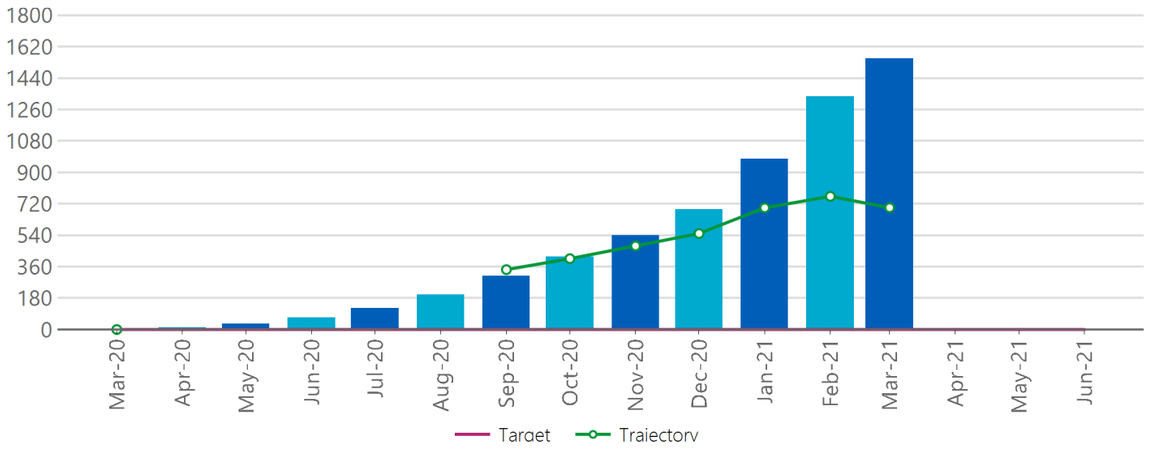
The patients are under the care of the following sub-specialities; Arthroplasty (504), Spinal Disorders (370), Knee & Sports Injuries (304), Upper Limb (186), Foot & Ankle (95), Spinal Injuries (31), Paediatric Orthopaedics (29), Tumour (14), Metabolic Medicine (9), Neurology (2), Orthotics (2), SOOS Physiotherapy (2), SOOS GPSI (1), Occupational Therapy (1) and Rheumatology (1).

The number of patients waiting, by weeks brackets is:
- >=52 to <60 weeks - 665 patients
- >=60 to <70 weeks - 556 patients
- >=70 weeks to <80 weeks - 207 patients
- >=80 weeks to <104 weeks - 123 patients

Performance over 24 months –



Trajectory



Actions

Action to Improve: The Trust has been asked to rapidly draw up plans for the highest possible levels of activity across elective services. Utilisation of this capacity will need to be balanced between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0	0	0	0	0	0	0	0	0	0	0	0	0	12	33	68	123	198	306	418	540	687	976	1,334	1,551

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patients Waiting Over 52 Weeks – Welsh

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

840 against 0 target

Breaching target red rated

Exec Lead:
Specialist Services Unit

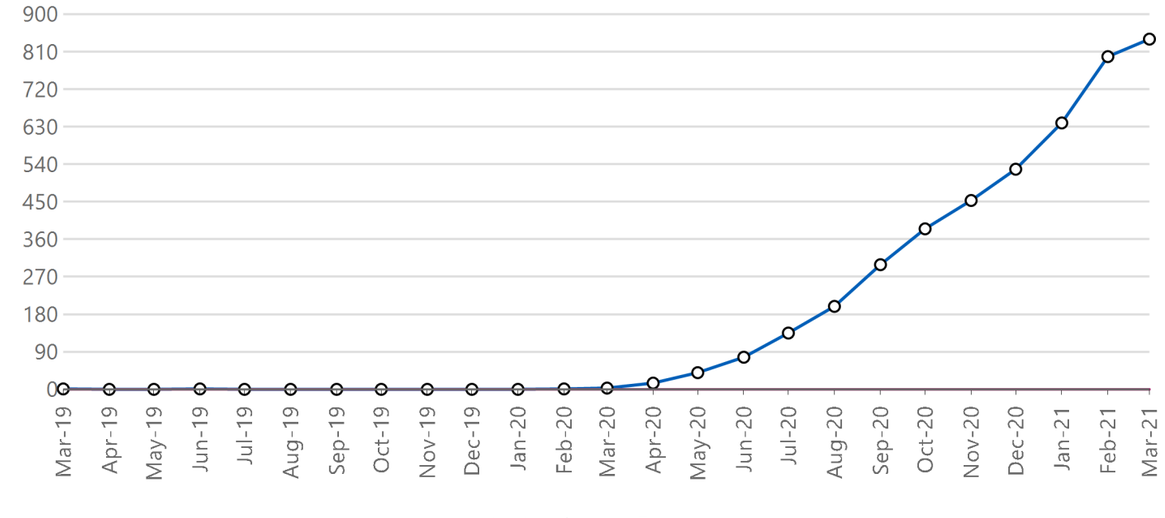
Integrated Performance Report

Narrative

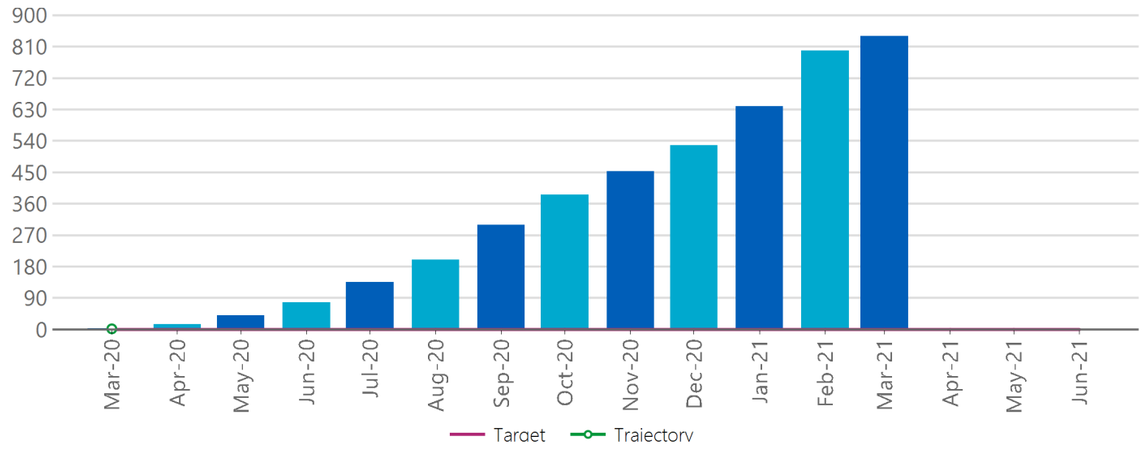
At the end of March there were 840 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (331), Arthroplasty (226), Knee & Sports Injuries (107), Upper Limb (70), Foot & Ankle (66), Paediatric Orthopaedics (20), Spinal Injuries (8), Tumour (5), Metabolic Medicine (3), Neurology (2), Physiotherapy (1) and Occupational Therapy (1) . The patients are under the care of the following commissioners; BCU (457), Powys (365), Hywel Dda (15) and Aneurin Bevan (3).

The number of patients waiting, by weeks brackets is:
- >=52 to <60 weeks - 279 patients
- >=60 to <70 weeks - 266 patients
- >=70 weeks to <80 weeks - 163 patients
- >=80 weeks to <104 weeks - 131 patients
- >=104 weeks - 1 patient

Performance over 24 months –



Trajectory



Actions

Action to Improve: The Trust has been asked to rapidly draw up plans for the highest possible levels of activity across elective services. Utilisation of this capacity will need to be balanced between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	0	0	1	0	0	0	0	0	0	0	1	3	15	40	77	135	199	299	385	453	528	639	798	840

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

6 Week Wait for Diagnostics - English Patients

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

90.53% against **99%** target

Below target red rated

Exec Lead:
Clinical Services Unit

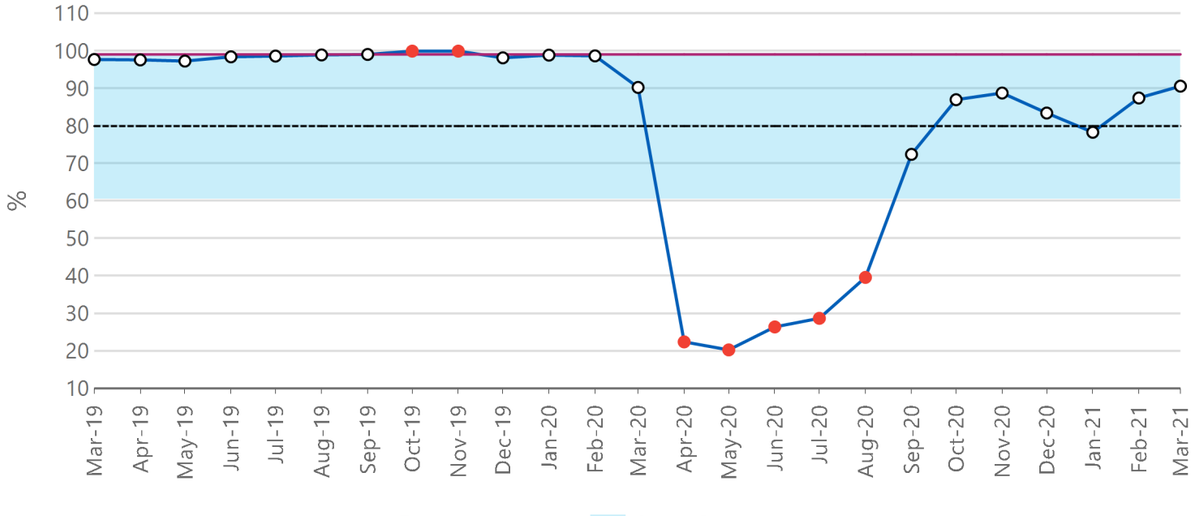
Integrated Performance Report

Narrative

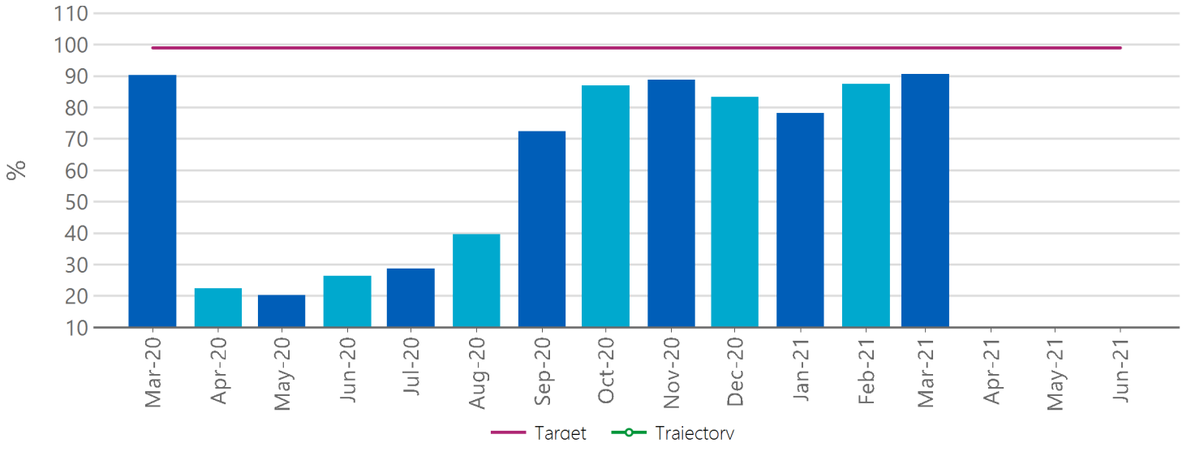
The 6 week standard for diagnostics was not achieved this month and is reported at 90.53%. This equates to 86 patients who waited beyond 6 weeks, a decrease of 19 from volume reported at the end of February.
The breaches occurred in the following modalities;
- MRI (75 - with 66 dated)
- Ultrasound (5 - all dated)
- CT (6 - with 3 dated)

The majority of breaches relate to the MRI modality. Reasons associated with the delays include capacity issues, delays due to COVID19 which also saw some exams temporarily postponed, and spinal injuries patients awaiting MCSI support to safely transfer patients. Furthermore, we have seen an increase of patients cancelling their appointments and choosing to wait due to COVID19.

Performance over 24 months – SPC



Trajectory



Actions

Action to Improve: • Continuation of extended working hours and weekend working.
• There were specific exams (MRI and CT) that were postponed at the Trust due to COVID. Activity for these exams recommenced in January 2021.
• Appointed radiographers to commence employment throughout quarter one.
• Ongoing review of workforce/skill mix, recruitment of support positions to release radiographer capacity that will improve activity levels delivered.
• Focus on the administrative part of processes to include; mentoring of recent employed Supervisor, review process to booking appointments and reiterate diagnostic standards to team.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
97.64%	97.53%	97.21%	98.35%	98.55%	98.85%	98.99%	99.87%	99.87%	98.09%	98.8%	98.6%	90.2%	22.38%	20.24%	26.36%	28.66%	39.56%	72.35%	86.92%	88.7%	83.37%	78.24%	87.38%	90.53%	59%

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

8 Week Wait for Diagnostics - Welsh Patients

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

94.4% against **100%** target

Below target red rated

Exec Lead:
Clinical Services Unit

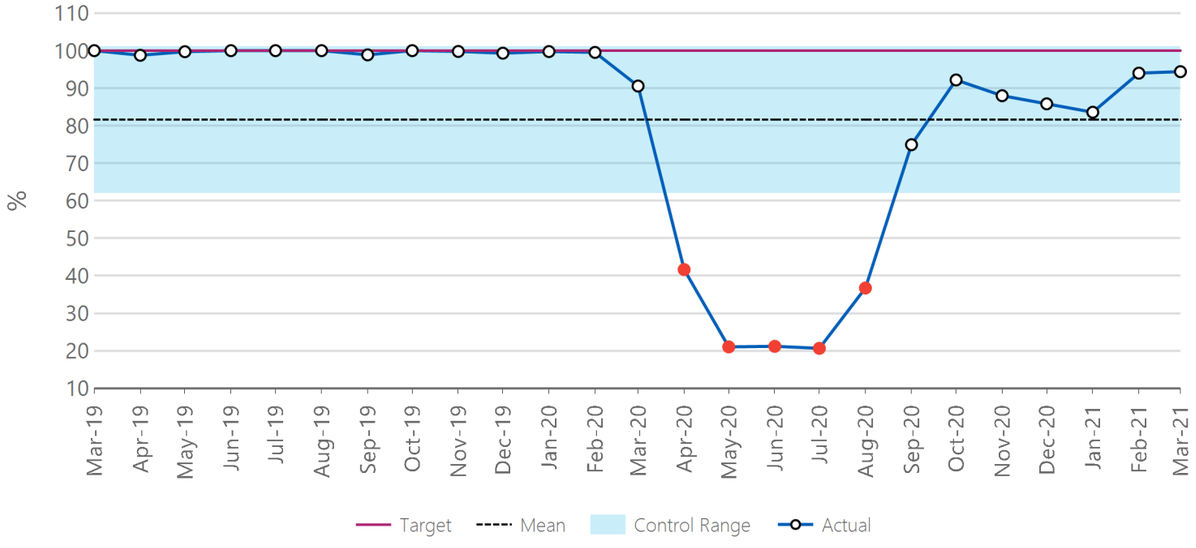
Integrated Performance Report

Narrative

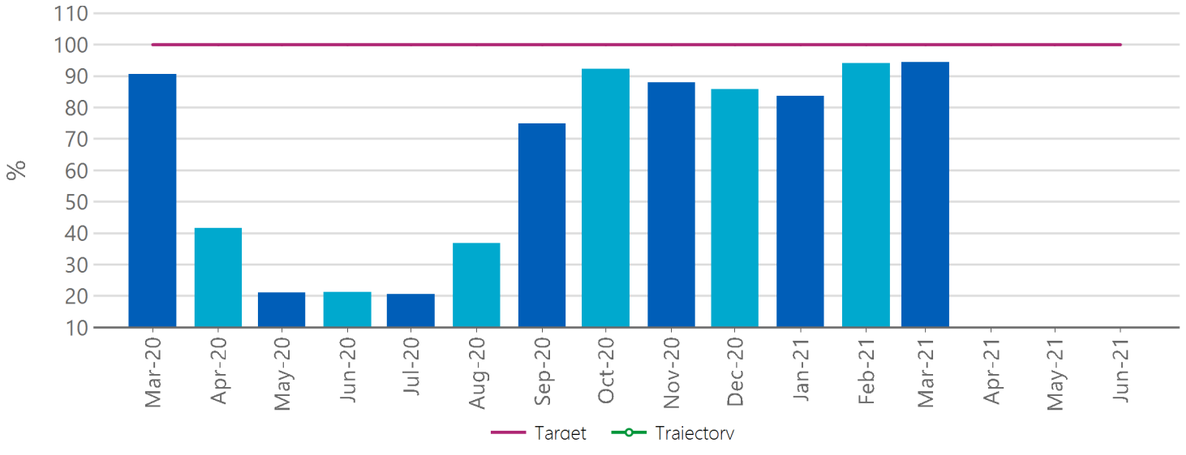
The 8 week standard for diagnostics was not achieved this month and is reported at 94.40%. This equates to 26 patients who waited beyond 8 weeks; an increase of 2 from volume reported at the end of February. The breaches occurred in the following modalities;
- MRI (26 - with 25 dated)

The majority of breaches relate to the MRI modality. Reasons associated with the delays include capacity issues, delays due to COVID19 which also saw some exams temporarily postponed, and spinal injuries patients awaiting MCSI support to safely transfer patients. Furthermore, we have seen an increase of patients cancelling their appointments and choosing to wait due to COVID19.

Performance over 24 months – SPC



Trajectory



Actions

Action to Improve: • Continuation of extended working hours and weekend working.
• There were specific exams (MRI and CT) that were postponed at the Trust due to COVID. Activity for these exams recommenced in January 2021.
• Appointed radiographers to commence employment throughout quarter one.
• Ongoing review of workforce/skill mix, recruitment of support positions to release radiographer capacity that will improve activity levels delivered.
• Focus on the administrative part of processes to include; mentoring of recent employed Supervisor, review process to booking appointments and reiterate diagnostic standards to team.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
100%	98.76%	99.72%	100%	100%	100%	98.87%	100%	99.78%	99.32%	99.75%	99.52%	90.57%	41.65%	21.04%	21.2%	20.66%	36.73%	74.93%	92.18%	87.99%	85.82%	83.58%	94%	94.4%	58.14%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Elective Activity

.

438 against 776 target

Within target red rated

Exec Lead:
MSK Unit

Integrated Performance Report

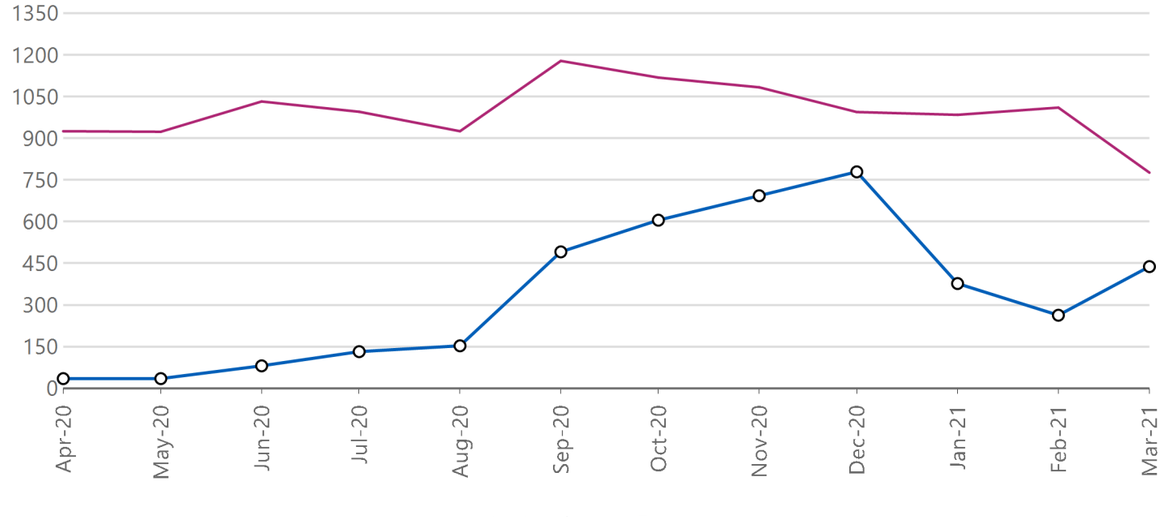
Narrative

Nationally, Trusts are being monitored against activity levels delivered in 19/20, therefore the 20/21 plans have been updated to monitor against these figures. In November the Trust revised the submitted phase 3 planning figures with revised plans for the months of December to March. These figures are represented as a trajectory in the trajectory graph.

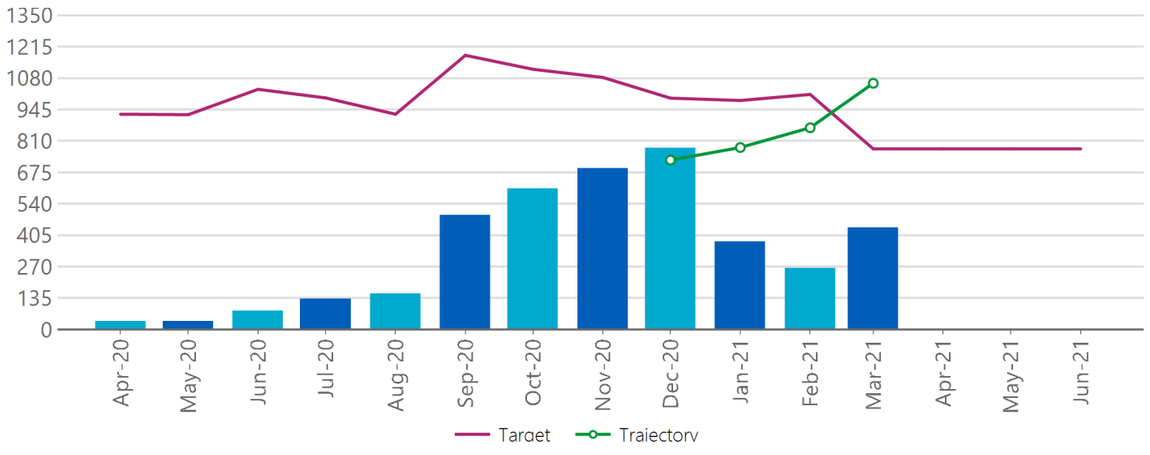
In March the total elective activity undertaken in the Trust was 438. The target within this KPI of 776 is the March 2020 actual figure with a working days adjustment. March 2020 was also impacted by COVID-19 which resulted in lower than expected activity levels. The NHS E/I tool makes a COVID adjustment so the baseline figure becomes 1166. The achievement against the NHS E/I COVID adjusted figure is 38%.

Although the Total Elective Activity plan was not met, it should be noted that the rate was achieved whilst the Trust was undertaking urgent clinical activity based on clinical priority and continued the redeployment of staff to a neighbouring provider to support the system COVID response. In March the Trust began repatriation of these externally deployed staff however the impact has not been seen yet; some staff remained redeployed internally at the end of March with plans to repatriate during April 2021.

Performance over 24 months –



Trajectory



Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
35	35	81	132	153	491	605	693	779	377	263	438	4,082

Actions

Action to Improve: The Trust has been asked to rapidly draw up plans for the highest possible levels of activity across elective services, which maximise physical and workforce capacity, prioritise the most urgent patients, incorporate clinically led reviews and validation of the waiting list, maintain effective communication with patients, address the longest waiters and addresses health inequalities, and safeguards the health and wellbeing of staff. Work is well underway in the Trust to meet the deadline for draft plan submission of 6th May 2021.

The Trust hopes to rapidly implement Phase 2 of the restore plan – to reallocate IJP lists according to capacity, split percentage wise per speciality, pending full restore of Job Plan.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

73.63% against 87% target

Within target red rated

Exec Lead:
MSK Unit

Integrated Performance Report

Narrative

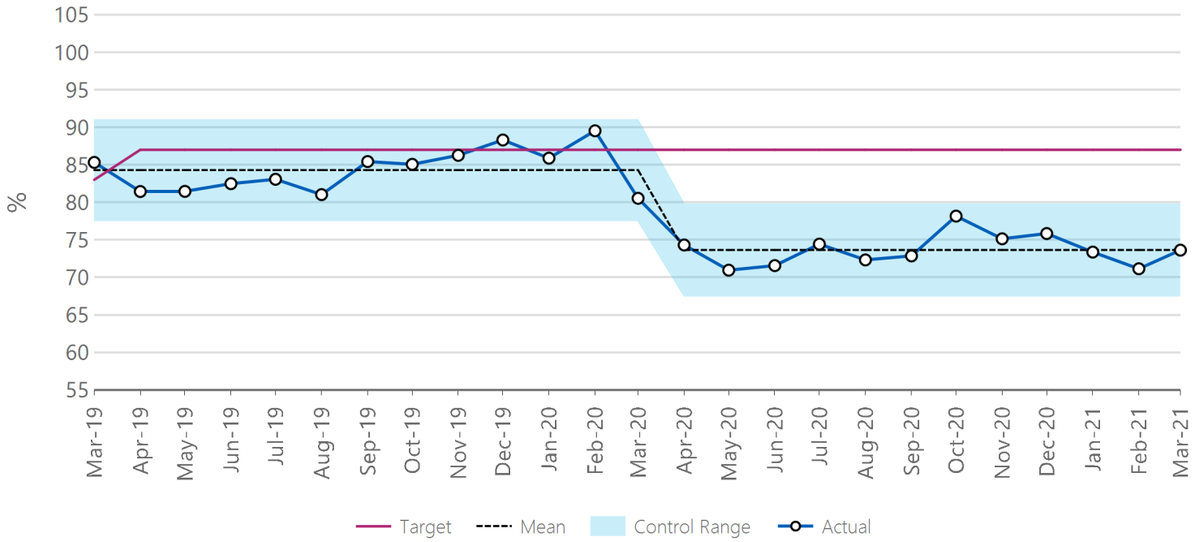
The occupancy rate for all wards is red rated this month at 73.63%. The breakdown below gives the March occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:

MSK Unit:
- Clwyd - 75.84% - compliment of 22 beds; open to 18-20 beds throughout month
- Powys - 72.02% - compliment of 22 beds; ward open to 14-18 beds second half of month following closure
- Kenyon - Ward closed throughout month
- Ludlow - 30.98% - compliment of 14 beds open throughout month - used for suspected/confirmed covid patients

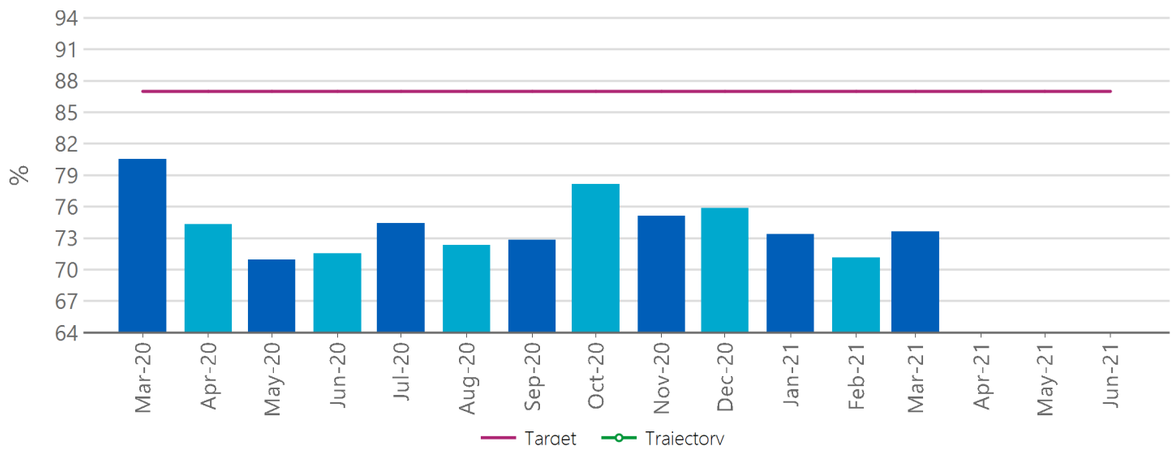
Specialist Unit:
- Alice - 29.82% - compliment of 16 beds open throughout majority of month with some reductions on and around weekends
- Oswald - 66.44% - compliment of 10 beds open throughout month
- Gladstone - 93.85% - compliment of 29 beds open throughout month
- Wrekin - 97.29% - compliment of 15 beds open throughout month
- Sheldon - 86.28% - compliment of 24 beds open throughout month

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: As part of the Trust's covid-19 system response we will need to continually review our availability and utilisation of beds.

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
85.32%	81.44%	81.46%	82.49%	83.07%	81.03%	85.43%	85.06%	86.26%	88.31%	85.88%	89.53%	80.53%	74.31%	70.96%	71.57%	74.43%	72.33%	72.86%	78.17%	75.14%	75.84%	73.37%	71.15%	73.63%	73.75%

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (Phase 3), Catchment Based)

11,937 against 12,043 target

Within target red rated

Exec Lead:
Clinical Services Unit

Integrated Performance Report

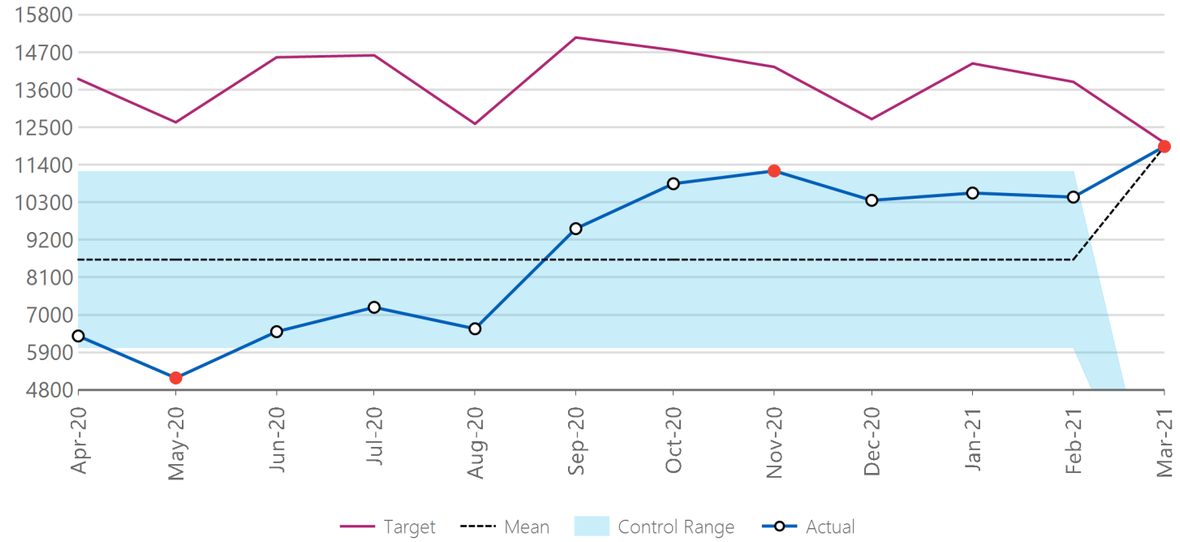
Narrative

This measure aligns with the NHS E/I inclusions and exclusions for restoration monitoring, effectively monitoring consultant-led activity. The target for this KPI is the delivered 19/20 activity, with the phase 3 plans included as a trajectory in the trajectory graph. The months of December to March represent the figures included in our planning refresh carried out in November. In March the total Outpatient activity undertaken in the Trust was 11,937. 106 behind the March 2020 levels (with working days adjustment) of 12,043. It is to be noted that March 2020 was the first month to be impacted by covid-19 that also resulted in lower activity levels.

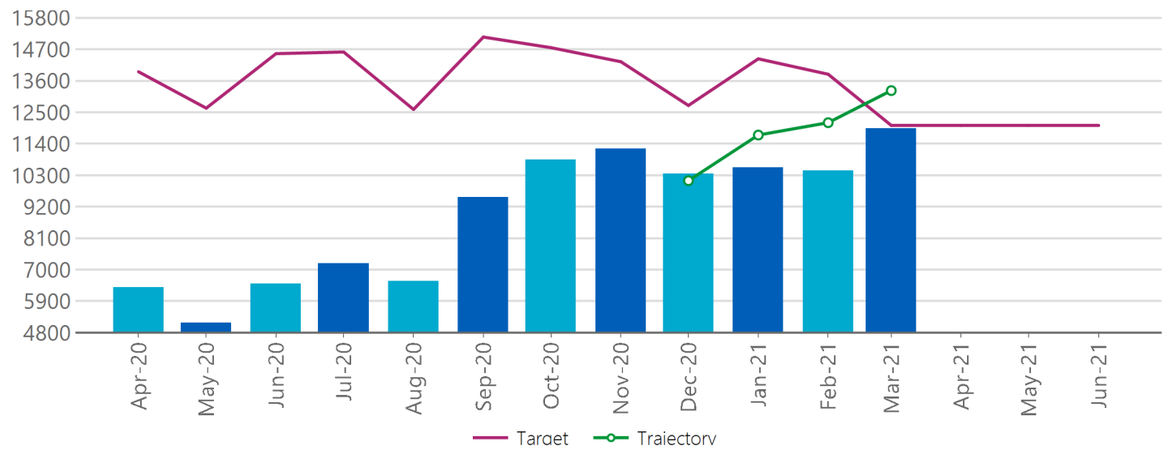
The Trust was 1,323 cases behind the phase 3 plan trajectory. Our Trust trajectory of 13,260 was based on restoring to levels greater than March 2020 recognising the covid impacts within the baseline.
As at 9th April (5th working day) there were 267 missing outcomes so once administrative actions are taken with these data entries, the March position will alter and updated figures will be included in the IPR next month. Taking into account the missing outcomes, this would mean that the Outpatient activity for March was 12,204 which would be 1,056 below our phase 3 plan of 13,260. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs. Last month February was reported as 10615, 1524 cases below our phase 3 plan, now with latest data available, as at 9th April, February is now reported at 10453, which is 1686 cases below our phase 3 plan.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Action to Improve: Actions include:

- A 'Breaking The Cycle' Improvement event, led by the Improvement and Organisational Development Manager took place on 23rd March for Access Team, Radiology and Outpatients. Objectives agreed to help improve the process within these areas.
- Sub-speciality review of under-performance to maximise bookings
- Saturdays and out of hours work in progress
- Meetings to recommence to discuss clinic plan v actual for current and forthcoming month
- Annual leave review
- Bookwise - planning and capacity

Heatmap performance over 24 months

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
6,382	5,152	6,508	7,222	6,593	9,528	10,845	11,221	10,358	10,572	10,453	11,937	106,771

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Financial Control Total

Surplus/deficit adjusted for donations and excluding STF funding

3,331 against -630 target

Above target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

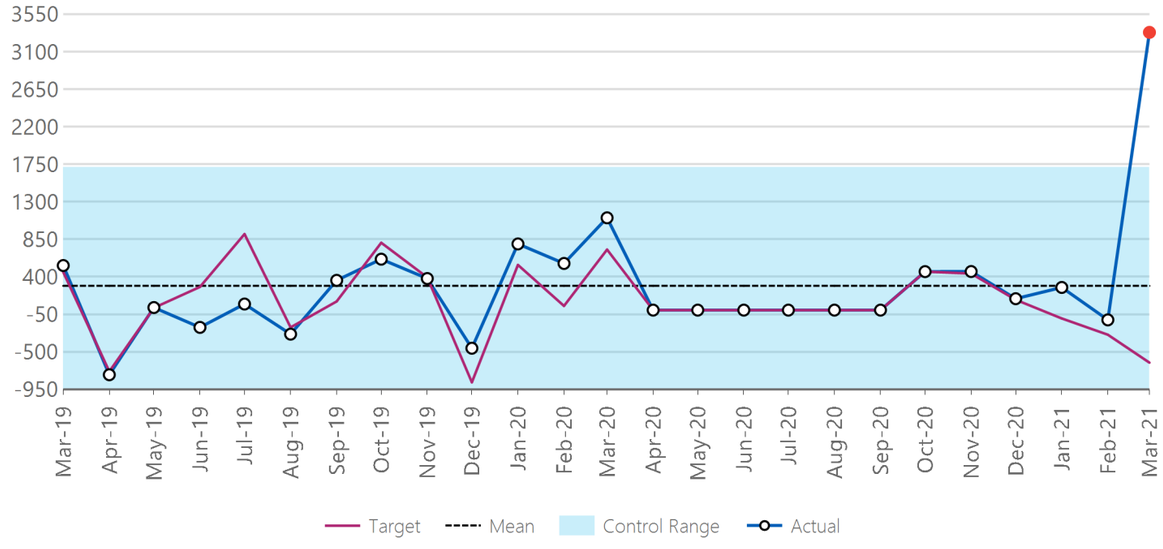
Narrative

Final surplus of £4.5m achieved against break-even requirement

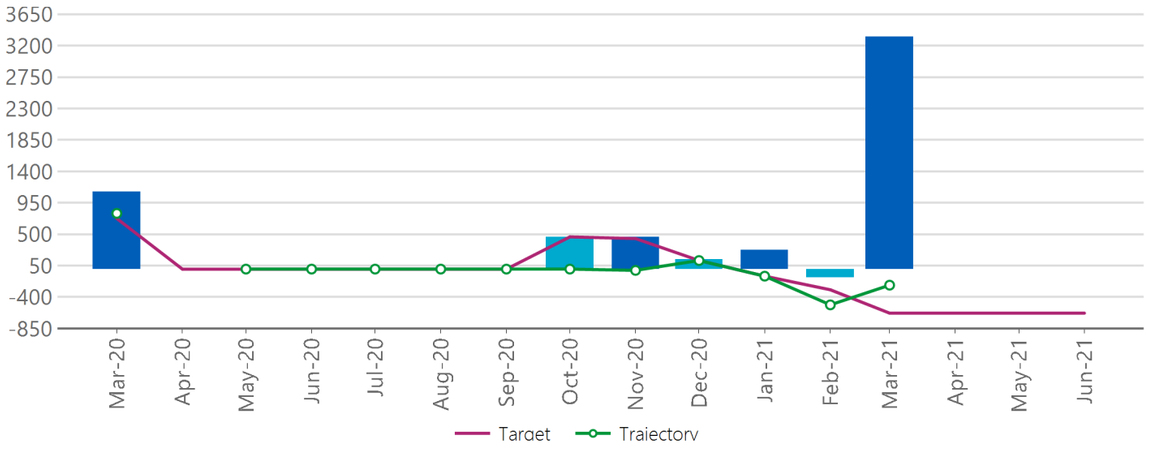
This is driven by new additional funding received from NHSI/E to offset costs of annual leave accrual and coverage for shortfalls of Non NHS income

Recurrent underlying financial position (COVID cleansed) is £1.8m deficit driven by missed efficiencies

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
535	-775	31	-207	73	-288	357	611	379	-457	794	560	1,107	0	0	0	0	0	0	462	463	137	272	-117	3,331	4,548

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Income

All Trust Income, Clinical and non clinical

14,180 against **9,502** target

Above target green rated

Exec Lead:
Director of Finance

Integrated Performance Report

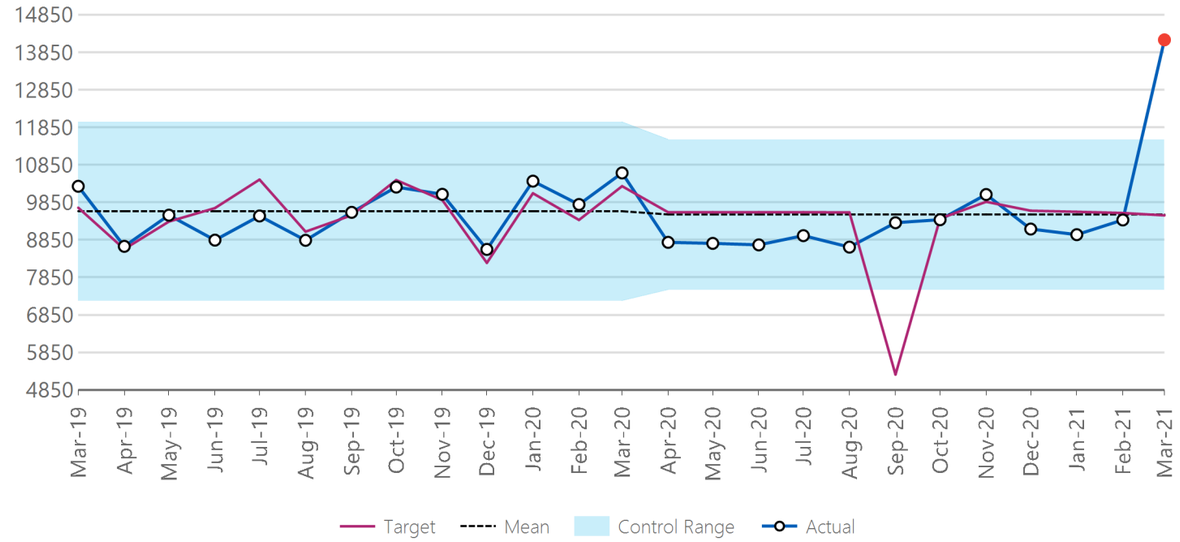
Narrative

Full year income drivers:

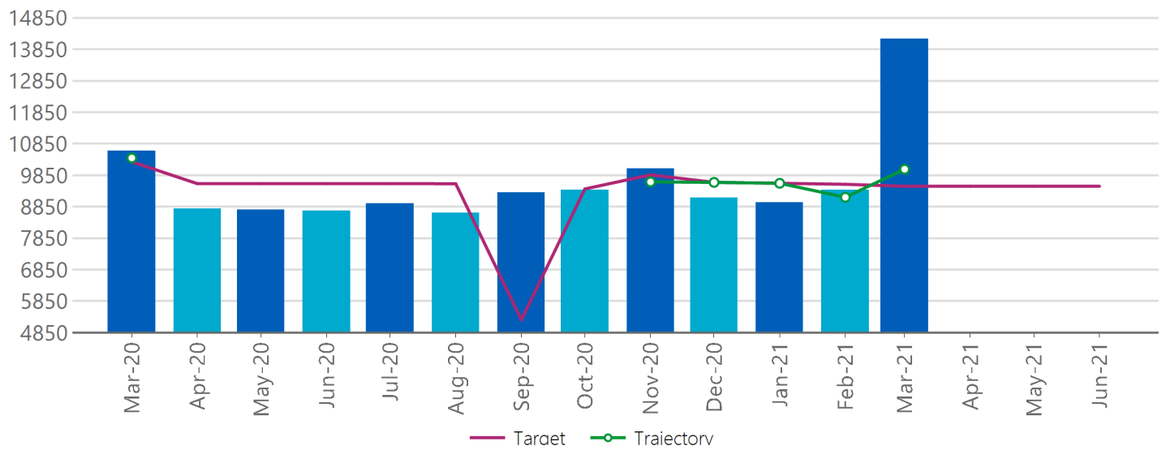
- COVID financial framework protected English NHS income at 19/20 activity levels
- Welsh income based on 19/20 levels with reduction linked to activity performance
- Funding received at year end to recognise shortfalls in non NHS income against 1920 baseline, previously mitigated through expenditure reductions
- Additional funding secured from NHSI/E to support costs of untaken annual leave £1.4m
- COVID direct costs fully funded by NHSI/E

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



Trajectory



Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
10,278	8,677	9,508	8,842	9,486	8,837	9,583	10,256	10,064	8,595	10,415	9,792	10,633	8,783	8,756	8,716	8,962	8,656	9,306	9,387	10,058	9,138	8,988	9,380	14,180	114,309

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

Expenditure

All Trust expenditure including Finance Costs

10,769 against **10,176** target

Breaching target red rated

Exec Lead:
Director of Finance

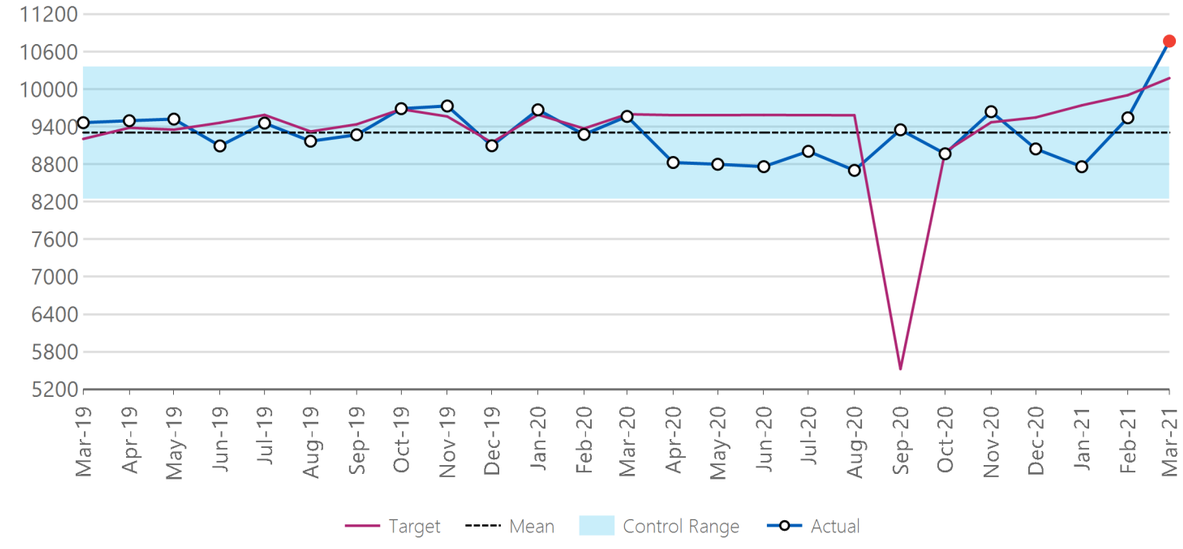
Integrated Performance Report

Narrative

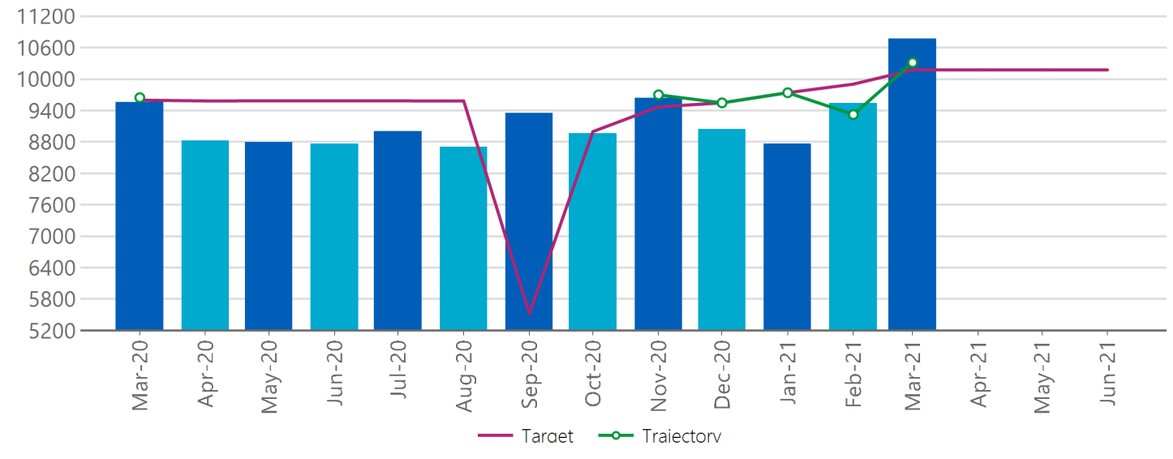
Full year expenditure drivers:

- Activity volumes (NHS and Private Patients) reduced marginal cost base
- COVID exceptional costs of £3.1m (fully funded)
- Costs of untaken annual leave fully recognised £1.7m
- Costs of backlog follow up list management and clearance recognised £0.5m

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
9,464	9,495	9,521	9,092	9,457	9,168	9,270	9,688	9,731	9,095	9,670	9,275	9,564	8,827	8,799	8,761	9,006	8,701	9,350	8,967	9,640	9,045	8,760	9,542	10,769	110,167

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

Efficiencies Delivery

Cost Improvement Programme requirement

140 against **92** target

Above target green rated

Exec Lead:
Director of Finance

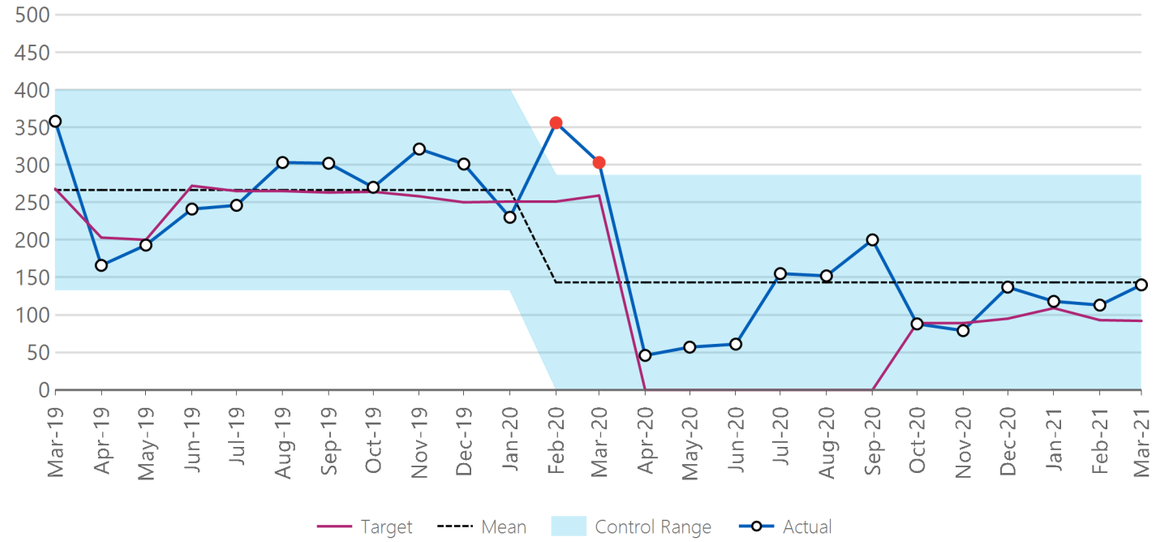
Integrated Performance Report

Narrative

£113k favourable full year.

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



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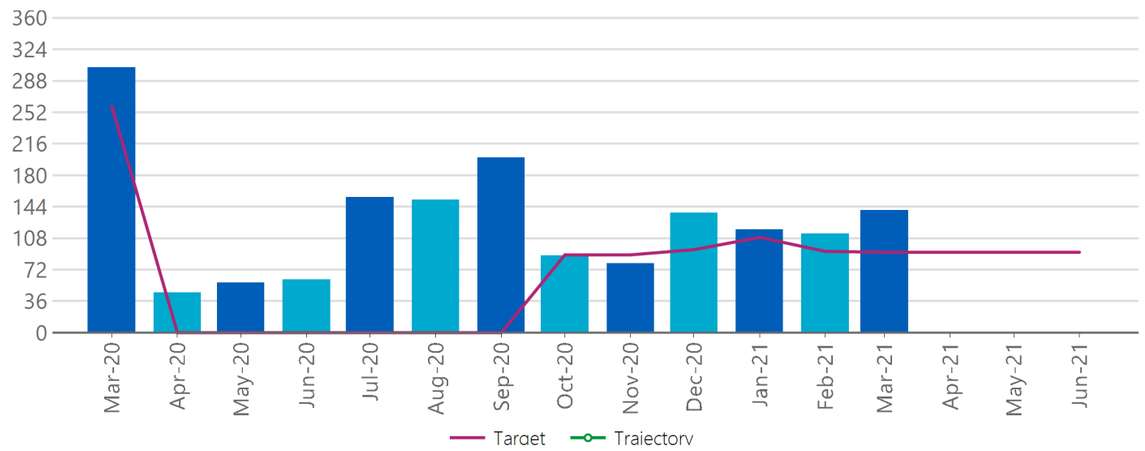


Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
358	166	193	241	246	303	302	270	321	301	230	356	303	46	57	61	155	152	200	88	79	137	118	113	140	678

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Cash Balance

Cash in bank

16,137 against 6,390 target

Above target green rated

Exec Lead:
Director of Finance

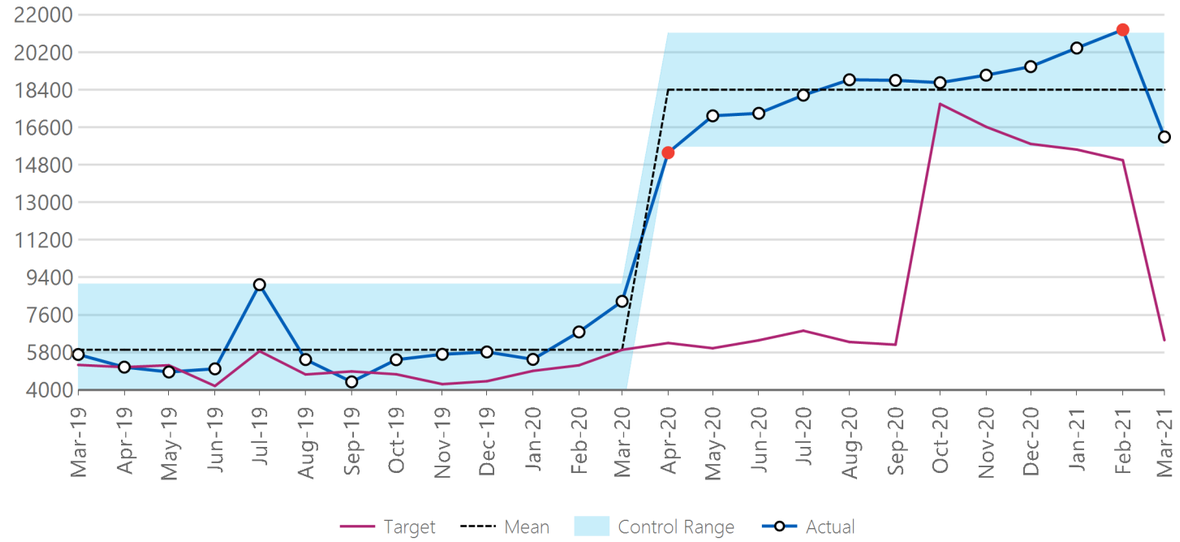
Integrated Performance Report

Narrative

Cash balances of £16.1m which reflects position before repayment of system support and adjustments to Welsh income

Performance over 24 months – SPC

SPC Alert - 7 or more consecutive points above or below the mean indciates a step change.



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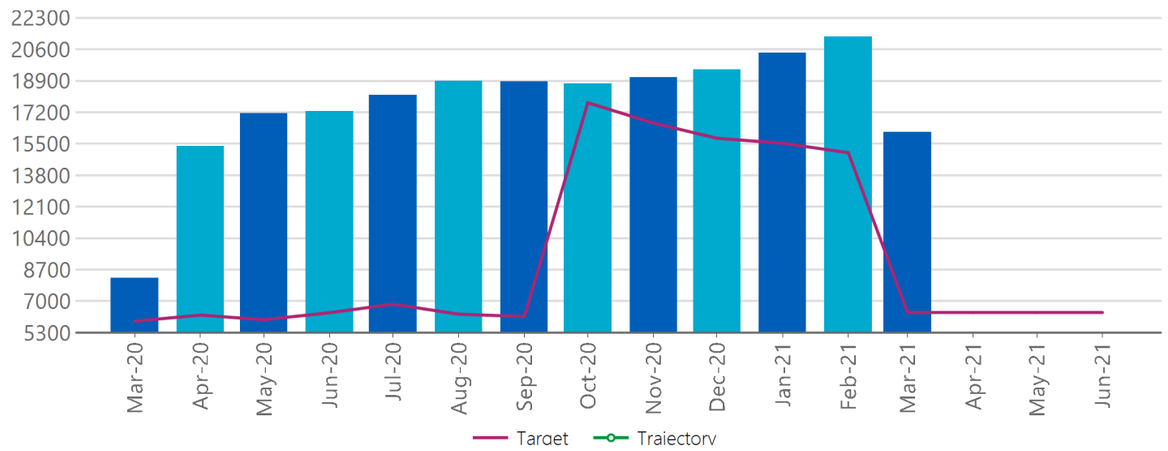


Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
5,700	5,094	4,861	5,013	9,051	5,457	4,387	5,450	5,708	5,822	5,467	6,781	8,250	15,380	17,150	17,270	18,140	18,880	18,850	18,740	19,100	19,510	20,402	21,278	16,137	16,137

Capital Expenditure

Expenditure against Trust capital programme

1,188 against **1,064** target

Breaching target green rated

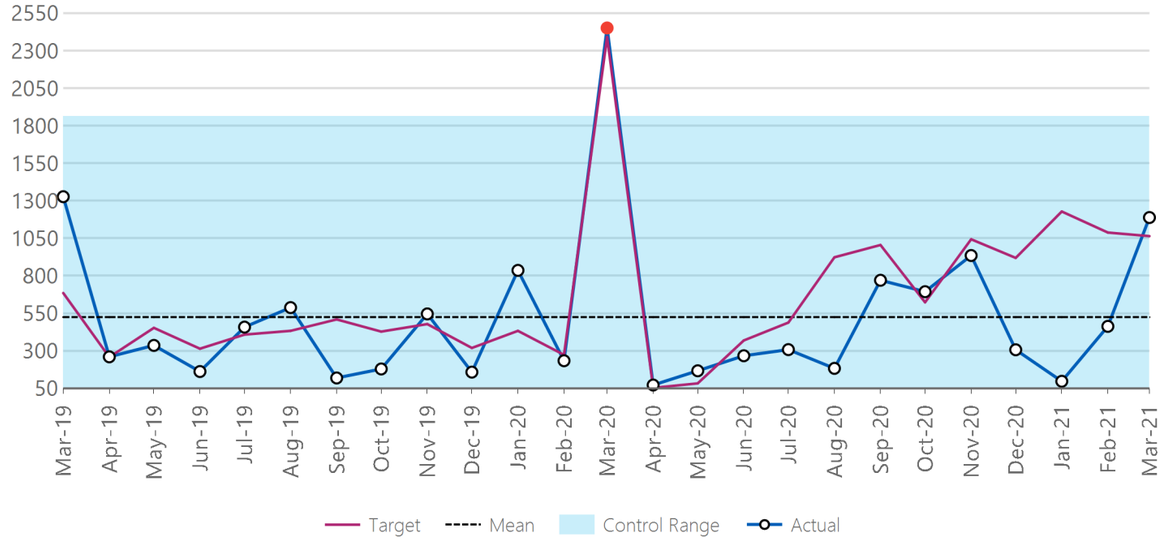
Exec Lead:
Director of Finance

Integrated Performance Report

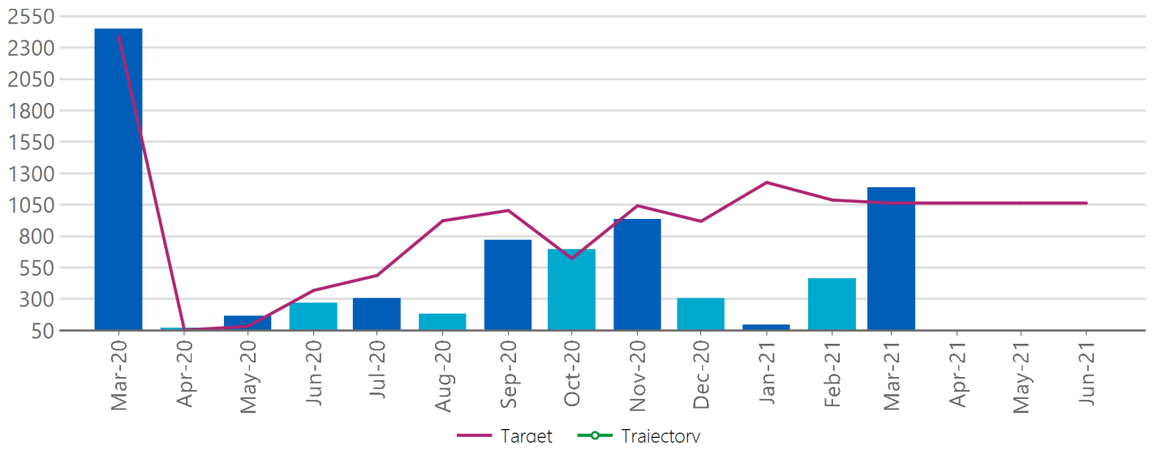
Narrative

Year to date £3,435k favourable to plan made up of £888k NHS and £2,547k donated.
- Slippage on NHS mainly linked to slippage on X-ray rooms carried into 21/22.
- Slippage on donated linked to Veteran's project which will be carried forward to 21/22.

Performance over 24 months – SPC



Trajectory



Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
1,327	260	336	162	458	588	119	179	546	158	836	234	2,451	72	167	267	308	183	770	694	935	307	97	463	1,188	5,451

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Use of Resources (UOR)

Overall Use of Resources indicator

1 against 1 target

On target green rated

Exec Lead:
Director of Finance

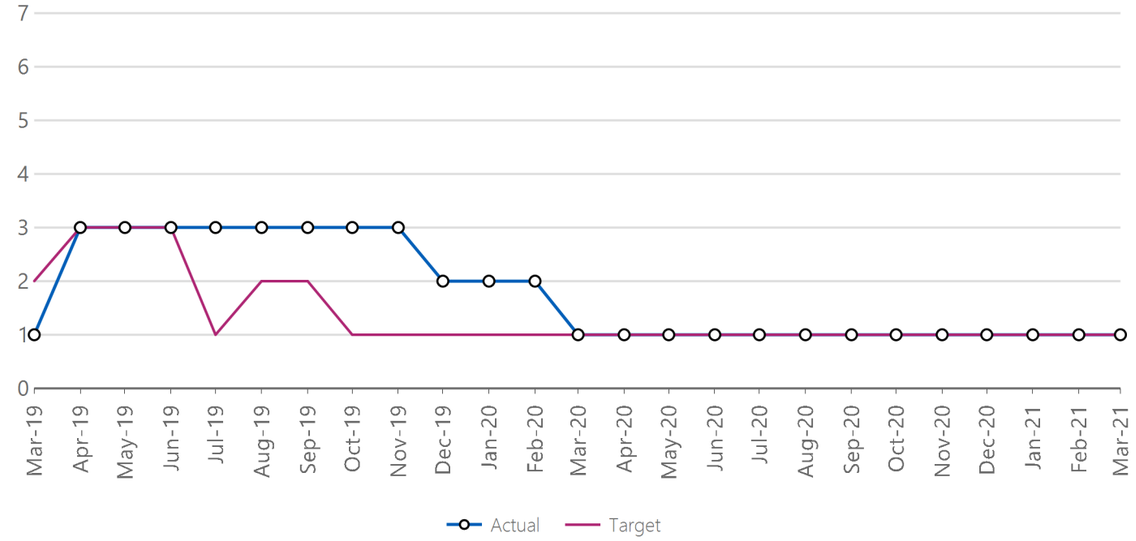
Integrated Performance Report

Narrative

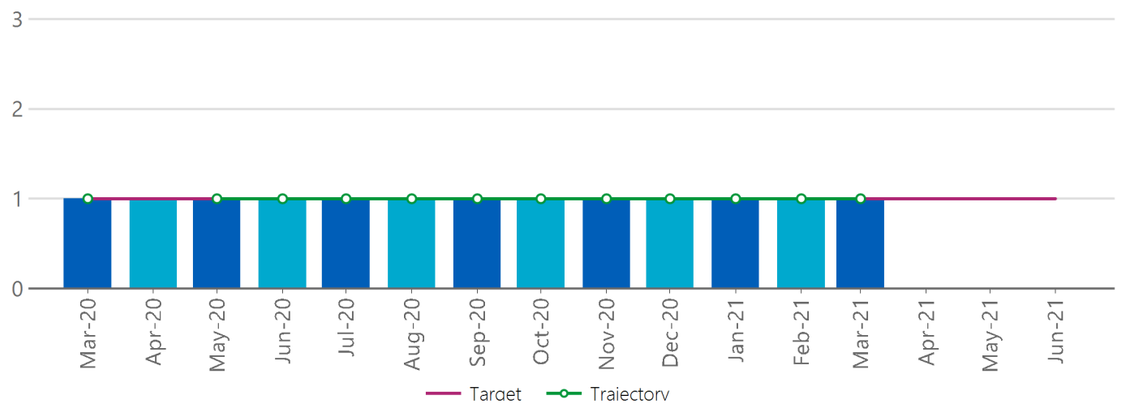
UOR 1 (Best)

Note - No formal UOR plan in place during 20/21, monitoring against historical indicators.

Performance over 24 months –



Trajectory



Actions

Heatmap performance over 24 months

Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
1	3	3	3	3	3	3	3	3	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Integrated Performance Report
March – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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

Reading guide

The Integrated Performance Report (IPR) is designed to provide the Board with a monthly balanced summary of the Trust's performance across the three areas of the Trust's mission: caring for patients, caring for staff and caring for finances. To achieve this, the Trust has identified the Board-level Key Performance Indicators (KPIs), which are considered to drive the overall performance of the Trust. The report highlights key areas of improvement or concern enabling the Board to identify those areas that require the most consideration. As such, this report is not designed to replace the need for more detailed reporting on key areas of performance, and therefore detailed reporting will be provided to the Board and its committees to accompany the IPR where requested by the Board, its committees or the Executive Team. Contents of the report include:

Heatmaps
In month, year-to-date and forecast performance against target for each KPI and rolling 13-month performance information. A data quality indicator for each KPI is also included where available.

Narrative
Supporting narrative and trend graphs (with statistical process control where appropriate) are provided for each KPI including mitigating actions for red rated indicators.

Key

Key Performance Indicator RAG Ratings

Green	**YTD: Performance meets or exceeds target** **Forecast: Little risk of missing target at year end**
Red	**YTD: Performance behind target and outside tolerance** **Forecast: High risk of missing target at year end**

KPIs reported in arrears

KPIs reported in arrears, for which no current-month values are available, are marked with an asterisk (*) next to their name. The latest values for these KPIs are from the previous reporting month.

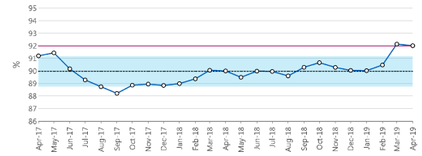
Data Quality Indicator

The data quality 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.

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

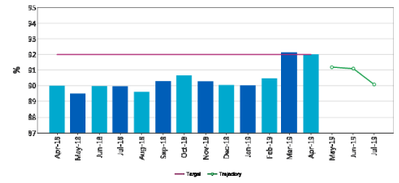
Trend graphs

Each KPI has a trend graph (or Statistical Process Control (SPC) where appropriate), which summarises performance over a rolling 24-month period.



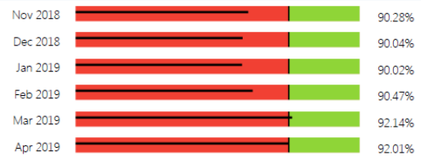
Trajectories

Where available, three-month trajectory data is included to indicate expected future performance. Historical trajectory data will be kept to compare actual performance with forecast performance.



Bullet graphs

Bullet graphs provide a clear visualisation to understand how well a KPI is performing against its target.



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

Income and Expenditure £'000s

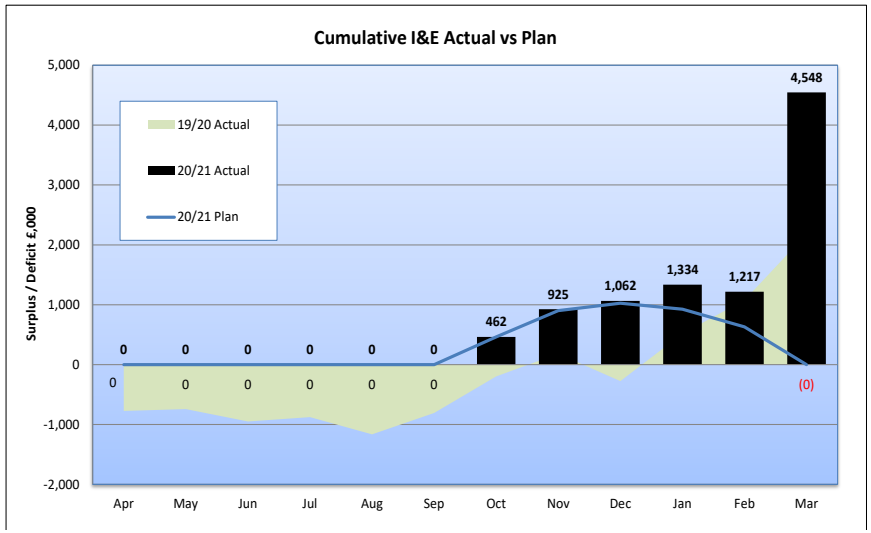
Category	Annual Plan	In Month Position			Full Year Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	97,326	8,013	9,599	1,586	97,326	97,716	391
System Discretionary Funding	980	127	(851)	(979)	980	0	(980)
System Top Up Funding	2,560	427	427	0	2,560	2,560	0
Covid-19 Funding	1,452	242	401	159	1,452	1,452	0
Private Patient income	1,880	263	147	(115)	1,880	1,467	(413)
Other income	6,552	430	4,457	4,027	6,552	11,113	4,560
Pay	(67,678)	(5,842)	(5,837)	5	(67,678)	(68,471)	(793)
Non-pay	(38,083)	(3,888)	(4,606)	(718)	(38,083)	(35,921)	2,162
EBITDA	4,989	(229)	3,736	3,965	4,989	9,916	4,927
Finance Costs	(5,520)	(446)	(454)	(8)	(5,520)	(5,904)	(384)
Capital Donations	1,170	555	376	(179)	1,170	552	(618)
Operational Surplus	639	(120)	3,659	3,778	639	4,564	3,925
Remove Capital Donations	(1,170)	(555)	(376)	179	(1,170)	(552)	618
Add Back Donated Dep'n	531	45	48	3	531	537	5
Control Total*	0	(630)	3,331	3,961	0	4,548	4,548
EBITDA margin	4.7%	-2.6%	28.0%	30.6%	4.7%	9.0%	4.3%

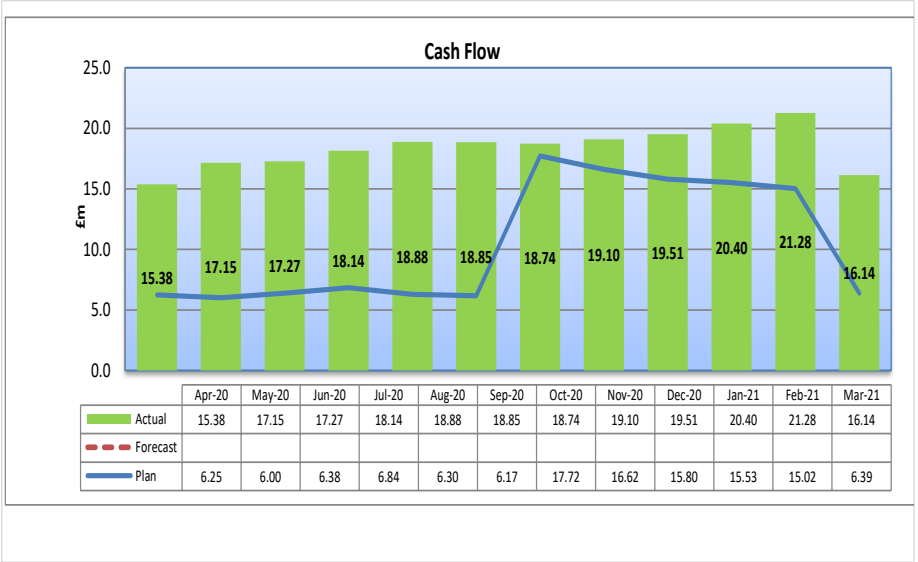
Capital service	1	I&E Margin	1
Liquidity (days)	1	Variance in I&E Margin	1
Agency	1		
Overall UOR			1

	YTD
Debtor Days	16
Creditor Days	38

Statement of Financial Position £'000s

Category	Feb-21	Mar-21	Movement	Drivers
Fixed Assets	76,352	79,946	3,594	Revaluation and additions
Non current receivables	1,135	1,194	59	
Total Non Current Assets	77,487	81,140	3,653	
Inventories (Stocks)	1,273	1,389	116	DHSC Covid 19 donated consumables
Receivables (Debtors)	5,064	7,525	2,461	Increase in prepayments due to non nhs income funding
Cash at Bank and in hand	21,278	16,137	(5,141)	Normalisation of cash balances following end to upfront payments from commissioners
Total Current Assets	27,615	25,051	(2,564)	
Payables (Creditors)	(21,899)	(15,258)	6,641	Decrease in deferred income following end to upfront payments from commissioners
Borrowings	(1,300)	(1,307)	(7)	
Current Provisions	(232)	(711)	(479)	Year end provisions
Total Current Liabilities (< 1 year)	(23,431)	(17,276)	6,155	
Total Assets less Current Liabilities	81,671	88,915	7,244	
Non Current Borrowings	(4,470)	(4,470)	0	
Non Current Provisions	(944)	(1,002)	(58)	Increase in clinician's pension tax provision
Non Current Liabilities (> 1 year)	(5,414)	(5,472)	(58)	
Total Assets Employed	76,257	83,443	7,186	
Public Dividend Capital	(35,486)	(36,108)	(622)	
Retained Earnings	(17,703)	(17,703)	0	
Revenue Position	(905)	(1,506)	(601)	Current period surplus
Revaluation Reserve	(22,163)	(24,938)	(2,775)	
Total Taxpayers Equity	(76,257)	(80,255)	(3,998)	



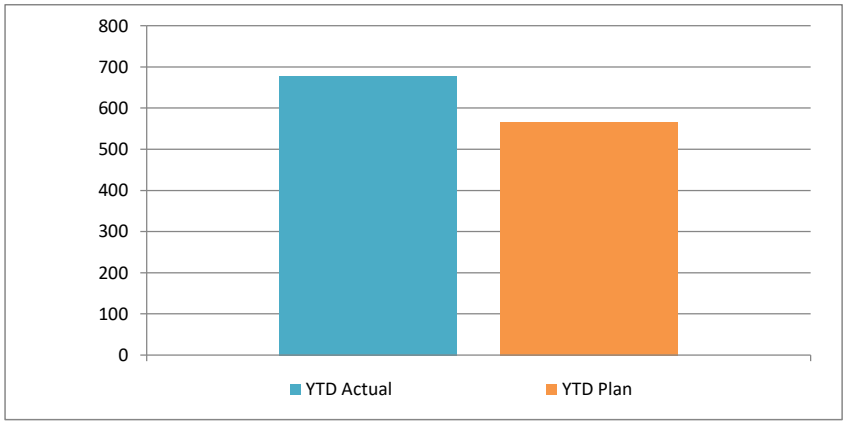


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	15.38	17.15	17.27	18.14	18.88	18.85	18.74	19.10	19.51	20.40	21.28	16.14
Forecast												
Plan	6.25	6.00	6.38	6.84	6.30	6.17	17.72	16.62	15.80	15.53	15.02	6.39

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

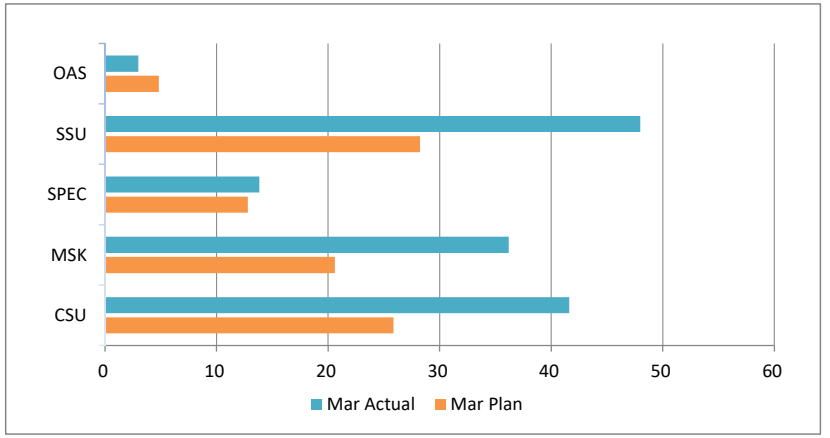
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



Efficiencies by Theme

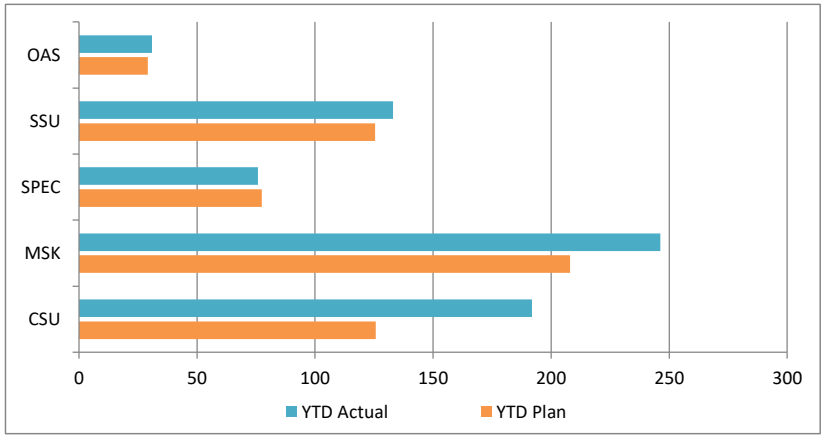
In Month Efficiencies Achievement £000's



Capital

Position as at	2021-12	Capital Programme 2020-21					
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**
Diagnostic equipment replacement	1,545	200	607	-407	1,545	1,785	-240
EPR planning & implementation	200	40	0	40	200	-128	328
Backlog maintenance (System CIR)	500	20	116	-96	500	519	-19
I/T investment & replacement	295	20	161	-141	295	363	-68
Equipment & service continuity	600	0	107	-107	600	596	4
Project management	50	9	10	-1	50	61	-11
Scheme slippage from 19/20	135	0	0	0	135	79	56
Salix energy improvements	1,210	0	30	-30	1,210	1,232	-22
E-job planning	86	0	5	-5	86	85	1
Covid-19	0	0	0	0	0	36	-36
Contingency	1,165	250	49	201	1,165	189	976
Restoration Schemes (System CIR)	0	0	0	0	0	82	-82
NHS Capital Funding	5,786	539	1,085	-546	5,786	4,898	888
Veteran's facility	3,000	500	31	469	3,000	304	2,696
Donated medical equipment	100	25	72	-47	100	248	-148
Total Capital Funding (NHS & Donated)	8,886	1,064	1,188	-124	8,886	5,451	3,435

Year To Date Efficiencies Achievement £000's



Chair's Report
Quality and Safety Committee
18th March 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29th April 2021
Director Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Quality and Safety Committee held on 18th March 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

- There was good progress of actions from the previous meeting with all actions completed or updated
- The Radiation Safety Policy was brought to the committee after a few months of delay and was approved.
- The committee still felt there was lack of assurance regarding the harms review and the waiting follow up patients, but hopefully at future committee's further assurance will be obtained.
- There was also discussion whether the WHO Process and Level 3 Safeguarding Training need to be considered as risks.

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from Quality and Safety Committee which met on 18th March 2021. A full list of the attendance is outlined below:

Attendance:	
Attendance:	
Chris Beacock	Non-Executive Director (Chair)
Stacey Keegan	Chief Nurse
Steve White	Medical Director
Shelley Ramtuhul	Trust Secretary
Hilary Pepler	Trust Board Advisor
Mark Brandreth	Chief Executive
Ruth Longfellow	Associate Medical Director
Ian Maclennan (part)	Assistant Chief Nurse for MSK Unit
Jo Banks (part)	Managing Director Clinical Services Unit
Nicki Bellinger	Assistant Chief Nurse for Specialist Service
Sian Langford (part)	Deputy Facilities Manager
Louise Arnold (part)	Imaging Quality Manager
Eric Hughes (part)	Radiology Services Manager
Apologies:	
David Gilburt, Non-Executive Director, Mark Salisbury, Operational Director of Finance and Sara Ellis, Assistant Chief of Professions. .	

3.2 Actions from the Previous Meeting

The Committee noted the actions of the previous meeting and received an update on the progress of each. All actions were marked as complete with a few minor amendments to be made by the Trust Secretary.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Serious Incidents, Never Events & Learning from Incidents		
The paper was well received by the committee and the committee were assured that good progress is being made on the actions. There was assurance that one incident in specific is being investigated and actions have been drawn	Y	

and are in the process of completion.		
2. Managing Our Patients Waiting		
Continuing work is being carried out on the number of patients waiting. The committee received partial assurance that those patients that are waiting and are experiencing harms are receiving harms reviews. There was discussion whether this paper would be better suited to sit under the Restoration Sub-Committee. Currently the terms of reference for this sub-committee would not cover this paper; however, the Quality and Safety Committee agreed that the Board should discuss amending the terms of reference for the sub-committee. Until this conversation happens, the paper will sit with Quality and Safety for at least another month.	Partial	Further work needs to be carried out on this process. The committee are aware that this process is not a quick fix.
3. MSK Unit Quality Report		
A different template of quality report was presented to the committee this month due to time scales in writing the paper. The paper was slightly more extensive than usual, which prompted further questions to detail. The committee were pleased however, to hear that a Tissue Viability Specialist Nurse has been recruited for the unit.	Y	
4. Board Assurance Framework & Corporate Objectives		
The BAF is in the process of being agreed for this month. It was clarified that the committee feel the target around Covid infections should be 0% and this target was included within the corporate objectives.	Y	
5. Integrated Performance Report		
The committee were partially assured with the data from the IPR. There has been an increase in grade 2 pressure ulcers; however, the committee have all acknowledged the complexity that the patients will all come into at the Trust. Work is currently being carried out to reduce the number of patients with grade 2 pressure ulcers and learning is being carried out to ensure that staff have the heightened awareness and education for the future.	Partial	Partial The committee received partial assurance around the IPR report, noting that full assurance cannot be received due to the current back log of patients and harms review project being carried out.
6. Radiation Safety Policy		
The committee were happy with the policy, congratulating the team on their hard work to get the policy put together. The committee approved the Radiation Safety Policy.	Y	
7. Food and Hygiene Strategy		
The committee were asked to approve a 6 month extension on the Food and Hygiene Strategy until September 2021 to ensure legal guidance is received on the food standards first. Once received, the policy will then be brought back to committee for approval.	Y	
8. Chair Reports		

Research Committee - The committee noted this chair report. *Patient Safety Committee* - The committee noted this chair report. *Safeguarding Committee* - The committee noted this chair report. *Infection Control Committee* - The committee noted this chair report. *Performance Improvement Meeting Minutes and Actions* – The committee noted the minutes and actions.	Y	
10. Review of the Work plan – 20/21 and 21/22		
The committee reviewed the work plan for 2021/22, wishing to ensure that Health Inequalities is focused on going forwards.	Y	

3.4 Approvals

Approval Sought	Outcome
Radiation Safety Policy	Approved

3.5 Risks to be Escalated

At the time if the Committee meeting the Non-Executive Directors asked for further assurance relating to the harms review. It was also agreed that Level 3 Safeguarding Training and the WHO Process need to be noted as potential risks. It was agreed at the meeting the Chair of the Committee would escalate the concerns via the Chair Report to the Board of Directors.

3.6 Conclusion

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

Chair Report
Finance, Planning and Digital Committee
23rd March 2021

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29th April 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Finance, Planning and Digital Committee meeting held on 23rd March 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The meeting was quorate
- The Veterans Business Case was approved (phase 1)

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Finance, Planning and Digital Committee which met on 23rd March 2021. The meeting was quorate with one Non-Executive Director and two Executive Directors in attendance. A full list of the attendance is outlined below:

Attendance:	
Members:	
Rachel Hopwood	Non-Executive Director (Chair)
Craig Macbeth	Chief Finance Officer
Kerry Robinson	Chief Performance, Improvement and OD Officer
Mark Brandreth	Chief Executive (part meeting)
In attendance:	
Shelley Ramtuhul	Trust Secretary
Simon Adams	Director of Digital
Mark Salisbury	Operational Director of Finance
Nia Jones (In part)	Managing Director for Specialist Unit
Mel Brown (In part)	Operational Manager- Spinal Disorders, Tumour & Veterans
Apologies:	
David Gilburt	Non-Executive Director

3.2 Actions from the Previous Meeting

The Committee received the action log.

It was noted that there had not been many explicit actions of late due to the current situation but it is hoped now that this latest phase of Covid seems to be easing, there may be a more action focused agenda.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured	Assurance Sought

Chair Report
Finance, Planning and Digital Committee
23rd March 2021

	(Y/N)	
1. Performance Framework		
The Committee were informed the Performance Framework has recently been reviewed due to the new structure has been embedded, learning has been received, and the impacts of Covid are being felt. The Committee discussed the role of the Policy Committee and the outstanding policies which are mainly linked to the People Committee. The Trust recognised a gap in the People Committee structure which is currently being addressed.	Y	
2. Performance Overview Report		
The Committee received the Integrated Performance Report for Month 11 and highlighted the following key points: • Many red rated items re waiting lists • Currently no operations except for P2s • Significant impact on 18 week RTT pathways • Prioritisation is ordered by clinical priority rather than length of time waiting • Both diagnostic standards are below target but both English and Welsh positions are improving • Elective activity reduced • Finance measures are rated green (except for month income) The Trust confirmed a new format for the report is being developed in line with best practise. The suggested format is currently being trialled in another committee. The 'Making Data Count' system uses statistical process control and symbolisation for assurance and improvement and therefore the RAG rating would no longer be required. The graphs will show an improvement or decline. The Trust reminded the Committee that patients are being prioritized on a clinical need basis. For elective surgery, patients are prioritised via the P2-6 system and booking is completed on this basis. Outpatients are prioritised via wait times, as first referrals haven't been seen yet so priority status is unknown, unless flagged as clinically urgent.	Y	
3. Restoration and Financial Impact Committee Update		
The Trust explained there will be a summary document that sets out the numbers more clearly, because mixed currencies have been used to talk	Y	

about activity/theatre sessions/in job plan capacity/out of job plan capacity. This information is due to be shared with the Non-Executive. The planning guidance is to be received on Thursday. At present the Trust is not in the standard situation of being able to plan for a year ahead. The Covid funding model has been rolled across to H1. An activity plan is being created against that, but it is linked to restart rather than restoration. It seems likely that the national expectation of the percentage of previous work could be set at around 75%. It could be possible for the Trust to attain this but this would require good will and out of job plan work from staff to complete this. In terms of assurance to the board, it may be more assurance regarding the process being undertaken, rather than a finalised plan as would normally be possible. The members of the meeting agreed a discussion regarding OJP is required at the Board meeting. The restart is beginning with in job plan capacity. This needs to be finalised before out of job plan work can be set up.		
4. Veterans Business Case		
The Committee were informed that there have been various updates against some of the assumptions originally made. Clarifications have been made around: • Workforce requirements • Income generation • Opportunities for other services The three phases of the plan Lift and Shift, Transformation and Growth. It was noted tenders for the build have been returned. The Non-Executive Directors noted the Business Case was clear and articulate and congratulated the Trust. The Committee discussed the growth assumptions and the Trust explained these assumptions have been made with knowledge about the work available out there, but also being mindful of the backlog that will need to be worked through. The Committee discussed the funds from Headley Court and how will the growth aspect be reflected in the System. There are new controls about to be implemented within the System about the approval of	Y	

investments. As such, this case will need to be taken to the System Chief Executive group which will need to be clear that the encouraged growth will be from Veterans further afield rather than from within the System. There will be no drain on the System's resources. The Trust informed the committee that the Finance, Planning and Digital Committee are able to approve the Business Case on behalf of the Board. The Non-Executive Directors suggested that an approval is granted for the business case for the build and phase one, with a formal reassessment to follow nearer the time (likely beginning of financial year 23/24) before proceeding to phase 2. The committee *approved* phase 1 of the Veteran's Business Case.		
5. Financial Planning Update		
The following was highlighted for the Financial Planning Update: • Normally the budget for next year would be ready for sign off at this point but given the delayed national guidance this would not be possible • Strong rumours that the interim COVID financial framework will roll forward for a further six months • As a System we are under specific interrogation at the moment from the regulator due to material deficit of £135 million • All organisations within the System have been asked to assess their underlying financial position. This involves picking up where things were left in 19/20 and making adjustments to cost base movements • The underlying financial position will be the baseline position for stabilisation and improvement going forward as opposed to performance under the COVID financial framework The Trust explained the allowance for the OJP plan is based on the 19/20 out turn that included pre COVID levels of OJP. It's a large number but when we know what our activity recovery position is, what the national expectations are and what the funding associated with it is, it will likely need to be flexed. There was clarity sought on the Intelligent Payment	Y	

System (IPS) and why the Trust will receive 5% of the System deficit. This was to encourage the System to work collectively to improve the position and was supported by the Regulator. The Trust confirmed some positive signs have been seen already in terms of 'peer rigor' i.e. being able to challenge/scrutinise colleagues within the system. Rejecting the proposal would have likely had negative consequences for RJAH in the long term as we move further into the ICS. Historically, financial targets have been achieved although in recent years the Trust's income has fallen short of planned levels due to activity shortfalls. As we move way from PbR in the future we will have less exposure to income fluctuations and managing to an agreed cost base will be the key measure. The Trust stated much of our inefficiency has come from doing increasing amounts of activity even when in the past the Trust has not been reimbursed correctly. The current model of out of job plan activity is untenable due to the lack of control this offers. The fixed block funding gives a good opportunity to rebase ourselves to reassess the amount of activity that can be delivered safely at that price. There is already evidence that the feeling amongst the System members has transformed from one of competition to collaboration, which is a valuable sign that this new way of doing things is having a positive effect.		
6. Finance Report		
The Committee received the Financial Report for Month 11 to the Committee and queried what the difference is between the System Discretionary funding and System Top Up funding. It was confirmed that the System Top Up funding is a national allocation given to all organisations via their systems to recognise nuances from the block contracts/pay up lifts, from Month 7 onwards. The Discretionary funding was agreed on top of this by the system to ensure a break even position was maintained for RJAH.	Y	
7. Strategic Update		
The Digital Aspirant Report was presented to the Committee. It was highlighted that the Business Case has been rescheduled from June to September which NHS E&I and NHS Digital have approved.	Y	

The Trust have a clinical sponsor to support engaging clinical staff and encourage more involvements with risks. The System are aware we are looking to procure an EPR and are supportive of the project and so no issues are anticipated. The Non-Executive Directors queried whether there was an opportunity for joined up digital working with SaTH due to their funding being approved. The Trust explained that joined up care is a priority. In the original strategic outline case, the possibility of sharing systems across the Trusts was looked at, but clinicians felt different needs across the Trusts meant different systems would probably be needed. It is however key that these systems join up. The Trust informed that real time data exchanged however the interfaces can be as up to date as needed within different areas. I.e. admissions information could send updates every 3 hours for example, whereas A&E information could send updates every few minutes. The Trust agreed to provide a monthly report to this committee.		
8. Security Update		
The Cyber Security report to the Committee and invited questions from the group. It was noted the risk went up in April/May 2020; this risk level hasn't gone down as yet.	Y	
9. Chair Reports		
Chair Report: Capital Management Group The key highlight for the meeting was the planning element for next year's capital programme. This is currently still in the planning stage and will be brought to the Committee for approval as appropriate. *Chair Report: Digital Steering Group* There was only partial assurance on the N365 roll out at present due to the timing. The Trust is awaiting information on what can be done to bring this forward.	Y	
10. Board Assurance Framework		
The amendments to the BAF included: • Reduction of risk- re instability arising from fluctuations in tariff • Addition of a new risk- Over reliance on OJP • Addition of a new risk- Uncertainty around the	Y	

new System Financial Framework It was noted the latter may need some work up once the new System Financial Framework is confirmed. The Committee were assured all risks had been identified.		
11. Work Plan		
It was noted this was an opportunity to sense check that the committee has received everything it should have, and also to decide if there is anything to add to the work plan. The Committee agreed to receive the ICS Financial Sustainability committee chairs report at future meetings.	Y	
12. Attendance Matrix		
The Committee *noted* the Attendance Matrix.	Y	
13. Top Risks		
No new risks were identified throughout the course of the meeting.	Y	

3.4 Approvals

Approval Sought	Outcome
Veterans Business Case	Approved (phase 1)

3.6 Risks to be Escalated

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

3.5 Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Microsoft Teams Meeting	22/04/21		13:30

1. Apologies 13:30

2. Policies for Review

2.1. Policy Tracker
2.2. People Policy Workplan
2.3. Pay Protection Policy
2.4. Disciplinary Policy and Procedure
2.5. Reserve Forces Training and Mobilisation Policy
2.6. Dignity and Respect in the Workplace Policy
2.7. Staff Smoke Free Policy
2.8. Recognition Agreement

3. Any Other Business 13:31

3.1. Next Meeting: Thursday 6th May 2021, 9:00am

Extra-Ordinary People Policy Committee Chair Report

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	29/04/2021
Director 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 Board of Directors and what input is required?

The Board of Directors is asked to note the policies submitted to the Extra-Ordinary People Policy Committee on Thursday 22nd April 2021. All policies were endorsed at JCG and submitted for approval to People Committee.

2. Executive Summary

2.1. Context

All policies below were reviewed and endorsed by JCG on Thursday 15th April 2021 and submitted to People Policy Committee for approval.

2.2. Summary

The following policies were submitted and approved:

- Pay Protection Policy
- Disciplinary Policy and Procedure
- Reserve Forces Training and Mobilisation Policy
- Dignity and Respect in the Workplace Policy
- Staff Smoke Free Policy
- Recognition Agreement

2.3. Conclusion

The Board is asked to *note* the meeting that took place and take *assurance* from the Policy Committee with regard to the policies it approved.