The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 04.05.2022

MEETING
4 May 2022 09:30

PUBLISHED
3 May 2022

Agenda

Location	*Date*	*Owner*	*Time*
Wynnstay Hotel, Oswestry	4/05/22		09:30
1. Part One - Public Meeting			09:30
1.1. Declarations of Interest		Chair	
1.2. Minutes of the Previous Meeting (April. 2022)		Chair	
1.3. Matters Arising		Chair	
2. Presentations			
2.1. Staff Story - Carrie Jenkins		Chief Medical Officer	09:40
2.2. Reflection - Patient Story		Chief Nurse and Patient Safety Officer	09:50
3. Chief Executive Update		Chief Executive	09:55
4. Quality & Safety			10:05
4.1. Chair Report: Quality and Safety Committee		Non Executive Director	
4.1.1. Learning from Deaths Q4		Chief Medical Officer	
4.2. Chair Report: IPC Quality Assurance Committee		Non Executive Director	
4.2.1. Infection, Prevention and Control Improvement Plan		Chief Nurse and Patient Safety Officer	
4.3. Ockdendon Report - wider learning		Chief nurse and Chief Medical Officer	
BREAK			10:55

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Agenda

Location	*Date*	*Owner*	*Time*
Wynnstay Hotel, Oswestry	4/05/22		09:30
5. Performance and Governance			11:10
5.1. Chair Report: Finance, Planning and Digital Committee		Non Executive Director	
5.1.1. Performance Report		Chief Finance and Planning Officer	
5.2. Chair Report: ExtraOrdinary Finance, Planning and Digital Committee		Non Executive Officer	
5.2.1. Operational Plan 2022/23 final submission		Chief Finance and Planning Officer	
5.2.2. Financial Plan 2022/23 final submission		Chief Finance and Planning Officer	
6. Corporate Objectives 2022/23 (Presentation)		Trust Secretary/Director of Governance	11:50
7. Risk Appetite and Tolerance		Trust Secretary/Director of Governance	12:00
8. Questions from the Governors		Trust Secretary	12:10
9. Questions from the Public		Chairman	12:15
10. Any Other Business		All	12:20
10.1. Next meeting: 6 July 2022 (Public)			

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Harry Turner ☎ 4358
Chairman

BOARD OF DIRECTOR – PUBLIC MEETING
6 APRIL 2022 AT 9:30AM AT THE LION QUAYS RESORT
MINUTES OF MEETING

Present:

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

In Attendance:

David Gilburt	Trust Board Advisor	DG
Sarah Sheppard	Chief People Officer	SS
Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
Dawn Forrest	Manging Director for Specialist Unit (part)	DF
James Neil	Anaesthetist - HDU presentation (part)	JN
Kirsty Foskett	Head of Clinical Governance - HDU presentation (part)	KF
Lowri Mansell	Ward Manager - HDU presentation (part)	LM

Governors:

William Greenwood	Trust Governor	WG
Katrina Morphet	Trust Governor	KM

HT welcomed all to the meeting and in particular the guest presenters at today's meeting.

MINUTE NO	TITLE
06/04/1.0	**APOLOGIES** Apologies were received from Kerry Robinson, Chief Performance, Improvement and OD Officer
06/04/1.1	**DECLARATION OF INTERESTS** None to note.
06/04/1.2	**MINUTES FROM THE PREVIOUS MEETING – JANUARY 2022** The minutes from the previous meeting were accepted as an accurate reflection of the meeting and therefore approved by the Board.
06/04/1.3	**MATTERS ARISING** Board Appointments – HT formally announced the appointment of Penelope Venables, Non-Executive Director who is to join the Trust in April and John Pepper, Associate Non-Executive Director who is to join the Trust in July. Ockendon Report – The Trust noted the final report which was published last week. HT highlighted that the System will be holding a meeting to reflect upon the report and encouraged the Trust to formally consider the recommendation outlined. ACTION: Reflect on recommendations within the Ockendon report and the findings to be presented at the next Board Meeting It was noted that the Board are committed to supporting those who have been affected by the report and will continue to support the System to drive improvement.
	PRESENTATIONS
06/04/2.0	**HDU CQC PRESENTATION** RL introduced James Neil, Kirsty Foskett and Lowri Mansell to the Board who joined the meeting to present the improvements within the HDU department following the last CQC inspection. JN led the presentation, highlighting the following:

	▪ In 2018 the CQC rated critical care as requires improvement (overall rating) ▪ Highlighted the key areas identified for improvement within each CQC domain and the action implemented to improve ▪ In 2019 the Faculty of Intensive Care Medicine updated their guidelines for the provision of Intensive Care Services, with specific reference to organisations that provide only level 2 care for patients. ○ A gap analysis was completed, and an action plan created ○ A Service Level Agreement with UHNM is in place for advice and guidance on critical care patients. The agreement also offers the opportunity for the organisation's anaesthetists to 'shadow' at UHNM ○ A regional critical care transfer team (AACOTS) to assist and advise on transfers to level three care ○ ICNARC fully implemented and results shared with Patient Safety Committee. Outcomes consistently positive compared with other units. ○ Policies, Procedures and Protocols tracked, updated, and reviewed at Well Led meeting. ○ Clinical Nurse Educator appointed to support the development of staff. ○ Training needs analysis completed for staff on the unit. ○ An MD team meet monthly and is upward reported to the Patient Safety Committee ▪ Moving forward – a hospital at night once 24/7 outreach embedded, nursing education – a critical care course, medical education – HDU shadowing at SaTH or UHNM) On behalf of the Board, HT thanked the team for their time and efforts in addressing the robust challenges. CB congratulated the Trust and noted there is no reporting on children. KF explained the unit is for adults only however children can be stabilised temporalty until the appropriate services are available. In 2015 the Trust were criticised for admitting children onto the unit therefore clear parameters have been set. PK suggested the team investigated advanced practitioners within the unit. DG queried the regional networks for level 3 and the transfer to Alderhay Hospital. The Trust confirmed the procedure is to transfer children to Birmingham. RL thanked the team for their continued hard work and with ensuring improvements are embedded within the unit and service. HT commended the presentation which highlighted the work completed to improve the service for patient and staff.
06/04/2.1	**PATIENT STORY** A patient story was shared with the Board – https://youtu.be/cpKnejwIZQQ The Board's reflections of the patient's story included the following: ▪ Commended the service which was an impressive story to be told ▪ Supporting the patient by ensuring the scan results are embedded into the patient's pathway ▪ Highlights the positives for enhanced recovery ▪ Highlighted the importance of care and responsive communications within a difficult time ▪ Empowering story which the Trust should use to develop ACTION: seek patients' permission to share the video wider with the Trust and make available on the Trust's website ACTION: add patient story reflection to the next Board agenda ACTION: send a letter of thanks to the patient
	CHIEF EXECUTIVE UPDATE
06/04/3.0	**CEO UPDATE** SK provided an update to the Board and highlighted the following: ▪ The system and NHS continue to face challenged and pressures in relation to Covid-19 due to the urgent demand and capacity with decreasing staffing levels ▪ Gold and Silver controls have been re-introduced with system meetings

	increasing too daily RJAH highlights: ▪ Executive Director Recruitment – the Trust have shortlisted candidates for the Chief Operating Office and Chief People Officer and interviews are scheduled for April 2022 ▪ Saplings – the Trust received 100 saplings which are to be planted along the path of positivity, this marks 100 years of the Hospital being on the Gobowen site and the Queens' Jubilee ▪ Overseas Workers – celebrated the day with events and communication, thank you to all! ▪ Trainee Nurse Associates – welcomed the second cohort of trainee's ▪ Health Hero (February) – Andrew Williams, Finance Business Partner who was nominated or stepping up to cover sickness absence within the team and hailed for going above and beyond. Well done, Andrew! ▪ Health Hero (March) – Tracy Knight, Switchboard who was hailed for taking on added responsibilities within the team and supporting the vaccination centre. Well done, Tracy! STW ICS highlights: ▪ Board appointments – confirmation received of the appointed Chief Finance Officer, Chief Medical Officer, Director of Delivery and Transformation, Director of Strategy, and Integration ▪ Elective Hub - £24m have been provisionally reserved for STW for phrase 1&2 of an elective hub at the PRH site. HT thanked SK for the updated and encouraged the Board for questions or comments. PK queried the length of stay presented which was shared with the Board via Geraint Thomas, SK confirmed the enhanced recovery programme is being rolled out across the Trust. DG noted the changes to the site and suggested the Trust share an update presentation on the Estates Strategy for awareness. ACTION: add the Estates Strategy and Plan to the Board workplan SN thanked SK for sharing the ED&I elements within the paper. HT noted the appointments made within the ICB and agreed to scheduling a development day with the ICB in the future. ACTION: to write to Sir Neil Mckay suggesting a collaborative Board development session
	QUALITY AND SAFETY
06/04/4.0	**CHAIR REPORT QUALITY AND SAFETY COMMITTEE** CB presented the assurance report to the Board, highlighting the following: ▪ Explained there is an IPC Quality Assurance Committee to be approved by the Board ▪ Partial assurances was reported on the clinical prioritisation agenda item as only a verbal update was presented to the Committee. Further information is to be provided at the next meeting and to become a standard agenda item. ▪ Partial assurance was reported in relation to the Chair Report received from the Health and Safety Committee due to concerns raised in relation to the H&S advisor chairing the meeting as well as the external inspections completed within Horatio's Garden which the Trust do not have oversight of. ▪ Commended the Trust on the harms review process and the assurance provided overtime which has become effective – well done team! HT thanked CB for the update and queried if the 'my recovery' app risk was added to the risk register to which SR confirmed. The Board noted the Chairs Assurance Report from the Quality and Safety Committee.
06/04/4.1	**INFECTION CONTROL REPORT Q3** SEA presented the report and highlighted the key points:

	▪ 1 E-coli bacteraemia in Dec 21. To date there have been 2 cases of E. coli blood stream infections against a target of 7 cases ▪ 7 IPC Quality assurance audits conducted ▪ Not all wards/departments have QR codes and access to Tendable relying on paper audits continuing. ▪ Overall, 98.6% compliance in Hand Hygiene and 99.4% compliance in Bare Below the Elbow was achieved for this quarter with three areas falling below target for both, Kenyon, Ludlow, and Pre-op assessment unit ▪ Individual RCAs and thematic analysis completed for Surgical Site Infections. One Together audit completed Dec 21. ▪ Four Covid-19 outbreaks – two of which reported as Serious Incidents due to disruption to service and escalation of care. CB queried the reporting line for all SSI and not only Hip, Knee and Spines and suggested the Board should have oversight to which the Trust agreed to report through the Quality and Safety Committee. The Board discussed the Covid-19 outbreaks, and it were informed that the Trust can not determine whether the outbreak was due to internal or external factors. SR confirmed areas of improvement have been identified but are unable to confirm the route cause due to the prevalence within the community. HT thanked SEA for presenting the comprehensive report which provides good assurance to the Board. HT commented on the lack of independent assurance provided and asked for further information to be reported at the time of the next presentation. The timeline of reporting to the Board was noted to be delayed therefore it was suggested a bridge report was offered in between to highlight any concerns. SR added that the IPC levels of assurance has been noted within the Governance review which the Trust are progressing. It was noted that in the meantime the IPCC meeting will continue to provide and assurance report to the Quality and Safety Committee, identifying any areas of concern. DG highlighted the bare below the elbow compliance rate being under 100% which is disappointing. SEA agreed with the comments and reassured the Board that work is being undertaken to address this. CB spoke about the importance of staff being empowered to challenge other members when processes are not being followed. The Board were content with the assurance provided throughout the report.
06/04/4.2	**CHAIR REPORT EXTRA ORDINARY QUALITY AND SAFETY COMMITTEE** CB presented the assurance report to the Board and noted the scale of work that is required to be undertaken. A single overarching action plan will be development to support reporting and monitoring of all aspects of the recommendations received. PK added there are issues which are relevant to the People Committee and therefore the Committee asked for support to gain assurance on IPC capacity and training requirements. It is a key focus area for the Trust and thanked the team for leading on the improvements before encouraging staff to ask for support when required. SK highlighted the importance of sustaining the mitigations embedded and supporting staff to continue new ways of working. The Board noted the Chairs assurance report.
06/04/4.2.1	**IPC QUALITY ASSURANCE TERMS OF REFERENCE** The Trust are recommending for an IPC Quality Assurance Committee to report directly to the Board overseeing all matters relating to infection, prevention, and control. The Terms of Reference for the newly established meeting were discussed at the Extra Ordinary Quality and Safety Committee. CB added that it would be useful to also have a member of the IPC team as a member of the meeting to offer further knowledge and support. The Board agreed and it was noted the Head of Clinical Governance and Quality will be added as a formal member to the

	Committee. DG queried if a member of the estates team would be beneficial to the Committee. SR explained that a member from the department will be asked to attend when a paper is provided to avoid the risk of the meeting becoming operational. HT asked for a reporting diagram to be incorporated into the terms of reference for further understanding of the reporting line. Subject to the two amendments noted, the Board approved the terms of reference.
06/04/4.2	**INFECTION, PREVENTION AND CONTROL IMPROVEMENT PLAN** The NHSE/I IPC team completed an assurance visit on 2nd of August 2021 highlighting areas for improvement. Subsequently RJAH was escalated to Red on the NHSE/I IPC Matrix and a subsequent improvement plan with external support was developed and progressed. Following the last visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance. The Trust therefore remains red on the NHSE/I IPC matrix with immediate remedial action and improvement required. A total of 6 immediate actions were identified and the progress against the trust wide improvement plan has been reported. SEA reported that 4/6 have been completed and noted further work to be completed in relation to: ▪ Medical leadership intervention with medical colleagues compliance with IPC including hand hygiene, bare below the elbows and the use of theatre hats/caps. ▪ Review of the IPC team structure and the team capacity and priorities The actions continue to be monitored through the weekly IPC meeting. HT noted that last year internal audit provided an assurance report on IPC. SK confirmed this has been reviewed and incorporated into the action plan. DG explained that he has completed a review of the report and agreed to share his findings with CB and SEA. ACTION: DG to circulate findings from the IPC internal audit report with CB and SEA SR explained that any concerns identified will be incorporated into the action plan with a note of source to support reporting. PK encouraged the one plan with one reporting direction to avoid confusion. HT requested a reporting diagram is to be developed. ACTION: a reporting line diagram in relation to IPC is to be created and circulated to the Board SN added that it would be beneficial for the Trust to seek support from internal audit to complete a review on IPC to which the Trust confirmed it has been scheduled within the draft plan. The Board noted the document welcomed a further update at the next meeting.
06/04/4.4	**INFECTION, PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK** SEA provided an overview of the report and process: ▪ New version 1.8 IPC Board Assurance Framework (BAF) released 24 December 2021 ▪ Governance review tracker added to monitor progress of the IPC BAF to Board ▪ New version 1.8 presented at IPC&C Committee following initial release 27 January 2021 ▪ Trust position to all KLOEs reviewed at IPC&C 1 March 2022. Out of 113 KLOEs 87 rated as green and 26 Amber with further actions required. ▪ Amber and Red RAG rated KLOES will form the basis of an action plan. Progress against actions monitored via the Infection Control & Cleanliness Working Group and presented at IPC&C for oversite and approval. ▪ Risks to escalate: o IPC team capacity to complete IPC assurance walks o Full training needs analysis and subsequent detailed training report required ▪ Progress: o IPC team structure has been reviewed and case of need approved with recruitment underway o Local training records for annual hand hygiene competencies being

	entered on ESR for full oversight and local induction for medical staff extended SEA added that the CCG are supporting by compiling quality audits and peer reviews are to be scheduled. HT queried the difference in the guidance's from 3months ago and how to ensure the Trust reflects the work completed throughout the pandemic in a timely way. SEA confirmed the Trust are awaiting reviewed guidance and this will be circulated to the team next month following consideration at the IPC Committee before upward reporting to the IPC Quality Assurance Committee. SK reminded the Board that the report will remain a live document and therefore continuously monitored and reviewed. The Committee noted the report and thanked SEA for the update.
06/04/4.5	**INFECTION, PREVENTION AND CONTROL HYGIENE CODE GAP ANALYSIS** SEA presented the report to the Board, highlighting the following against the criterion: • Overall compliance of **92%** with no red rated criterion • Criterion 2 scored **89%** - this identifies resource requirements within the facilities team. The implementation of the National Cleanliness Standards from 1st of April will see improvement with compliance. • Criterion 3 scored **83%** - antimicrobial stewardship membership and upward reporting to IPCC requires improvement • Criterion 4 – scored at **88%** identifies improvements that can be made to public facing information on IPC • Criterion 6 scored lowest at **78%** - full training needs analysis required and focus on training at induction • Criterion 7 – scored at **89%** - this will be improved with the completion of bay doors being installed on Kenyon ward • The improvement plan has been developed with clear action owners and timescales to be identified, this will be monitored through IPC working group with upward reporting to Infection Control and Cleanliness Committee. It was noted that the Extra Ordinary Quality and Safety committee discussed the detail of the report acknowledging a further deep dive into the green rag rated areas was to be provided to provided assurance on the standards reported within the criterion. DG welcomed the increased assurance via a self-assessment and peer review. The Board noted the report highlighting the importance in relation to patient/staff safety as well as reputation for the organisation.
	PEOPLE UPDATE
06/04/5.0	**CHAIR REPORT PEOPLE COMMITTEE** PK presented the assurance report to the Board, highlighting areas of concern and therefore further assurance requested in the following areas: ▪ Staff turnover ▪ Overall workforce plan linked to the operational plan and its deliverability ▪ Clearer and accurate data to be provided on consultant recruitment ▪ DBS checks on overdue staff to be completed ▪ The compliance target in relation to MCSI training report ▪ A written proposal to be received on freedom to speak up Following HT query regarding the interim freedom to speak up process, SK confirmed that the initiative will be relaunched across the organisation and has been aligned to the patient safety specialist within clinical governance. SR explained there have been conversations with Shropshire Community Trust in relation to seeking a shared guardian which will support staff who wish to raise concerns with a member who is external from the Trust. CB asked for an update on the system wide arrangements. SS reminded the Board that this process is an important function for raising concerns but should not be used as the primary way of raising concerns, staff should feel confident and comfortable seeking support from their lines manages and noted there is further work to be completed and improves to be implemented. PK suggested this is to be communicated when advertised the relaunch of the freedom to speak up guardians. SK explained KR is currently completing some work in relation to improving the culture of the Trust which includes the staff survey and what training staff need to be empowered and feel confident

	within their roles. PK asked what more can the Trust do to support recruiting of Anaesthetists? RL explained the Trust are investigating Associate Anaesthetists, advertising oversea and looking to create a preoperative assessment post only. Further work is to be completed on researching what would make a more attractive role, although this was noted for all roles across the organisations. SS added that the Trust are not poor at recruiting and that one of the mains issues is there isn't availability of people and therefore asked the Board to reflect on what can we do to change the services we provide.HT reminded the Board that one of the key focus areas for the Trust this year is to review the services to which workforce will be an enabler. CB suggested the Trust consider trainee Anaesthetists, RL explained there are limited number of trainees across the nation and due to the nature of the services the Trusts provides and therefore it would be difficult to retain staff therefore fellowships are being considered. The Board noted the Chair assurance report from the People Committee.
06/04/5.1	**STAFF SURVEY (VERBAL)** SS gave a verbal update on the recent staff survey results which supports the Trust in benchmarking against the whole NHS as well as other Specialists Trust which are our comparators. The key highlights included: ▪ Staff have had a difficult and challenging 2 years ▪ Staff do not feel confident in speaking up ▪ People feel less valued ▪ Overall, staff are reporting this Trust is a positive organisation to work for The Trust are proposing to continue with listening and supporting with co-designing work noting the Trusts approach to these finding is vital. Staff absences was highlighted as key concerns especially with the requirement to ask more from staff in relation to supporting the system and being re-deployed to other areas. HT thanked SS for sharing the important insight and noted that recruitment is an issue but highlighted the importance of retention and supporting staff therefore HT encouraged the Trust to gain support from external companies on ways to improve. SK commented on the importance of making sure the staff are aware that Board is aware of how they are feeling and will look to improve. CB shared his disappointment in the scores reported. DG highlighted the positive reporting of 95% of staff would recommend the hospital to friends and family for treatment. SS explained that further understanding is required before implementing any changes. RL added that the Civility Saves Lives included a peer review which asked staff what they would want to see/do differently – this may be beneficial to the organisation. The Board highlighted the positive affect visibility has on staff. SEA explained the patient safety walkabouts are to commence in April and staff questions time are arranged frequently. The informal, non-structure chats when walking down the corridor are invaluable. The Board asked for a proposal of how to move forward to be reported via the People Committee.
	PERFORMANCE AND GOVERNANCE
06/04/6.0	**CHAIR REPORT FINANCE, PLANNING AND DIGITAL COMMITTEE** SN presented the report as the Chair of the meeting and highlighted the main concern being the deliverability of the operational and financial plan for 2022/23 – the Trust need to continue to monitor CB noted that both the People and Finance, Planning and Digital Committee have questioned the deliverability of the plan.

	CM explained there is a disconnect between the guidance and the realistic re-instating productivity levels for the Trust. The guidance does not currently consider the Covid-19 impact which is challenging. The Board noted the challenges faced across the Trust, System and NHS as a whole and asked for the Finance, Planning and Digital Committee to continue to monitor the risks.
06/04/6.1	**PERFORMANCE REPORT** The Board received a detailed summary of the performance report for month 11. The impacts of covid continue to be seen in the delivery of our statutory targets and will continue not to be met due to pausing of elective services last year. Therefore, assurance cannot be given for meeting the targets, hence assurance should be through the processes in place to manage such impact as described in the action section of all exceptions. Patients continue to be booked in line with guidance regarding clinical priority as a primacy rather than date order, illustrated in the long wait patients impact. HT suggested that within future reports the Trust uses a flash report to support the changing reporting information to which the Trust agreed. *Caring for Staff* ▪ Sickness Absence – continues to be high across the organisation o Metric showing special cause variation of a concerning nature; remaining above control range o Short term sickness showing special cause variation of concern o Long term sickness within normal variation *Caring for Patients* ▪ Serious Incidents o Low number of incidents have taken place – 1 reported in February and no severe harm recorded ▪ WHO o Quality Audit – decrease in compliance; Included to highlight process issues in data collection; resulted in fewer audits in February o Documentation Audit; reported below target o Further investigation to understand why stage 4 has noted to decrease a robust audit has been implemented. o Discussion were held in relation to electronic system to support where you cannot move on to the next page until it is completed ▪ Cancer Waits Standards o 62 Days Standard; reported below target o One was patient choice and one was a tracking issue. Each case is discussed at a weekly meeting to ensure the process is followed. ▪ 18 Weeks RTT Open Pathways o Metric is showing special cause variation of concerning nature and continues to fail the 92% target. As expected from covid impact, this will continue for a significant time. o Whilst this metric remains affected from the covid impact, and will not be met NHSEI H2 planning guidance has set out the expectation that Trusts should stabilise waiting list numbers at the level seen at the end of September 2021 as the assurance around process rather than target. ▪ Patients Waiting Over 52 Weeks o Both English and Welsh showing special cause variation with increases reported this month. o NHSEI H2 planning guidance documents that as a Trust we should hold or where possible reduce the number of patients waiting over 52 weeks. For month 11 our English patients waiting over 52 weeks is 216 patients below our planned trajectory and Welsh patients 167 below our planned trajectory. ▪ Patients Waiting Over 104 Weeks o English and Welsh individually showing special cause variation of concern o At RJAH the Trust has a trajectory to eliminate non-spinal 104+ week

	waits by March 2022. The Trust however is expecting spinal disorder 104+ weeks to still be present by March 2022. ○ Currently 94 patients below our planned trajectory (English & Welsh). ▪ 6 and 8 Week Wait for Diagnostics ○ Both metrics shown as normal variation but remain off target *Caring for Finances* ▪ Total Elective Activity ○ 81.38% of plan delivered in February ○ 75.74% of 19/20 baseline ▪ Total Outpatient Activity ○ 81.66% of plan achieved in February ○ 77.13% of 19/20 baseline ▪ Bed Occupancy – All Wards – 2pm ○ Metric shown as special cause variation of an improving nature, although consistently failing target ▪ Expenditure ○ Adverse in month ▪ There were no concerns to raise regarding the forward look to year end DG noted the high income from private patients reporting and suggested communications is shared with the Trust as a way of explaining the reasons. CM explained the private patient and NHS process has been re-instated and therefore controls are put in place similar to the pre-pandemic process. Private patients' activity increased in the earlier part of the year when capacity was high due to no-elective surgery being scheduled. The Board noted the Performance Report for month 11.
06/04/6.2	**PERFORMANCE MANAGEMENT AND ACCOUNTABILITY FRAMEWORK** Following consideration at the Finance, Planning and Digital Committee it was recommended the Board approve the reviewed framework and note that the document will require a further review once the management structure has been implemented. The key changes to the framework include: ▪ Recognise a constant cascade of priorities is required as new guidance is received ▪ Focus on transformation and clear trajectories to ensure performance against plans are met ▪ Clarity on governance arrangements for performance monitoring changes The Board approved the Performance Management and Accountability Framework.
	QUESTIONS:
06/04/7.0	**QUESTIONS FROM THE GOVERNORS** There were no questions from the Governors however, WG highlighted the discussion regarding the green RAG ratings and noted it was encouraging to know the Non-Executive Directors were seeking assurance on the underlying statements.
06/04/7.1	**QUESTIONS FROM THE PUBLIC** None to note.
	ANY OTHER BUSINESS:
06/04/8.0	**ANY OTHER BUSINESS** HT encouraged the Board to reflect on todays meeting which will support future meetings. HT thanked everyone for attending the meeting and for their contribution in the discussions.
	NEXT PUBLIC MEETING: WEDNESDAY 4TH MAY 2022 AT 9:30AM

BOARD OF DIRECTOR – PUBLIC MEETING
6 APRIL 2022
SUMMARY OF ACTIONS

REFERENCE/TITLE	LEAD	STATUS
Actions from the Previous Meeting – January 2022		
None outstanding.		
Actions from the Meeting – April 2022		
1. Ockendon Report Reflect on recommendations within the Ockendon report and the findings to be presented at the next Board Meeting	Chief Nurse and Patient Safety Officer / Chief Medical Officer	Complete - on the agenda
2. Patient Story Seek patients' permission to share the video wider with the Trust and make available on the Trust's website	Chief Nurse and Patient Safety Officer	
3. Patient Story Add patient story reflection to the next Board agenda	Chief Nurse and Patient Safety Officer	Complete – on the agenda
4. Patient Story Send a letter of thanks to the patient	Chief Nurse and Patient Safety Officer	Complete
5. CEO Update Add the Estates Strategy and Plan to the Board workplan for a future meeting	Trust Secretary	Complete – added to work plan
6. CEO Update To write to Sir Neil McKay suggesting a collaborative Board development session	Chairman	
7. IPC Improvement Plan DG to circulate findings from the IPC internal audit report with CB and SEA	Trust Board Advisor	
8. IPC Improvement Plan a reporting line diagram in relation to IPC is to be created and circulated to the Board	Chief Nurse and Patient Safety Officer	
9. Performance Report Key metrics with highlights to be added to the front sheet of the IPR	Chief Finance and Planning Officer	Complete

Menopause

What are we doing for our service users?

Carrie Jenkins
Deputy Chief and Pre-op Lead
Pharmacist

What do we know?

We ARE talking about it

- 80% of women will be menopausal by the age of 54
- up to 80-90% will have some symptoms,
  - 25% describing them as severe and debilitating

Over half a million prescriptions for HRT each year

England are moving to reducing the cost of HRT 2023

- ~£220 to £18.70

Consultation on OTC formulations

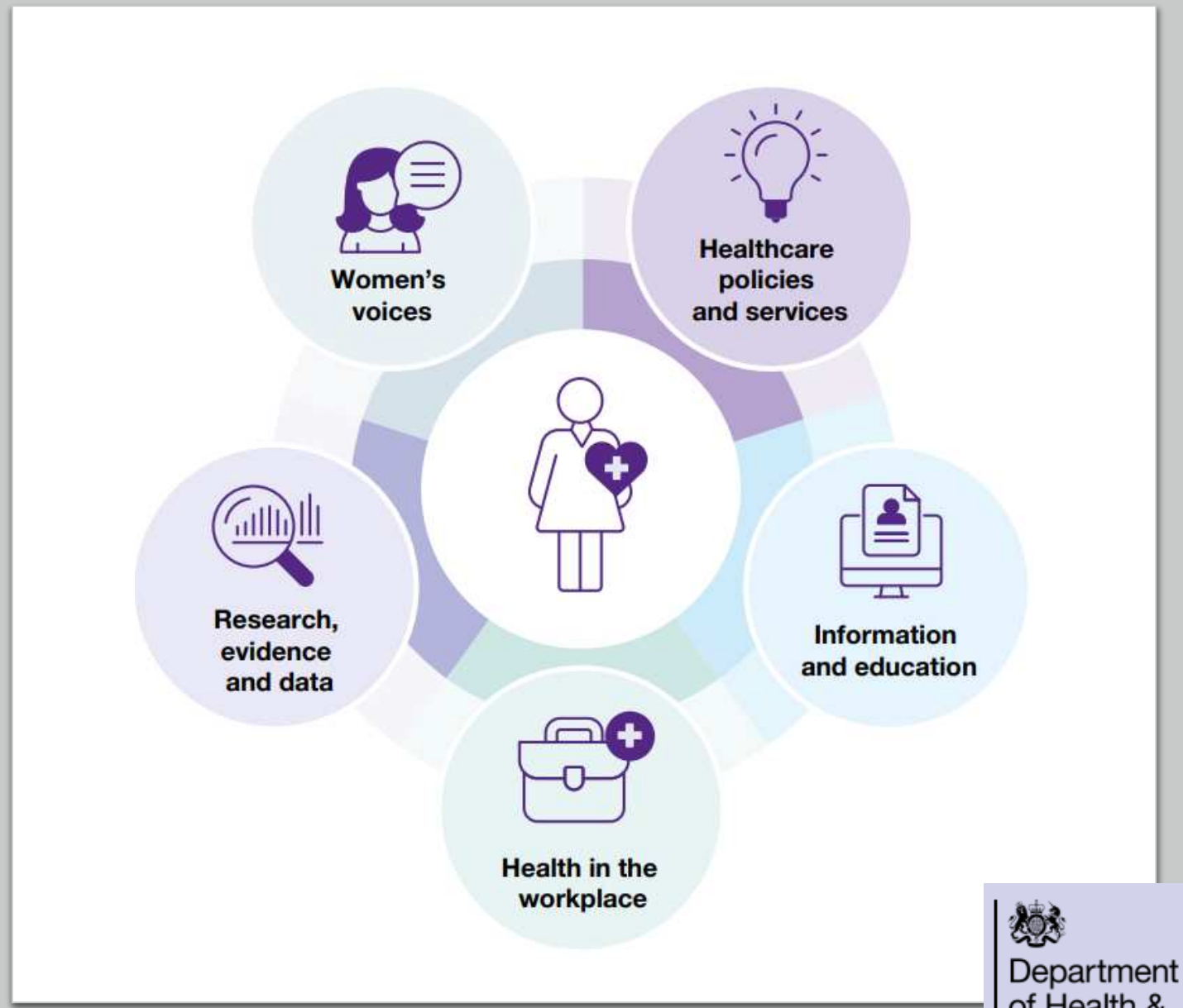
England and Wales moving to change legislation

Vision for the Women's Health Strategy Dec 2021

"to better understand and tackle disparities in experience and outcomes throughout women's lives"

"The Call for Evidence told us that women do not feel heard within the healthcare system."

"We also heard calls for healthcare professionals to be better educated on the menopause and HRT…to be well informed about the menopause."



Department of Health & Social Care

Department of Health & Social Care

Ambition

- National healthcare policy and services consider women's needs specifically, and by default
- Women feel better listened to and heard by healthcare professionals – concerns and symptoms are taken seriously
- Women receive accurate and up-to-date advice from healthcare professionals
- Guidelines represent the latest evidence on women's health conditions and consider differences between men and women
- Healthcare professionals are supported in implementing these guidelines

RJAH Challenges

- Outdated management of HRT in the organisation
- Medical and Rehab patients not represented
- Surgical preferences required updating

Appendix 3 - Pre Op Assessment Protocol for HRT

HRT CONTAINING Oestrogen must be stopped 4 weeks prior to all **joint replacement Surgery for all surgoens below**
Mr N Graham
Mr Whittaker (Do not stop for scopes)
Mr Karlakki (except for knee scopes which may stop 2 weeks prior)
Mr S Phillips
Mr S Lewthwaite
Prof Richardson (and fracture & osteotomy work)
Mr Steele

HRT containing Oestrogen must be stopped 4 weeks prior to Surgery (minimum)
All Foot and Ankle Surgeons
All Spinal Surgeons (no need to stop for caudal epidural inj, trigger spot inj &mua inj coccyx)
Mr P Cool (except malignant tumours -when not necessary)
Miss G Cribb (except malignant tumours when not necessary)

HRT containing Oestrogen must be stopped 6 weeks prior to all Surgery
Mr N Kiely (& OCP 6 weeks)
Mr Burston

Continue HRT
Mr R Roach (as SaTh policy)
Mr A Smith
Mr S White
Mr Spencer Jones
Mr C Evans
Mr R Banerjee
Mr C Kelly (Hopes for consensus in Hand & upper limb team)
Mr D Ford
Mr S Pickard (Hopes for consensus in Hand & upper limb team)
Mr R Dodenhoff
Mr P Moreau
Mr S Hay
Mr M Van Liefland

Mr Potter
Mr Gallacher
Mr Gregson
Col. Meyer (unless significant VTE risk)

Stop HRT containing oestrogen 4 weeks before op if patient has been on HRT for less than one year
Mr A Roberts

No Guidance given by surgeons follows below ask surgical team
Mr S NJ Roberts

Goal of Project

1

Create a policy that gives people using HRT options when using our services

2

Ensure that risks for adverse outcomes remained low

3

Ensure all stakeholders were consulted in the development

Evidence

Evidence has changed

- Menopause gained significant recognition
- Review management in specialties

Key messages

- Decisions should be made on an individual basis, considering individual preferences
- VTE - small increased risk with tablet but not transdermal HRT.

Review the management

Discussion with the specialties 2021-2022

Multidisciplinary working

Education of preop teams

Include the nature of the procedure in the decision

Include new evidence/consensus

Align policy from similar trusts

Provide patients with options and advice

Refer to surgical teams where appropriate

Oral HRT preparations

The risks of VTE are considerably lower with oestrogen containing oral HRT compared to any form of CHC. However, some risks remain, and consideration should be given to stopping oral oestrogen containing HRT 4 weeks before:

- Planned major surgery
- Surgery to the legs (does not apply to minor surgery with short duration of anaesthesia)
- Surgery which involves prolonged immobilisation of the lower limb

Treatment should not be restarted until the patient is fully mobile

A list of surgical team preferences for HRT may be found in the perioperative medicines policy.

If there are concerns about rebound menopausal symptoms, the patient may be switched to a non-oral HRT preparation e.g., patches. Transdermal forms of HRT do not increase the VTE risk in the general population. Clotting factors in the liver are not activated due to escape of first pass metabolism. The risk has not been fully validated in the surgical setting however it is widely accepted that transdermal forms of HRT are suitable for women with risk factors for VTE.

The use of hormone therapy for transgender individuals

Although data on VTE risk in transgender women taking hormone therapy undergoing surgery are not available, best evidence suggests stopping estrogen therapy four weeks before major procedures to the legs or with immobilisation. Once fully mobile, oestrogen therapy may be resumed, typically within four weeks.

Failure to stop hormone therapy in relevant patients

Consideration should be given to moving the date of surgery for any patients seen in preoperative assessment with insufficient time to stop oral HRT. If a patient is admitted who has not stopped oestrogen containing contraceptive or oral HRT, the admitting clinician must discuss this with the operating surgeon and anaesthetist, who must consider all risks. Decisions must be discussed with the patient and documented in the patient's notes. Women who do not have other predisposing risk factors for VTE may continue with oral HRT. Oral HRT may be continued in the peri-operative period provided appropriate thromboprophylaxis is prescribed e.g., LMWH.

For non-surgical patients

Continuing use of hormone therapy should be discussed with the patient and where appropriate modifiable risk factors such as hormone therapy should be reviewed in patients with VTE risks.

Patients using hormones for a hormone deficient diagnosis may continue with these treatments e.g., testosterone injections

- ✔ Considers procedural risk
- ✔ Consensus from specialties
- ✔ Inclusive
- ✔ Provides options
- ✔ Reduces cancellations
- ✔ Medical/Rehab represented

Oral HRT preparations

The risks of VTE are considerably lower with oestrogen containing oral HRT compared to any form of CHC. However, some risks remain, and consideration should be given to stopping oral oestrogen containing HRT 4 weeks before:

- Planned major surgery
- Surgery to the legs (does not apply to minor surgery with short duration of anaesthesia)
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If there are concerns about rebound menopausal symptoms, the patient may be switched to a non-oral HRT preparation e.g., patches. Transdermal forms of HRT do not increase the VTE risk in the general population. Clotting factors in the liver are not activated due to escape of first pass metabolism. The risk has not been fully validated in the surgical setting however it is widely accepted that transdermal forms of HRT are suitable for women with risk factors for VTE.

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Failure to stop hormone therapy in relevant patients

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For non-surgical patients

Continuing use of hormone therapy should be discussed with the patient and where appropriate modifiable risk factors such as hormone therapy should be reviewed in patients with VTE risks.

Patients using hormones for a hormone deficient diagnosis may continue with these treatments e.g., testosterone injections

Policy in action

"I'd rather carry on in pain then stop my HRT"

Supports service users

- Women make an informed choice
- Since Nov 2021 – all women using topical HRT have been able to continue

March 2022 – Foot and Ankle

Patient transitioned to patch

Due for surgery April 2022

Cancelled

Managing - thankful for the relief the patch provides

April 2022 - Spine

Oral HRT, requires 4 week stop

Anxious to stop

Anxious to have surgery

Advised transdermal

Return for advice if problems arise

National healthcare policy and services consider women's needs specifically, and by default

Women feel better listened to and heard by healthcare professionals – concerns and symptoms are taken seriously

Women receive accurate and up-to-date advice from healthcare professionals

Guidelines represent the latest evidence on women's health conditions and consider differences between men and women

Healthcare professionals are supported in implementing these guidelines

0. Reference Information

Author:	Stacey Keegan, Interim Chief Executive Officer	Paper date:	4 May 2022
Senior Leader Sponsor:	Stacey Keegan, Interim Chief Executive Officer	Paper written on:	28 April 2022
Paper Reviewed by:	N/A	Paper Type:	Update
Forum submitted to:	Board of Directors - Public Session	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides and update to Board members on key local activities not covered within the main agenda.

2. Executive Summary

2.1. Context

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

2.2. Conclusion

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

3. The Main Report

The Robert Jones and Agnes Hunt Hospital (RJAH) Update

3.1. RJAH staff supporting the system covid effort.

We are grateful to the 22 RJAH staff who temporarily moved across to The Shrewsbury and Telford Hospital NHS Trust (SaTH) during April to support with the response to the latest spike in coronavirus cases.

Community Covid prevalence, and the numbers of admissions increased significantly in April to the highest levels seen in the entire pandemic, and that, combined with high levels of staff absence across the system as well, meant that the system declared a critical incident. That remained in place for almost three weeks.

SaTH, and indeed all system partners, were grateful for the additional resource and we thank the volunteers who came forward, as well as their colleagues back at RJAH who ensured that we continued operating with as little disruption as possible.

3.2. Headley Court visit progress on Veterans' Orthopaedic Centre

Air Vice Marshal Anthony J. Stables, Chairman of the Headley Court Charity, visited RJAH to see the progress of the Headley Court Veterans' Orthopaedic Centre. Works on the state-of-the-art building, which is the first dedicated orthopaedic centre for Armed Forces veterans in the UK, began back in June 2021 following a £6 million donation from the Headley Court Charity.

Headley Court was the leading medical rehabilitation base for members of the Armed Forces before the transfer of those services to a new facility at Stanford Hall, and following that move, Trustees of the Headley Court Charity, had been looking for worthy causes in keeping with their ethos and aims to support in the form of charitable grants from their reserves.

3.3. Fundraising appeal launched for Alice Ward garden.

The RJAH Charity launched a dedicated fundraising appeal to create an outdoor garden for paediatric patients and their families.

The aim is to provide a safe, private, and stimulating environment which promotes health and wellbeing as well as being a calming escape from the ward environment.

Plans for the garden have been designed by volunteer Olivia Copley and will include a covered canopy, woodland walk, vegetable patch as well as rehabilitation areas and a weatherproof zone to host outdoor games and learning.

3.4. Centenary Cycle raises funds for RJAH Charity

The Centenary Cycle raised almost £4,000 and took place at the end of March, it saw over 50 cyclists take on a 60k or 100k route around Shropshire's countryside. The charity bike ride was organised to mark 100 years of RJAH being based as its current site in Gobowen.

3.5. Vaccination Centre transformed into mini jungle.

The RJAH Vaccination Centre at RJAH has been transformed into a mini jungle to help put young children at ease when they come for their covid vaccinations.

Murals of animals have been supplied by Welshpool Printing Group and funded by the League of Friends to make the vaccination bay more fun for children.

The vaccination centre has been busy with vaccinations for children aged between 5 and 11, who have been eligible to come forward since early April.

3.6. Heath Hero Awards

Our April winner was Nurse Julie Cole who works as part of the Metabolic Bone Team. Julie was nominated by her colleague Tracey Roberts for stepping up and running the Intra Venous (IV) service independently when Tracey was required to isolate due to testing positive for covid-19.

Tracey said: "Julie's hard work ensured that no patients had their treatment cancelled and the service continued to run smoothly. I cannot thank for enough for her hard work."

Well done, Julie!

Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) Update

3.7. Executive and Non-Executive Appointments

A further appointment to the STW Integrated Care Board (ICB) have been confirmed.

- Chief Nursing Officer – Alison Bussey

Further discussions have also taken place with NHSE/I with a view to appointing a fourth Non-Executive Director to the ICB.

3.8. Communication and Engagement Update

As part of the ICB constitution, the principles, and arrangements for how we will work with our people and communities need to be set out.

Our involving and communities' strategy will enable a system-wide approach to hearing and learning the needs, experiences and wishes of local people and ensure they inform our priorities and decisions.

Last month, to inform the strategy a workshop was held which brought together people representing organisations and communities across Shropshire, Telford, and Wrekin to discuss principles and approach to involvement.

A final draft strategy is proposed to come to the May ICB meeting ahead of submission to the Regional NHSE/I team in early June.

3.9. Health and Care Bill

The Health and Care bill received Royal Assent on the 28 April 2022, becoming the Health and Care Act 2022. Integrated Care Systems will fulfil their statutory responsibilities from the 1 July 2022.

3.10. Conclusion

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

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

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	4 May 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	27 April 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1 Context

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

2.2 Summary

- The Committee was quorate
- The Committee received the standard agenda items which included the SI and Never Events paper, a Unit quality report, the Harms presentation, and the performance report.
- The Committee approved the Medical Devices Loan Policy
- Areas to highlight to the Board include:
    - Reporting of clinical prioritisation to be embedded in the Committee agenda
    - Findings of the SSI review to be shared with the Committee
    - Reporting falls as avoidable and unavoidable to the Committee via the Performance Report
    - LPS to be established within the system and reporting/oversight to be confirmed internally

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Quality and Safety Committee which met on 17 March 2022. The meeting was quorate with 2 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Paul Kingston	Non-Executive Director
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow	Chief Medical Officer
In Attendance:	
Shelley Ramtuhul	Trust Secretary/Director of Clinical Governance
Dawn Forrest	Managing Director for Specialist Unit
Kirsty Foskett	Head of Clinical Governance and Quality
Lisa Newton	Assistant Chief Nurse for Specialist Unit
Tracey Slater	CCG Representative (observing)
Lorraine Fearne	Minute Secretary
Apologies:	
Apologies were received from Stacey Keegan	

3.2 Actions from the Previous Meeting

The Committee discussed the action plan in detail and an update was provided for each action. There were 6 actions noted as outstanding a forwarded on to the next meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There was no declaration of interest shared	N/A	
2. SI and Never Event Report		
Due to the time in which the paper is written a verbal update will be presented on those actions which are overdue to ensure the Committee can gain assurance.	Yes	

There were 4 serious incidents currently open and 1 never event. The Committee were assured of the process in place regarding the SI and Never Events.		
3. Harms Presentation		
The Committee were informed that: ▪ Cohort 1, 2248 harms reviews completed. 16 outstanding (11 in spinal injuries and 4 in Tumour) ▪ Cohort 2, 956 reviews undertaken. The Trust confirmed that the timescales for a query moderate harm to see a patient in clinic is 3 weeks, this is monitored and any exceeding this timeframe will be escalated. It was confirmed the proposed submission to the HSJ is nearer completion.	Yes	
4. Clinical Prioritisation (verbal)		
The Trust informed the Committee that progress has been made and through the mutual support provided to SaTH some benefits had been gained. The teams have been developing a desk top review process like the Harms Review process which requires little involvement from the consultants although support has been gained from retired professionals. A report will be shared at the next meeting advising the Committee on next step including figures which will be required nationally as this is part of the planning guidance.	Partial	Verbal update was obtained at the meeting. Further information on the Clinical Prioritisation to be reported at the next meeting. The Committee agreed for the subject to become a standard agenda item and added to the work plan monthly.
5. Safer Sharps Update		
Overall, a positive position was reported to the Committee, noting the external peer review completed which provided further assurance and low levels of incidents reported. The Trust have substantial assurance and compliance against Health & Safety regulations. To gain a better understanding of compliance in relations to preventing the recapping of needles, the Committee have asked the Health and Safety Committee to report more information. The Trust is continuing to gain 100% safer sharps compliant devices across the Trust so 100% which will provide full assurance. The Committee asked for the definition of terminology to be included in next report for awareness. It was noted that sharps need to be fit for purpose and theatres still use sharps not safer sharps, but assurance is supported by the low number of incidents. The	Yes	

Committee were content with the process in place and monitoring of safer sharps as well as the actions to improve.		
6. Learning from Deaths Q4 Report		
The Trust report 5 deaths in last quarter - 3 being investigated and 2 in January were associated to a covid outbreak and have been investigated as part of SI's No themes raised and good practice reported as part of a structure judgement review in December. Learning from Deaths well linked within the System with a trained Medical Examiner now in SaTH and managing the role across the System which provides assurance.	Yes	
7. Performance Report		
The Committee discussed the CB avoidable/unavoidable falls. The Trust advised the difference in falls - if all risk assessments in place such as staffing level, buzzers in place then this would be classed as unavoidable. Most avoidable falls were from patients who had been advised not to mobilise unaided but do. The Committee asked for further information within future reports. The Committee asked where the SSI review findings will be reported to which the Trust explained the IPC QA will gain assurance through the IPCC Chair report next month.	Yes	Further information required at future meetings regarding SSI review and falls.
8. Specialist Unit Quality Report		
Highlights from the report included: ▪ Last 12 months highest incidences reporting in staffing (vacancies and absences) and 2nd safeguarding (DoLs patients) ▪ an Increase in complaints in Rheumatology and suggested responses don't appear to be meeting the need so may need to review how this is approached. ▪ advised that there were some concerns around staff behaviours and communication with complaints. And reported a group (Band 6 task and finish) has been set up to review complaints and what actions were taken and if these were embedded A review of plans going forward included: • Actions reviewed and managed in a timely manner • SI's and lessons learnt are embedded • Complaints Band 6 task and finish group, review follow up and actions. • Reviewing all risks within the unit and working with Governance. Checking quality of them so risks are current and not historical.	Yes	Deep dive in to complaints reporting concerns in to staff behaviours and communication to be presented at Patient Experience Committee.
9. Board Assurance Framework		

The Quality and Safety were advised that the BAF risks will go to the Audit and Risk Committee then to Board and informed the Committee the IPC progress update requires further narrative and new risks have been identified. Gaps in Control and Assurance and subsequent actions are being worked through and it was proposed these are presented to the IPC Quality Assurance committee at the end of the month for comment.	Yes	
10. Legal Claims Update		
The Committee noted the report ahead of onward presentation at the next Private Board meeting. Full assurance was provided in relation to the process to monitoring the claims.	Yes	
11. Chair Report – Patient Safety Committee		
It was noted that the remains a delay with VitalPAC and that the issue specifically to the sepsis module and this will be part of the EPR upgrade due in 18 months. The Non-Executive queried the gap analysis for Complex Spinal Surgery. The Trust advised this had been picked up at Patient Safety Committee to do a gap analysis against guidelines to ensure any gaps are being mitigated. The Committee agreed for the Quality Priorities to be presented to the next meeting.	Partial	Further assurance to be provided following the completion on the gap analysis
12. Chair Report – Safeguarding Committee		
The following areas were identified: ▪ LPS - code of practice under consultation and will prepare an organisation and System response and risk has been added to risk register for preparedness and potential resource required for implementation. ▪ Level 3 safeguarding training - seeing improvement as people are meeting their 8 hours but still more work to do. The Committee noted the issues identified	Partial	Further understanding is required in relation to the LPS and the reporting line internally
13. Chair Report – Medical Devices Committee		
It was reported that all assurances were obtained and Medical Devices Loan to patient procedure was agreed at committee.	Yes	
14. Chair Report – ICS Quality Committee		
The Committee noted the Chairs report which is shared for information only.	N/A	
15. Review of the Work Plan		
The Committee noted the workplan for 2022/23 and will continue to reflect upon the document throughout the year.	N/A	
16. Attendance Matrix		
The Committee noted the attendance matrix which is shared for information.	N/A	

3.4 Approvals

Approval Sought	Outcome
Medical Devices Loan Policy	Approved

3.5 Risks to be Escalated

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

4. Conclusion

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

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	4 May 2022
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee 21/04/2022	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?

Learning from Deaths summary report Board of Directors following consideration at the Quality and Safety Committee in April.

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.

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

See Numbers Below.

2.3. Conclusion

No Concerns or specific learning identified.

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	SI	Death likely due to problems with care	Themes/Family feedback.	Actions
December 2021	1	1	1	0	No theme/Feedback	Good practice re early use of interpreter to help with orientation to MCSI.
January 2022	3	3	2	0	No theme/Feedback	None required
February 2022	1	awaited	0	0	No theme/Feedback	None required
March 2022	1	awaited	0	0	No theme/Feedback	None required

3.3. Associated Risks

Two January cases included in SI investigation of COVID outbreak on Sheldon. (Both with multiple co-morbidities).

3.4. Next Steps

Discussions in progress with SATH concerning a link with their Medical Examiner and Bereavement system. DPIA done but outstanding clarification awaited (I am chasing up next week).

LFD lead now working as a Medical Examiner at SATH.

LFD lead at RJAH now attends Mortality steering group at SATH, although this has been moved recently so I am unable to currently attend.

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

3.5. Conclusion

No concerns identified.

Good practice noted from SJR re early use of interpreter to help with patient orientation on MCSI.

Appendix 1: Acronyms

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

Chair's Assurance Report
IPC Quality Assurance Committee 28 April 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	4 May 2022
Executive Sponsor:	Chris Beacock, Quality and Safety Committee Chair	**Paper written on:**	3 May 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the IPC Quality Assurance Committee meeting held on 28 April 2022 for assurance purposes. The Trust Board is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

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

2.2 Summary

- All members of the Committee were in attendance and therefore quorate
- The Committee received the LM Report, IPC Improvement Plan, IPC Quality Report and Estates Requestions report for assurance
- Further assurance is to be provided on:
    - The exit criteria required to improve and progress out of the red rating
    - SSI reporting for all infections (not only hips, knees and spines)

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Trust Board from the Extra Ordinary Quality and Safety Committee which met on 28 March 2022. The meeting was quorate with 2 Non-Executive Directors and 2 Executive Directors in attendance. A full list of the attendance is outlined below:

Chair/Attendance:	
Membership:	
Chris Beacock	Non-Executive Director (Chair)
Paul Kingston	Non-Executive Director
Sara Ellis Anderson	Interim Chief Nurse and Patient Safety Officer
Ruth Longfellow	Chief Medical Officer
In Attendance:	
Shelley Ramtuhul	Trust Secretary/Director of Clinical Governance
Kirsty Foskett	Head of Clinical Governance
Kerry Robinson	Chief Performance, Improvement and OD Officer (part)
Phil Davies	Head of Estates and Facilities (part)
Mary Bardsley	Assistant Trust Secretary (Minutes)
Apologies:	
Apologies noted from Stacey Keegan, Interim CEO	

3.2 Actions from the Previous Meeting

The minutes and actions from the Extra Ordinary Quality and Safety Committee were presented to the Board – it was noted that all actions were complete or tabled for discussion at the meeting.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There was no declaration of interest shared	N/A	
2. LM Report		
The Committee considered the report which highlighted the following: ▪ 4 IPC themes of Audit, IPC team, Uniform Policy and Communication were identified with recommendations outlined for each within the report ▪ A related theme of nurse staffing levels was also identified	Yes	

The Committee confirmed that each recommendation has been added to the overarching IPC Improvement Plan and therefore content with the process in place to monitor the recommendations. Discussions were held in relation to theatre attire – the Trust confirmed the MSK clinical chair and matron are leading on creating a policy which will be communicated to the organisation once complete.		
3. IPC Improvement Plan		
The Committee discussed the position of the plan, highlighting the following: ▪ Immediate actions with 5 out of 6 completed ▪ 60 actions across 9 themes identified in IPC Improvement plan incorporating actions and recommendations from various sources ▪ 3 actions behind plan with progress being made ▪ 13 actions complete and 5 fully implemented ▪ 27 actions in progress with clear action owners and timescales ▪ Key successes and achievements for April highlighted The Committee raised concerns in relation to the exit criteria and the lack of understanding on how the Trust is to progress out of the red rated area.	Partial	The Committee were content with the reporting/monitoring of the improvement plan but raised concerns regarding the lack of understating in relation to the exit criteria. The information is to be presented to the next meeting.
4. Estates Backlog Requestions		
The Committee discussed in detail the reasons behind the backlog. Overall, the Committee gained understanding of the reasons for the high levels of outstanding jobs however, it was suggested a clinical representative is asked to attend the Capital Management Group to ensure there is oversight of IPC risks and safety against capital spending. The Committee were assured that the requestions were prioritised and risk rated to ensure the IPC requestions were completed first. It was noted that all recommendations following the independent audits/assessment have been submitted onto the system.	Yes	
5. IPC Quality Report		
The Committee welcomed the first IPC Quality Report. Following a discussion, the Committee requested further assurance on the SSI across the whole of the organisations and not only the mandatory reported hip, knees and spines. The Trust agreed to complete a deep dive on SSI in time for the next meeting	No	Further assurance is requested on all SSI as this currently isn't being reported.
6. Culture Presentation		
The Committee received the presentation for information. It highlighted the work being undertaken to	N/A	

support the IPC team and modelling to improve culture. The Committee asked for an update to be presented in once the summit has been completed to which the Trust agreed.		
7. Work Plan		
The Committee noted the workplan which is a standard agenda item for the Committee to reflect upon after each meeting. The following was added: ▪ Culture Presentation update ▪ SSI Deep Dive	Yes	
8. Attendance Matrix		
The Committee received the matrix for information only.	N/A	

3.4 Approvals

Approval Sought	Outcome
None to note	

3.6 Risks to be Escalated

In the course of its business the Committee confirmed there are no risks to be escalated to the Board.

4. Conclusion

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

0. Reference Information

Author:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper date:	4 May 2022
Senior Leader Sponsor:	Sara Ellis-Anderson, Interim Chief Nurse and Patient Safety Officer	Paper written on:	25 April 2022
Paper Reviewed by:	IPC Quality Assurance Committee	Paper Type:	Governance and Quality
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

The report was presented for consideration at the IPC Quality Assurance Committee on 28 April 2022.

2. Executive Summary

2.1. Context

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

2.2. Summary

- Outlines progress against immediate actions with 5 out of 6 completed
- 60 actions across 9 themes identified in IPC Improvement plan incorporating actions and recommendations from various sources
- 3 actions behind plan with progress being made
- 13 actions complete and 5 fully implemented
- 27 actions in progress with clear action owners and timescales
- Key successes and achievements for April highlighted

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

NHSE/I have continued to provide support to RJAH and the IPC team and alongside colleagues from partner organisations have visited the site regularly. Following the last visit on the 11th of February 2022 there were heightened areas of concern identified with IPC practice and governance. The Trust therefore remains red on the NHSE/I IPC matrix with immediate remedial action and improvement required.

3.2. Immediate Actions

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

Table 1: Immediate Actions outlined in NHSE/I Letter

	Recommended Action	Progress update
1	Review of assurance and sign off processes for actions plans and a review of all actions plans that are currently marked as completed	This has been completed and all outstanding actions transferred to Tendable.
2	Complete the GAP analysis and action plan against the Code of Practice for the prevention of infection and related guidance (Hygeine Code) and ensure this has been presented to Trust Board within the next month.	GAP analysis completed in November 2021 with actions identified. Presented at IPCC and Q&S in March 22 and Trust Board April 22.
3	IPC BAF needs to be updated and presented to the Trust Board within the next month.	Revised IPC BAF received Dec 2021. Presented at IPCC and Q&S in March 22 and Trust Board April 22.
4	Development of recommendations of the One Together audit, presented to the Trust IPC Committee.	One Together Audit completed and circulated to key stakeholders in Dec 21. Presented at IPCC. Working group set up to progress actions with upward reporting to IPCC and subsequently Q&S via Chairs report.
5	Medical leadership intervention with medical colleagues compliance with IPC including hand hygiene, bare below the elbows and the use of theatre hats/caps.	Medical Director has written to all medical colleagues outlining expectations. Further actions oulined in Improvement Plan
6	Review of the IPC team structure and the team capacity and priorities	Review and benchmarking undertaken in Dec 21. CCG supporting with review of IPC lead job plan. Case of need outlining re-structure and strengthening of the IPC team approved at SLG 22/03/2022. IPC Team development day planned for 27/04/2022.

3.2.1. IPC Improvement Plan

The IPC improvement plan has been developed to ensure actions are embedded trust wide and improvements are sustained. The plan has been developed to include all actions and recommendations from the following:

- NHSE/I Letter following February visit outlining immediate actions and recommendations
- IPC Governance review recommendations
- Independent IPC review by Lisa Miruszenko
- CCG Assurance Visits
- Hygiene Code Gap Analysis

The IPC Covid-19 BAF released in December 2021 is due to be revised in line with the publication of the National infection prevention and control manual for England and therefore a further review of the updated BAF will be completed before any further actions are added to the IPC Improvement Plan.

A thematic review of all outbreaks over the last 12 months has been commissioned by the Chief Nurse and DIPC, any specific actions that have not already been considered will also be added to the IPC improvement plan following the review.

The IPC improvement plan has been split in to nine themes (please see appendix A) with a total of 60 actions.

Table 2: Overview of progress against actions IPC Improvement Plan on 25/04/2022

Theme	Not Started	Behind Plan	In Progress	Complete	Implemented	Total
Leadership & Culture	2	0	2	0	0	**4**
IPC team & capacity	2	0	3	2	1	**8**
Governance & process	0	0	5	5	2	**12**
Cleanliness	0	1	2	2	1	**6**
Estates	0	1	4	0	1	**6**
Patient equipment & storage	2	1	5	0	0	**8**
Uniform policy/BBE/HH	1	0	2	1	0	**4**
Training	0	0	3	2	0	**5**
Communications & trust wide learning	5	0	1	1	0	**7**
Total	**12**	**3**	**27**	**13**	**5**	**60**

The final two columns on the improvement plan describes the evidence required to close the action and methods of ongoing assurance.

The three actions behind plan are:

- Action 4.1 Case of need for stores management/housekeeper role as part of ward team.
  - There is a case of need in draft with revised costings being applied. This is due for submission to SLG in May.

- Action 5.1 Prioritisation matrix for estates works to be developed to ensure estates improvements are IPC risk assessed.
  - This piece of work has commenced with IPC and Estates teams working together and a paper to outline progress and next steps is due at IPC QA Committee

- Action 6.8 Trust wide mattress audit to be conducted including numbering of mattresses and beds
  - This has been delayed, the trust is currently awaiting a delivery of replacement mattresses before the audit commences.

3.2.2. Key successes and achievements in April

- NHSE/I informal monthly IPC visit on 7th of April demonstrated improvements and progress noted since the February visit particularly in the environment and storage with further work to do on cleaning of patient equipment and replacement of equipment.

- IPC Fair launched on the 19th of April with over 250 attendances from all disciplines. The staff feedback has been very positive and demonstrates commitment and engagement from teams.

- The first IPC newsletter from the Chief Nurse and Chief Medical Officer was published to ensure key issues and good practice can be shared across the organisation.

- Ludlow ward renovation near completion and opportunity to complete estates works in Theatres whilst mutual aid redeployment in place is in progress.

3.3. Associated Risks

- Risk 2859 - Environment Maintenance - Patient Safety.
- Risk 2864 - Non-Compliance with Hygiene Code
- Risk 2865 - IPC team capacity

3.4. Conclusion

The Trust will remain RED on the NHSE/I Midlands Infection Prevention and Control internal escalation matrix. A follow up inspection will be scheduled with NHSE/I in June. The Trust is currently being supported by Improvement Director Jacqueline Barnes.

The improvement plan will be monitored through internal IPCC, IPC Quality Assurance Committee with system oversight at the STW System Quality Group.

The Board is asked to note the actions taken and proposed improvement plan and seek additional assurance if required.

Appendix 1: Acronyms

ANTT	Aseptic Non Touch Technique
BAF	Board Assurance Framework
CCG	Clinical Commissioning Group
DIPC	Director of Infection Prevention and Control
E&F	Estates and Facilities
ESR	Electronic Staff Record
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
MCSI	Midlands Centre for Spinal Cord Injury
MRSA	Methicillin-resistant Staphylococcus aureus
NHSE/I	NHS England and Improvement
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
SLG	Senior Leadership Group
STW	Shropshire Telford and Wrekin

TRUSTWIDE

Exec Lead: Sara Ellis-Anderson
Last updated by: Sara Ellis-Anderson
Last updated on: 25/04/2022

Red	Behind plan
Amber	In Progress
Green	Complete
Blue	Implemented
NS	Not Started

No	Area for Improvement	Reference	Action Cross Reference	Hygiene Code Criterion	Theme	Start Date	End Date	Revised Date	Accountable Exec	Responsible Lead	RAG Status	Progress Updates	Date of progress update	Supporting Evidence	Method of ongoing assurance
1. Leadership and Culture															
1.1	Leadership development programme to be considered for the IPC Team	Gov review	R1	Criterion 6	Leadership / Culture	25/04/2022	30/06/2022		Chief Nurse	Kerry Robinson	Amber	Series of IPC team away days (x3); first away day scheduled for 27/04/2022	25/04/2022	PPT presentation and attendance	IPC team objectives
1.2	Development plan for senior nurses to ensure succession planning for corporate roles	Gov review	R7 and R10	Criterion 6	Leadership / Culture	01/04/2022	30/06/2022		Chief Nurse	Kerry Robinson	Amber	Clinical Leadership programme starting April 22. Roles and Responsibilities 1/2 day w/c 09/05/22. Working with Staffordshire Uni on development of short IPC course (Level 5 40 credit module	21/03/2022	Attendance of Clinical Leadership programme.	Senior Nurse team objectives
1.3	Consider an IPC pledge from each of the senior leader team to re-enforce the standards expected	Gov review	R13	Criterion 6	Leadership / Culture		30/06/2022		Chief Nurse	Sara Ellis-Anderson	NS	To link in with re-launch of IPC strategy	21/03/2022	IPC Strategy document. Video/Poster pledges from SLG	Monitoring of IPC strategy against annual programme of works (IPCC)
1.4	Dedicated campaign regarding reporting cleanliness or IPC concerns to further improve awareness	Gov review	R14	Criterion 6	Leadership / Culture		30/06/2022		Chief Nurse	FTSU Guardian	NS	To link in with re-launch of IPC strategy			FTSU report
2. IPC Team and Capacity															
2.1	Review IPC nurses job plans and workload to ensure priority of works, allocating resource appropriately	Gov review/LM Review	R2 and 3.2.4	Criterion 1	IPC team & capacity	24/02/2022	30/05/2022		Chief Nurse	Olivia Evans	Amber	CCG IPC Lead reviewing job plans w/c 28/2/22. Stop, Start, Carry on exercise scheduled for IPC team - Series of IPC team away days (x3); first away day scheduled for 27/04/2022	01/04/2022	PPT presentation and attendance. Copy of Job plans	IPC team objectives
2.2	Review of microbiology provision and update of current SLA with SATH	Gov review	R6	Criterion 3	IPC team & capacity	04/03/2022	30/06/2022		Chief Nurse	Dawn Forrest	Amber	Current SLA renewed for further 6 months.	25/04/2022	SLG workplan and papers. Updated SLA	
2.3	Add additional levels of IPC observation in clinical areas to add independent level of assurance	Gov review	R26	Criterion 1	IPC team & capacity	24/02/2022	30/04/2022		Chief Nurse	Sara Ellis-Anderson	Green	Reinstate sit and see visits. Patient Safety walkabouts to be reintroduced from April 22.	25/04/2022	Documentation from sit and see observations and patient safety walkabouts.	Quarterly report to Patient Safety Committee and Patient Experience Committee
2.4	Review annual IPC audit schedule and align with IPC policies	Gov review/LM Review	R11 and 3.2.1	Criterion 1	IPC team & capacity	28/02/2022	13/05/2022		Chief Nurse	Kirsty Foskett	Amber	To align with policies and Hygiene code gap analysis. Audit frequency updated and circulated to wards and departments. Next steps to review 'monitoring of compliance' sections within IPC Pol	13/04/2022	12 month audit plan	Audits presented at IPCC
2.5	Re-launch of IPC champions (link roles)	IPCWG/LM Review	3.2.4	Criterion 1	IPC team & capacity		30/05/2022		Chief Nurse	IPC/Matrons	NS	To link in with re-launch of IPC strategy			
2.6	Consideration of whether it is appropriate for IPC to sit within an operational unit	Gov review/GAP	R3 and 1A	Criterion 1	IPC team & capacity	04/03/2022	11/03/2022		Chief Nurse	Sara Ellis-Anderson	Blue	Reviewed and agreed reporting lines for IPC team to sit within Assurance and Standards Team	11/03/2022	Organisational structure chart.	N/A
2.7	IPC Structure Review to address capacity of IPC team	Gov review/NHSE/I Letter/GAP	R2/4/5/18/27 and 1A	Criterion 1	IPC team & capacity	24/02/2022	25/03/2022		Chief Nurse	Sara Ellis-Anderson	Green	IPC to sit with A&S team reporting to Head of Clinical Governance as interim measure - Complete. New lead IPC joint post with ShropComm case of need approved at SLG 22/03/2022	22/03/2022	Organisational structure chart.	Vacant posts filled
2.8	Access to out of hours IPC specialist advice to be considered as an ICS	Gov review	R17	Criterion 1	IPC team & capacity		30/07/2022		Chief Nurse	Sara Ellis-Anderson	NS				
3. Governance and Process															
3.1	Annual programme of IPC assurance to be presented at Q&S Committtee (Programme of Works)	Gov review/LM Review/GAP	R11 and 3.2.4 and 9A	Criterion 1	Governance	04/03/2022	21/04/2022		Chief Nurse	Sue Sayles	Amber	Programme of works for 22/23 to be presented to IPCC 03.5.22 and IPC Q&S in May	21/03/2022	IPCC and Q&S minutes	Monitoring of Programme of Works quarterly at IPCC
3.2	Develop Trustwide IPC screening documentation for regular audits to be conducted	NHSE/I Letter		Criterion 5	Governance	29/04/2022	30/04/2022		Chief Nurse	Anna Morris	Amber	Screening process documentation under review to incorporate an admission checklist.	01/04/2022	Copy of standardised screening documentation	Audits presented at IPCC
3.3	Review and update IPC Governance Framework with clear lines of upward reporting from IPCC sub-structure	Gov review	R23	Criterion 1	Governance	04/03/2022	31/03/2022		Chief Nurse	Kirsty Foskett	Green		10/03/2022	IPC Governance framework structure chart	Annual IPC report
3.4	Review Tendable IPC audit schedule and ward to Board reporting	LM Review	3.2.1	Criterion 1	Governance	10/04/2022	30/05/2022		Chief Nurse	Ian Maclennan	Amber	Paper and draft reporting schedule due to be presented at Patient Safety Committee on 3rd of May 2022	25/04/2022	Outline reporting schedule within PSC paper	Tendable monthly report to IPWG. Quarterly Unit IPC reports to IPCC.
3.5	Governance review of Post Infection Review SOP and timescales	GAP	1B	Criterion 1	Governance	30/03/2022	12/05/2022		Chief Nurse	Kirsty Foskett	Amber	SSI and PIR SOP being reviewed and updated to aligned timescales for completion	25/04/2022	SSI and PIR SOP updated	
3.6	Anti-microbial Stewardship governance review	GAP	3A and 3B	Criterion 3	Governance	30/03/2022	30/04/2022		Chief Nurse	Kirsty Foskett	Amber	Proposal to align with DTC to be presented at Patient Safety Committee on 3rd of May 2022	25/04/2022	PSC minutes	Chairs report from DTC/AMS to IPCC
3.7	Clear governance process to be set out for surgical site infections (SSIs) to align with the Trust's usual governance processes	Gov review	R24	Criterion 1	Governance	04/03/2022	04/03/2022		Chief Nurse	Sue Sayles	Green	Complete and signed off by IPCC - Datix and RCA now completed for each SSI	04/03/2022	Flowchart outlining SSI process agreed	IPCC quarterly report. Monthly Unit Governance meetings
3.8	Strengthen attendance and review workplan for IPC Working Group to ensure adequate reporting to IPCC	Gov review	R22	Criterion 1	Governance	28/02/2022	04/03/2022		Chief Nurse	Sara Ellis-Anderson	Blue	TOR reviewed and circulated to group. Workplan developed. Admin support sourced. IPCWG meeting weekly from 11/03/2022	24/02/2022	Minues and attendance matrix for IPCWG	Upward chairs report to IPCC
3.9	Improve Ward/Departmental IPC action plan oversight and sign off process to include external reviews	Gov review and NHSE/I letter	R29	Criterion 1	Governance	24/02/2022	11/03/2022		Chief Nurse	Kirsty Foskett	Green	All outstanding actions from various inspections will be entered on to tendable following IPC general audit.	04/03/2022	Process integrity ensuring sustainable actions. BDO Unit Governance internal audit.	Tendable monthly report to IPWG. Quarterly Unit IPC reports to IPCC.
3.10	QR assignment - 2nd phase roll out of Tendable	IPWG/LM Review	3.2.1	Criterion 1	Governance	24/02/2022	01/04/2022		Chief Nurse	Hayley Gingell	Blue	QR codes obtained. Audits configured for all areas. Training schedule in progress.	11/03/2022		Quarterly unit reports to IPCC
3.11	Consider IPC/E&F combined audit to reduce duplication and strengthen MDT working	IPWG/LM Review	3.2.1	Criterion 1	Governance	11/03/2022	25/03/2022		Chief Nurse	IPC/E&F	Green	Annual programme for efficacy audits presented to IPWG 25/03/2022. Risk stratification applied starting with high risk areas.	25/03/2022	Minutes of IPCWG	National Cleanliness Efficacy audits annual programme
3.12	Review IPC reports that go to Q&S and Board to ensure key issues and risks are escalated	Gov review	R30/31/32	Criterion 1	Governance	04/03/2022	30/04/2022		Chief Nurse	Sara Ellis-Anderson	Green	Feedback from NHSE/I IPC team recieved April 22. GGI Board developement session delivered on 24/03/2022.	24/03/2022	IPC Quarterly report revised format for Trust Board for Q4	Quarterly IPC reports to Trust Board
4. Cleanliness															
4.1	Case of need for stores management/housekeeper role as part of ward team	Gov review/LM Review	R12 and 3.2.5	Criterion 2	Cleanliness	28/02/2022	12/04/2022		Director of Finance	Phil Davies	Red	Paper being submitted for review by Chief Finance & Planning Officer for 04/04/2022	21/04/2022	Copy of business case	
4.2	Escalate system cleanliness business case and consider other options for bed cleaning	NHSE/I Letter/GAP	2F	Criterion 2	Cleanliness	30/03/2022	30/05/2022		Director of Finance	Phil Davies	Amber	Email sent from JB to NHSE/I to support review of risk assessment process for system business cases	14/04/2022		
4.3	Clear roles and responsibilities defined for cleaning aligned with implementation of National Standards for Cleanliness	Gov review/LM Review/GAP	R10 and 3.2.1 and 2A	Criterion 2	Cleanliness	28/02/2022	11/03/2022		Chief Nurse	Sian Langford	Green	Meeting to review and agree responsibilities occured on 10/03/22. Update presented at SNAHP 21/03/22. Quarterly review required.	21/03/2022	Display of cleanliness charter in clinical areas.	
4.4	Standardised bed cleaning checklist for all wards for daily checks	NHSE/I Letter/GAP	2C and 2G	Criterion 2	Cleanliness	24/02/2022	18/03/2022		Chief Nurse	Kirsty Ditcher	Green	Email sent to all ward managers for standardised bed cleaning checklist to be in use from 01/04/2022	22/03/2022	Standardised checklist available on all wards	Included in National Cleanliness Technical Efficacy Audits
4.5	Trust process required for the cleaning of water coolers - to be included in action 4.3 roles and responsibilities	NHSE/I Letter		Criterion 2	Cleanliness	24/02/2022	11/03/2022		Director of Finance	Sian Langford	Blue	Contractor completed Trust wide descale/deep clean w/c 7th March. Risk (2854) identified referencing ongoing provision of monthly descale - included in National Cleanliness charter	11/03/2022	IPC Q4 report	Water coolers included in the National Cleanliness Technical Audits
4.6	Standardised patient equipment cleaning checklist for all wards/departments	GAP	2C and 2G	Criterion 2	Cleanliness	30/03/2022	30/05/2022		Chief Nurse	Matrons	Amber		21/04/2022	Standardised checklist available on all wards	Included in National Cleanliness Technical Efficacy Audits
5 Estates															
5.1	Prioritisation matrix for estates works to be developed to ensure estates improvements are IPC risk assessed	NHSE/I Letter		Criterion 2	Estates	24/02/2022	31/03/2022		Director of Finance	Phil Davies	Red	First draft prioritisation complete and being worked to; second phase with Governance / IPC for input to clarify. Update to be presented at IPC QA Committee April 22	01/04/2022	Copy of Matrix . IPCWG minutes. IPC QA progress paper	Estates dashboard with reporting to IPCC and SOP
5.2	Trust programme of ward/department closure to address flooring replacement to be agreed for 22/23	NHSE/I Letter		Criterion 2	Estates	24/02/2022	12/04/2022	30/05/2022	Director of Finance	Phil Davies	Amber	Programme of works prepared for Clwyd Ward works - options include shortened and standard programme based on Ward opening - considered by SLG and agreed on 19/04/22	21/04/2022		
5.3	Policy for PPM to be written	GAP	2D	Criterion 2	Estates	30/03/2022	30/06/2022		Director of Finance	Phil Davies	Amber				
5.4	Adequate provision of hand wash basins on Ludlow Ward	GAP	2B	Criterion 2	Estates	30/03/2022	30/07/2022		Chief Nurse	Phil Davies	Amber	Risk assessment and proposal to IPCWG May 22	21/04/2022	Sinks installed. Copy of Risk Assessment	
5.5	Review Infection Control in the Built Environment Policy	Gov review and NHSE/I letter	R28	Criterion 2	Estates	03/03/2022	10/03/2022		Director of Finance	Phil Davies	Blue	E&F to meet weekly to update on projects being undertaken - Policy to be updated to reflect the weekly meet	11/03/2022	Updated policy	
5.6	Install remaining glass doors on Kenyon and Gladstone ward to increase ability to cohort patients	GAP	7A	Criterion 7	Estates	30/03/2022	30/06/2022		Chief Nurse	Phil Davies	Amber	Dates for installation of glass bay doors on Kenyon agreed April 22	25/04/2022		
6. Patient Equipment and Storage															
6.1	Explore replacement of water coolers	NHSE/I Letter		Criterion 2	Patient Equipment	24/02/2022	01/08/2022		Director of Finance	Sian Langford	Amber	LoF (who pay current lease) are supportive of replacement and rationalisation. First leases to epire 08/22 - Mitigated with procurement of cup dispensers for those without.	02/03/2022	All water coolers replaced trust wide	Water coolers included in the National Cleanliness Technical Audits
6.2	Apply 65 methodology to storage cupboards on wards/departments	NHSE/I Letter		Criterion 2	Storage		30/09/2022		Chief Nurse	Olivia Evans	NS	To be supported by facilities and ward/dept managers as part of the Productive ward series re-launch.	24/02/2022	Improvement in IPC environmental audits	Tendable monthly report to IPWG. Quarterly Unit IPC reports to IPCC.
6.3	Trust wide review and replacement of bins to ensure standardisation	NHSE/I Letter		Criterion 2	Storage	24/02/2022	29/04/2022	12/05/2022	Director of Finance	Sian Langford	Amber	Order raised and approved for replacement bins x 178. Lead time expected to be 3 weeks minimum	10/03/2022	All non-compliant bins replaced trust wide	National Cleanliness Technical audits and IPC environmental audits
6.4	Wipes are required to be in wall mounted bracketsto ensure adequate access for effective cleaning	NHSE/I Letter		Criterion 2	Storage	24/02/2022	29/04/2022	12/05/2022	Director of Finance	Sian Langford	Amber	PDI Rep attending site w/c 19/04 to review and recommend bracket replacement	14/04/2022	All clinical areas to have wipe brackets installed	National Cleanliness Technical audits and IPC environmental audits
6.5	Beds have enamel chipping on side areas and require replacement	NHSE/I Letter		Criterion 2	Patient Equipment	24/02/2022	29/04/2022		Chief Nurse	Linda Head	Amber	Linet will be replacing all hinged parts of siderails with chipped paint. Update received from Linet, confirming dates of replacement w/c 25/04/2022 for 3 days	19/04/2022	All chipped siderails to be replaced by bed manufacturer. Asset register	National Cleanliness Technical audits and IPC environmental audits
6.6	Obtain quote for digital solutions to equipment library to assist with storage solutions in clinical areas	IPCWG		Criterion 2	Storage	28/02/2022	30/07/2022		Director of Digital	Steph Wilson	Amber	SW to liaise with Director of Digital for investment opportunities	24/02/2022		
6.7	Re-launch of Productive ward series	NHSE/I Letter		Criterion 2	Storage		30/09/2022		Chief Nurse	Kerry Robinson	NS		01/04/2022	Improvement in IPC environmental audits	Tendable monthly report to IPWG. Quarterly Unit IPC reports to IPCC.
6.8	Trust wide mattress audit to be conducted including numbering of mattresses and beds	NHSE/I Letter		Criterion 2	Storage	28/02/2022	11/04/2022		Chief Nurse	Julie Beaumont	Red	estates together with record of yearly service. Numbering of mattresses to be conducted during audit. 60 New mattresses on order - Waiting on delivery date to arrange Trust Wide Audit.	19/04/2022	Email recieved from Linet confirming order.	
7. Uniform Policy/Bare Below Elbow/Hand Hygiene															
7.1	Address non-compliance with wearing theatre hats outside theatre complex	NHSE/I Letter/LM Review	3.2.2	Criterion 6	Uniform Policy/BBE/HH	24/02/2022	13/05/2022		Medical Director	Rachael Flood	Amber	Daily reminders in theatre huddles. Additional sigange in Denbeighs and Theatre exits. Review Uniform Policy, disseminate and re-launch campaign. End date extended to support review of un	14/04/2022	Updated Uniform policy and comms	HH/BBE audits and escalation process as required
7.2	Address non-compliance with HH/BBE /Uniform policy	NHSE/I Letter/ LM Review	3.2.2	Criterion 6	Uniform Policy/BBE/HH	24/02/2022	13/05/2022		Medical Director	Sara Ellis-Anderson	Amber	Letter sent to all medical staff end of Feb 22 by Medical Director. Review Uniform Policy, disseminate and re-launch campaign. End date extended to support review of uniform policy by JB.	14/04/2022	Updated Uniform policy and comms	HH/BBE audits and escalation process as required
7.3	Review of all clinical entry and exit points with clear signage for BBE and Use of Hand Gel	LM Review	3.2.2	Criterion 6	Uniform Policy/BBE/HH	19/04/2022	30/05/2022		Chief Nurse	Sue Sayles	NS				
7.4	IPC practices session with portering staff	NHSE/I Letter		Criterion 6	Uniform Policy/BBE/HH	24/02/2022	01/03/2022		Chief Nurse	Sue Sayles	Green	Session completed with Porters 03/03/2022.	11/03/2022		BBE/HH audits
8. Training															
8.1	IPC training report to include details of HH/ANTT/Donning and Doffing per discipline	Gov review/GAP	R15 and 9B	Criterion 6	Training	04/03/2022	15/04/2022	30/05/2022	Chief Nurse	Kirsty Foskett	Amber	Training needs analysis to be conducted and IPC training to be updated with regular reporting through IPCC. Report due at IPCC in April. Training needs analysis to be undertaken by the Trainin	13/04/2022		Monthly training report at IPCC
8.2	IPC week focussing on IPC skills stations promoting education and development on all elements of IPC for staff	Gov review	R10	Criterion 6	Training	28/02/2022	30/04/2022		Chief Nurse	Lisa Newton	Green	IPC Fair succesfully delivered w/c 19/04/22	25/04/2022	Recorded attendance at skills stations. % increase in compliance across IPC training	ESR/Training reports to IPCC quarterly
8.3	IPC training role to be developed to offer practical PPE/HH training for all disciplines on a rolling programme	IPCWG		Criterion 6	Training	28/02/2022	30/05/2022		Chief Nurse	Sue Sayles	Amber	Funding identified for post, Post Approval complete, JD developed and post advertised on 18/03/2022. Theatre ODP being tempoararily re-deployed to IPC team to facilitate hand hygiene trair	13/04/2022	Succesful appointment to IPC Band 3 post	ESR/Training reports to IPCC quarterly
8.4	Antimicrobial training for doctor induction from April 22	GAP	3C	Criterion 6	Training	30/03/2022	30/04/2022		Chief Nurse	Antimicrobial Pharmacist	Green	IPC induction for junior doctors extended to 1 hour from April 22 to include antimicrobial stewardship training	25/04/2022		
8.5	IPC training needs analysis to be undertaken	GAP	6B	Criterion 6	Training	30/03/2022	30/05/2022		Chief Nurse	Kirsty Foskett	Amber	To support action 8.1	25/04/2022		
9. Communications and trustwide learning															
9.1	Hand washing posters not visible at some handwashing sinks	CCG assurance visit		Criterion 6	Communications	02/03/2022	01/04/2022		Chief Nurse	Matrons	Green	Handwashng poster emailed to all ward and department managers	11/03/2022	Handwash posters to be available at every sink	National Cleanliness Technical audits and IPC environmental audits
9.2	Improve trust communications and engagement with IPC introducing regular trustwide IPC newsletter	LM Review	3.2.3	Criterion 6	Communications	01/04/2022	20/04/2022		Chief Nurse	IPC/KF	Amber	IPC bulletin issued 20/4/22 and fortnighty thereafter.	13/04/2022	Fortnightly bulletin	
9.3	Ensure patient facing information is up to date	GAP	4A	Criterion 6	Communications		30/05/2022		Chief Nurse	Comms team	NS				
9.4	Ensure IPC Intranet page is maintaned and up to date including supporting Excellence in IPC toolkit	GAP	4A	Criterion 6	Communications		30/05/2022		Chief Nurse	Comms team	NS				
9.5	Review of BBE posters and signage trust wide to align with policy	LM Review	3.2.2	Criterion 6	Communications		30/05/2022		Chief Nurse	Med Illustration	NS				
9.6	Consideration and implementation of enhanced staff appreciation scheme linked with excellent IPC practice and innovation	LM Review	3.2.3	Criterion 6	Communications		30/05/2022		Chief Nurse	Comms team	NS				
9.7	Options appraisal for IPC alert/flagging system to identify patients	GAP	1C	Criterion 1	Communications	30/03/2022	30/05/2022		Chief Nurse	Hayley Gingell	NS				

0. Reference Information

Author:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper date:	4 May 2022
Executive Sponsor:	Sara Ellis-Anderson, Chief Nurse and Patient Safety Officer	Paper Category:	Quality and Safety
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?

This paper presents the final Ockendon Report published on the 30th of March 2022 which outlines the findings of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. The papers is presented for the Board's information.

2. Executive Summary

2.1. Context

In mid-2017 the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review of the maternity services at SaTH following concerns raised by a number of bereaved families. The initial terms of reference had a limited scope but in 2019 this was widened following a large number of families coming forward.

Whilst a significant amount of the report is focussed on the specifics of a maternity service, the review did identify a number of themes which can be translated across all aspects of healthcare and these are therefore worthy of consideration in order that any wider learning and opportunities for improvement within the Trust can be identified.

2.2. Summary

The final Ockenden report sets out the findings and recommendations from a five-year review of maternity care at the Shrewsbury and Telford Hospital NHS Trust (SaTH). It focuses predominantly on the period from 2000 to 2019 and looked at 1,592 clinical incidents. A review of the cases identified thematic patterns in the quality of care and investigation procedures carried out by the trust where opportunities for learning and improving quality of care had been missed.

The report draws on 4 key pillars

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up.

The table below provides an overview of current progress within the organisation and areas for further consideration / opportunities for improvement.

Pillar	What we're currently doing well	Opportunities for Improvement	Committee oversight
1. Safe Staffing Levels	• Safer staffing levels and CHPPD reported monthly on IPR • 6 monthly staffing reviews with CNO/CFO • Safer Staffing escalation policy in place • SafeCare and monitoring of red flags daily via state of play meetings	• Safer staffing board reports 6 monthly	Quality and Safety People Committee
2. A well-trained workforce	• Training levels monitored on IPR • 12 monthly training needs analysis completed in role specific training • Human Factors Faculty • Patient Safety syllabus launched June 2021 • Trust induction	• Embed mechanisms in place to support emotional and psychological needs of staff following an incident using TRiM • Protected learning, training and development time as teams	People Committee
3. Learning from incidents	• Patient Safety Strategy • Monthly monitoring of SI actions • Patient Safety Committee • Patient Harms Group monitoring themes and trends in patient safety incidents • Patient Safety bulletin • Three courses on Incident Investigation (using no blame Systems Based Analysis), training have been run over the last 6 months	• Change in practice identified from SI to be evaluated/audited in 6 months • Continue more regular updates via Patient Safety bulletin and Quality Forum • Establishing Learning from incidents page on staff intranet	Patient Safety Committee Quality and Safety Committee
4. Listening to families	• Patient stories to board • Patient Experience Strategy • FFT data monitored • Quarterly patient experience report • In-patient CQC survey • MCSI listening events for patients	• Focus groups • Re-establish patient panel members • Regular thematic review and triangulation of patient experience date • Re-fresh of 'You Said, We Did'	Patient Experience Committee Quality and Safety Committee

The Trust continues to implement the patient safety strategy with action plan being monitored through Patient Safety Committee. The strategy aims to further develop our culture as a Learning organisation

to encourage and reach a level where all staff are thinking 'learning all the time' and moving from a safety 1 position (reacting to incidents) to a safety 2 position (focusing on what goes right and doing more).

As a Trust we have 3 patient safety specialists and are currently in the process of rolling out patient safety champions across the organisation. This will support the overall aim of embedding just culture and creating a safe environment for staff to speak up about patient safety concerns.

The report will be taken through each of the identified Committees in more detail for oversight of any further opportunities to enhance the Trust's culture, leadership and processes around patient safety.

2.3. Conclusion

The Board of Directors is asked to ***note*** the 4 pillars of the Ockendon Report and opportunities for wider learning.

Acronyms

CHPPD	Care hours per patient day
CQC	Care Quality Commission
CFO	Chief Finance Officer
CNO	Chief Nurse Officer
IPR	Integrated Performance Report
FFT	Friends and Family Test
MCSI	Midlands Centre for Spinal Cord Injury
SI	Serious Incident
TRiM	Trauma Resilience Management

Chair's Assurance Report
Finance, Planning and Digital Committee – 26 April 2022

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	4 May 2022
Executive Sponsor:	David Gilburt, Chair of the Meeting	**Paper written on:**	26 April 2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance and Assurance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Finance, Planning and Digital Committee meeting held on 26 April 2022 for assurance purposes. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The meeting was not quorate – actions but in place to ensure the operational and financial plan for 2022/23 were approved ahead of submission.
- The Committee received the standard agenda item – Performance and Financial Report for consideration
- The Terms of reference was deferred to the next meeting

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Finance, Planning and Digital Committee which met on 21 March 2022. The meeting was not quorate with 1 Associate Non-Executive Director and 3 Executive Director in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Membership:	
David Gilburt	Associate Non-Executive Director (Chair)
Craig Macbeth	Chief Finance and Planning Officer
Kerry Robinson	Chief Performance, Improvement and OD Officer
Stacey Keegan	Interim Chief Executive Officer
Simon Adams	Director of Digital
In Attendance:	
Nia Jones	Head of Planning
Alyson Jordan	Managing Director for CSU and SSU
Mark Salisbury	Operational Director of Finance
Mary Bardsley	Assistant Trust Secretary
Amber Scott	Minute Secretary
Apologies:	
Apologies were received from Sarfraz Nawaz and Shelley Ramtuhul	
Quoracy:	
David Gilburt chaired the meeting as Associate Non-Executive and led discussions. It was noted that the items which required approval by the Board were discussed in detail and a briefing paper was circulated to Board Members. The formal approval of the Operational and Financial Plan 2022/23 was sought at the Extra Ordinary FPD Committee Meeting on 28 April ahead of the final submission.	

3.2 Actions from the Previous Meeting

The Committee noted that all actions were complete.

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
There were no declarations shared	N/A	
2. Performance Report		
The Committee received a detailed summary of the Trusts performance for month 12.	Partial	The Trust is to incorporate the actions mitigated into the paper

The Committee commended the Trust on the improving performance and requested further information to be included into the paper to highlight the actions implemented to support the overdue backlog. This will support the figures when reporting concerns.		to support the reporting content.
3. RJAH and Midlands Comparisons		
The value judgment was raised as an issue within the report this month, as Welsh patient activity has been removed from the baseline reporting. The paper was deferred to the next meeting for full consideration; however, the Trust noted the difficulty in determining the upper and lower quartiles within the report as being positive or negative.	N/A	
4. RJAH Financial Performance Report		
The following highlights were presented • £8k favorable to plan in month. • £5.9m surplus for the end of the year under the Covid Financial Framework, being £2.7m favorable to plan driven by the fixed nature of income and the strong private patient performance from earlier in the year. • The surplus isn't reflected in the recurrent position, although is in the net surplus cash for 21/22 which can be used it invest in 22/23. • Efficiencies sit at 2% with c£170k shortfall with targets rolling into next year. • The NHS capital was underspent by £0.7m from slippage in the EPR program that is moving to 22/23 offset by pulling forward schemes from 22/23 into 21/22. • Cash balance £25m being the strongest position seen for the Trust, supported by the I&E position and slight slippage on the capital programme. • Noted the overall deficit within the system being a concern which the Trust will continue to monitor and support - this is forecast to be £2.5m	Yes	
5. Final Operational Plan 2022/23 / Final Financial Plan 2022/23		
The Committee discussed the report in detail however overall assurance and approval is scheduled to be obtained from the Extra Ordinary Finance, Planning and Digital Committee on 28 April – a Chairs assurance report will also be presented to the Board of Directors. OPERATIONAL PLAN 2022/23 The Committee sought further assurance in the following: ▪ Deliverability of March plan 2022/23 – noted this is to be supported with recruitment. A recruitment plan is being overseen by the People Committee.	Yes	Noted that the Committee supported the plan content with the process in place to ensure effective monitoring of the risks highlighted. Noted the plan is also based on the success of the recruitment plan which is a concern.

▪ OJP Levels – spiking of activity is linked to phrasing of annual leave within August and December. ▪ Elective Spells (104 target) – it was recognised that the Trust is currently falling short of the targets set, with Mutual Aid resulting in taking 2% off the target ordinarily achieved. ▪ Outpatient Trajectory – asked for an update on the Trusts Estates Strategy to support activity ▪ 78 weeks - the Trust are not meeting waiting time trajectories although there is clarity on the reasoning for this and the challenges due to be faced. When planning guidance was published targets were originally set with the vision of Covid being behind us. There has been significant disruption due to new variants and high levels of staff absences and patient cancellations impacting on capacity and activity. All options have been presented and the Trust will not be able to clear all breaching patients from these routes. The key risks identified were presented to the Committee which will be monitored and reviewed frequently. The Trust highlighted the importance of all Committees being fully sighted on the risks to the plan. It was suggested that the risks are aligned to each Committees risk register and the Corporate Risk Register to ensure a full understanding is held on the importance of delivering to the plan which the Committee agreed. FINANCIAL PLAN 2022/23 The following was highlighted to the Committee: ▪ Noted a system deficit plan of £54m – this is to be improved following a review of the systems finances including the Covid costs. ▪ Following the draft plan, uncommitted cost pressures have been removed, being a consistent application with all System partners. The Trust enhanced cleaning case will need to be submitted to the System for approval. ▪ ERF costs of £3.2m are assumed to be covered by system income but the complexity of the ERF regime means the position this has not been confirmed. ▪ Mutual aid to SaTH impact for M1, has resulted in a £0.4m net adverse impact on the plan since the draft submission. ▪ Inflation risks have been escalated to the regulator through a national template with no outcome received to date		

▪ Strong cash balance of £25m for the year end for 21/22, this is projected at £16.2m at the end of 22/23 due to loan repayment, capital commitments and I&E deficit. ▪ If the Trust overdeliver on the activity plan a payment will be received for this, therefore if productivity improvements can be made and if the IPC guidance changes this will have a favorable impact on the financial position. It was confirmed the Trust take a 5% portion of the System deficit in a year equating to about £2.8m. As this is a transitional year, the Trust are only taking 50% of the impact in the numbers. It was noted that the Committee supported both plans and highlighted the requirement from them to be presented to a quorate meeting ahead of submission.		
6. EPR Update		
The Committee were informed that the case has not yet been reviewed by the national team due to further information being sought relating to match funding. The Trust confirmed the case is due to be presented for approval on 5 May. The financial case has been updated and the contingency has been reintroduced along with support costs, (which were previously removed), offering a more positive stand in terms of the risk, to support unforeseen consequences and to bring in resources where needed. Due to the delay in external approval, the profile for 22/23 has been updated to show spending to start from mid-year and incurring costs to start on most items, this profile takes the Trust through to 24/25 for the final year of implementation. The capital requirement and the capital support from the regulator remains the same. The Trust confirmed the contracts are due to be signed in May following approval and that advisors are in place to support the implementations.	Yes	
7. Security Update		
The Trust confirmed that patching has been applied across all the desktops by the Team and all old versions of Windows 10 have now been removed and the new Windows version installed. Going forward the Cyber Report will include a projection of what programs are due to go out of date to ensure oversight of any risks. Additionally, there have been less cyber alerts in the last month, with all alerts being responded to within the required time frame.	Yes	
8. Chair Report ICS Sustainably Committee		
The Chairs report was noted by the Committee with no risks raised.	Yes	
9. Chair Report Capital Management Group		

The Chairs report was noted by the Committee with no risks raised.	Yes	
10. Terms of Reference		
Formal approval for the Terms of Reference was deferred to the next meeting due to the Committee not being quorate.	N/A	
11. Committee Workplan		
The Committee reflected on the workplan, and it was suggested an update on the Veterans was to be presented to which the Committee confirmed information will be shared at the Strategy Session.	Yes	
12. Committee Attendance Matrix		
The Committee received the matrix for information only.	Yes	

3.4 Approvals

Approval Sought	Outcome
None to note	

3.5 Risks to be Escalated

The Committee had no risks to escalate to the Board.

4. Conclusion

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

RJAH – Flash Report

0. Reference Information

Author:	Stephanie Wilson, Performance Insight & Improvement Manager and Claire Jones, Principal Analyst & Data Quality Lead	Paper date:	4 May 2022
Executive Sponsor:	Craig Macbeth, Chief Finance Officer	Paper Category:	Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The 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 board currently reviews a validated Integrated Performance Report (IPR) for this assurance.

This additional paper is to compliment the validated IPR whilst providing a forward look of a handful of Trust Board of Directors metrics. Metrics selected are to support in a continued focus of our restoration and recovery efforts. The board is asked to note current unvalidated positions ahead of next month's board where further review will be undertaken.

2. Executive Summary

2.1. Context

The Trust Board of Directors IPR continues to be the validated report for Trust performance. This paper provides an unvalidated snapshot of the current month's performance.

This paper provides information summarising the key performance indicators for a handful of qualitative and activity metrics.

The positions within this report are subject to further validation and have been obtained from various sources. This report provides indicative performance ahead of next month's Trust Board of Directors.

2.2. Summary

Internally performance is under continuous review.

This report is intended to compliment the Trust Board of Directors IPR as well as enabling further discussion for areas to celebrate and areas to note as a potential concern ahead of next month's board.

It is not intended to cover all performance but to flag a handful of KPIs.

The paper will cover snapshots for never events, serious events and current activity positions.

3. The Main Report

3.1. Flash report

It is recognised at time of the Trust Board of Directors the subsequent month's position is ending and being processed and further validated.

RJAH – Flash Report

Internally operational performance is under continuous review. There are various Trust reports and monitoring processes that support these reviews. There are also weekly externally submitted NHSEI reports.

Unvalidated snapshots have been taken for a handful of metrics relating to quality and activity. Further detail and final validated positions will be reported at the subsequent Board of Directors.

It is to note that positions could improve or worsen for multiple factors inclusive of but not limited to:

- Theatre cancellations reducing booked activity.
- Outstanding outpatient outcomes as processing continues resulting in an artificially low position.
- Patients who cancel/DNA planned activity.

Sources and snapshot dates are shown within the below table. The current IPRs validated position is shown alongside the snapshot positions to support comparisons. The flash report is as follows:

	IPR Position	April 2022 Unvalidated Position		
Metric	**Mar-22**	**Snapshot Date**	**Snapshot Position**	**Supporting commentary**
Never Events	0	28/04/2022	0	
Serious Incidents	1	28/04/2022	0	
Total Elective Activity against Plan	872 against a plan of 1,135	28/04/2022	566 against a plan of 516	April 2022 plans and activity reduced to provide support within the system.
Total Outpatient Activity against Plan	13,396 against a plan of 16,235	28/04/2022	11,166 against a plan of 12,030	Snapshots include upcoming booked activity. Subject to change.

The Trust Board of Directors is asked to note the unvalidated performance for a handful of activity and RTT metrics. This is ahead of next month's Trust Board of Directors where validated positions will be further reviewed.

Month 12 Integrated Performance Report

0. Reference Information

Author:	Claire Jones	Paper date:	04/05/2022
Executive Sponsor:	Craig Macbeth	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

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

The committee is asked to note the assurance provided on overall performance as presented in the month 12 (March) Integrated Performance Report, against all areas, and actions being taken to meet targets where missed, providing assurance on the process to meet the target.

2. Executive Summary

2.1. Context

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

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

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

2.2. Overview

The Board through this IPR should note the following;

The impacts of covid continue to be seen in the delivery of our statutory targets and will continue not to be met due to pausing of elective services last year. Therefore, assurance cannot be given for meeting the targets, hence assurance should be through the processes in place to manage such impact as described in the action section of all exceptions.

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

Month 12 Integrated Performance Report

Caring for Staff;

- Sickness Absence
  - Metric showing special cause variation of a concerning nature; remaining above control range
  - Short term sickness showing special cause variation of concern
  - Long term sickness within normal variation
- Voluntary Staff Turnover – an exception at Trust level and specific Staff Groups are consistently off target
  - Add Prof Scientific and Technic
  - Additional Clinical
  - Administrative and Clerical
  - Estates and Ancillary
  - Nursing and Midwifery

Caring for Patients;

- Serious Incidents
  - One incident reported
- RJAH Acquired E. Coli Bacteraemia
  - One infection reported
- RJAH Acquired Klebsiella spp
  - One infection reported
- WHO Documentation Audit - % Compliance
  - Three months off target
- 18 Weeks RTT Open Pathways
  - Metric continues to fail the 92% target. As expected from covid impact, this will continue for a significant time.
- Patients Waiting Over 52 Weeks
  - Both English and Welsh showing special cause variation with increases reported this month.
  - For month 12 our English patients waiting over 52 weeks is 140 patients below our planned trajectory and Welsh patients 251 below our planned trajectory.
- Patients Waiting Over 104 Weeks
  - English and Welsh individually showing special cause variation of concern
  - Currently 134 patients below our planned trajectory (English & Welsh).
- 6 and 8 Week Wait for Diagnostics
  - Both metrics shown as normal variation but remain off target

Caring for Finances;

- Total Elective Activity
  - 74.09% of plan delivered in March
  - 76.83% of 19/20 baseline
- Total Outpatient Activity
  - 82.51% of plan achieved in March
  - 74.36% of 19/20 baseline
- Bed Occupancy – All Wards – 2pm
  - Metric shown as special cause variation of an improving nature, although consistently failing target
  - Occupancy reported at 82.40%; should be noted that 26 beds were closed that are not reflected in the calculation of this KPI
- Expenditure
  - Adverse in month

2.3. Conclusion

The Board is asked to **note** the assurances provided on overall performance as presented in the month 12 (March) Integrated Performance Report, against all areas and actions being taken to meet targets providing assurance on process to meet the target and where insufficient assurance is received seek additional assurance.

Integrated Performance Report
March 2022 – Month 12

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Aspiring to deliver world class patient ca

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

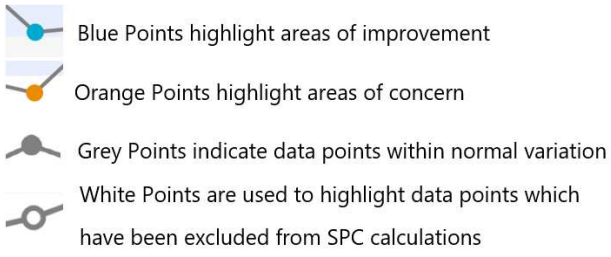
Different colours have been used to separate these trends of special cause variation:

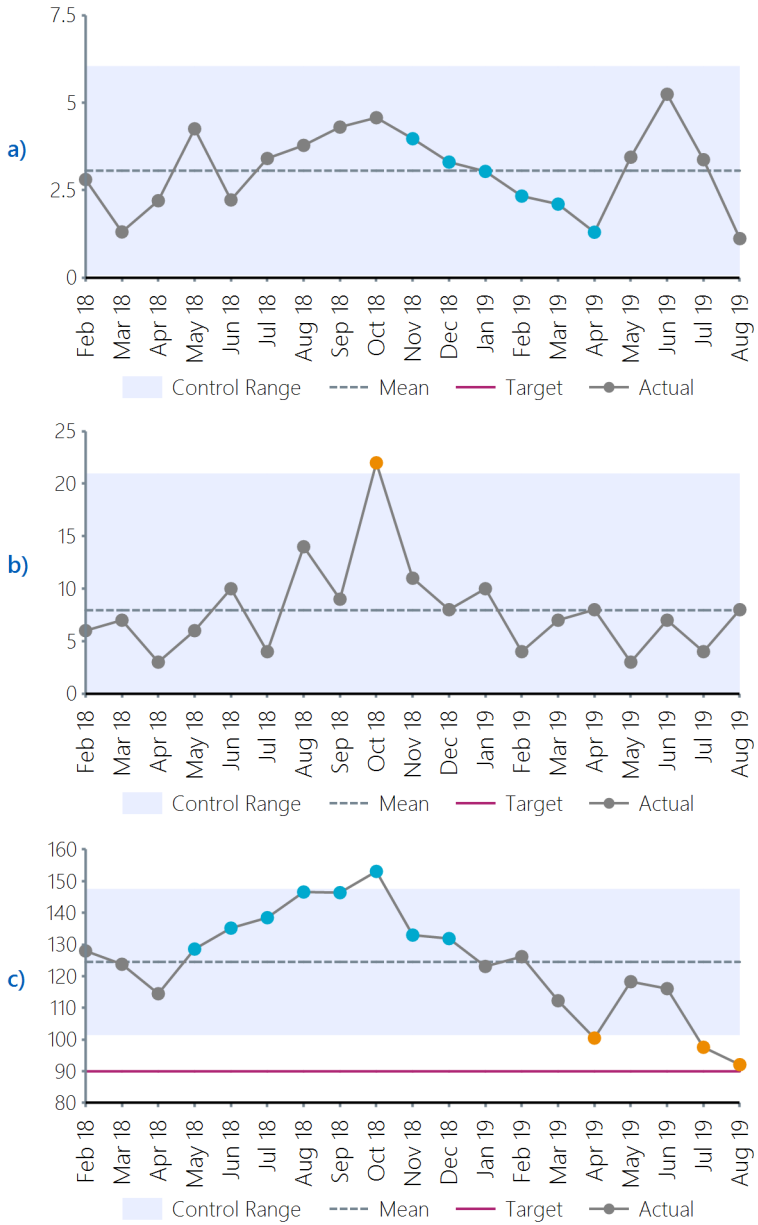
Some examples of these are shown in the images to the right:

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

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

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





Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	7.10%		H	?	+	27/02/20
Voluntary Staff Turnover - Headcount	8.00%	8.62%		H	?	+	24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	1		N/A to SPC	F	+	
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	11			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Klebsiella spp	0	1		N/A to SPC	?	+	24/06/21
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Unexpected Deaths	0	0		N/A to SPC	P		16/04/18
WHO Quality Audit - % Compliance	100%	100%		N/A to SPC	P		

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
WHO Documentation Audit - % Compliance	100%	98%		N/A to SPC	F	+	
31 Days First Treatment (Tumour)*	96%	100%		H	?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85%	100%			?		
6 Week Wait for Diagnostics - English Patients	99.00%	70.56%			F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	71.98%			F	+	
18 Weeks RTT Open Pathways	92.00%	52.60%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,832	1,972	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	883	1,134	H	F	+	24/06/21
Patients Waiting Over 104 Weeks - English	0	106	167	H	F	+	
Patients Waiting Over 104 Weeks - Welsh	0	86	159	H	F	+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/Plan (H1&H2)	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	1,177	872	1,135		Moving Target	+	24/06/21
Bed Occupancy – All Wards – 2pm	87.00%	82.40%		H	F	+	09/03/22
Total Outpatient Activity	18,016	13,396	16,235	N/A to SPC	Moving Target	+	24/06/21
H1 & H2 Plan Performance	113	202		N/A to SPC	Moving Target		
Income	10,668	12,150		N/A to SPC	Moving Target		
Expenditure	10,600	11,996		N/A to SPC	Moving Target	+	
Efficiency Delivered	217	361		N/A to SPC	Moving Target		
Cash Balance	18,800	25,024		H	Moving Target		
Capital Expenditure	2,416.00	3,730.43		N/A to SPC	Moving Target		
Recurrent Financial Performance (Sustainability Plan)	17	21		N/A to SPC	Moving Target		

Sickness Absence

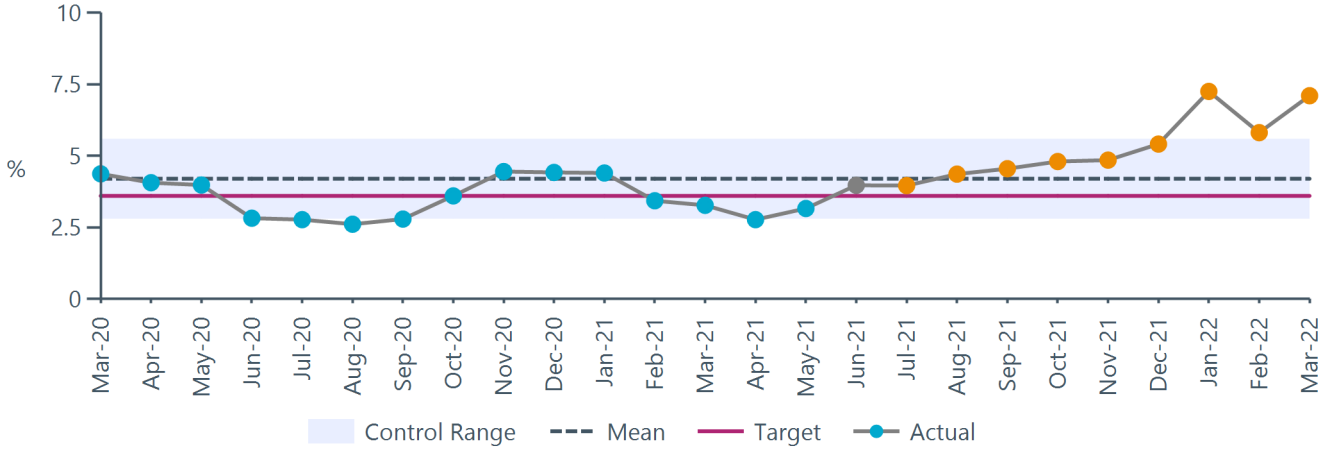
FTE days lost as a percentage of FTE days available in month 211161

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
3.60%	7.10%	H	?

Trajectory/Plan (H1&H2)

Actual
Trajectory



What these graphs are telling us

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

Narrative

The sickness absence reported for March is 7.10% (4.45% sickness without covid). This remains above target and is shown as special cause variation with a third data point outside our control range. Unit level detail below for those areas that are above target:
* MSK Unit - 8.99%, highest sickness rate seen this year in that Unit
* Specialist Unit - 6.87%
* CSU - 6.86%, highest sickness rate seen this year in that Unit
* SSU - 4.24%
* Assurance & Standards Team - 6.31%, remaining above target for a third month

The highest reason for absence was 'Infectious diseases' across all areas of the Trust.

Staff groups with the highest levels of sickness absence were:
* Healthcare Assistants - 14.45%
* Physiotherapists - 8.33%
* Registered Nursing Staff - 7.94%
* Orthopaedic Consultants - 6.12%

Actions

Increased levels of covid continue to impact on the Trust so the silver tactical meetings that commenced in December remain in place where operational issues are discussed, of which sickness levels are included. Adapted daily reporting to assess sickness by staff groups is available.

Mitigating actions remain in place to help address some of the gaps in ward areas by instigating an enhanced rate for some staff groups.

Utilisation of the sickness absence policy continues with pro-active milestone management. The People Business Partners have recently held training sessions to support managers in the use of the sickness policy.

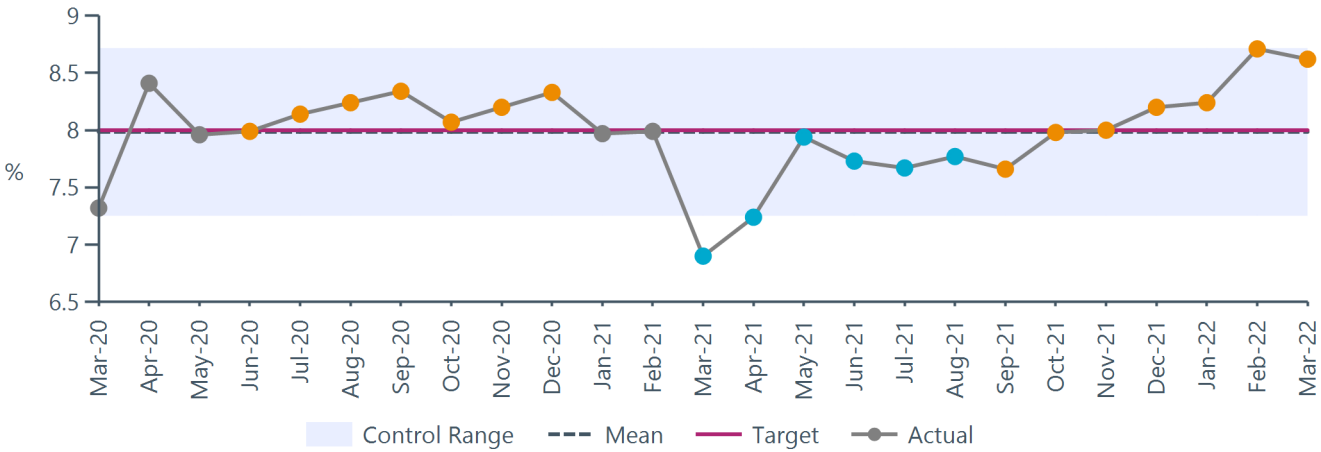
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
3.27%	2.77%	3.16%	3.97%	3.96%	4.36%	4.55%	4.80%	4.85%	5.41%	7.25%	5.81%	7.10%

Voluntary Staff Turnover - Headcount

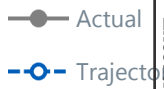
Total numbers of voluntary leavers in the last 12 months as a percentage of the total employed 217394

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
8.00%	8.62%	H	?



Trajectory/Plan (H1&H2)



What these graphs are telling us

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

Narrative

Voluntary Staff Turnover, at Trust level, has now exceeded the 8% target for four months, and is shown as special cause variation. In the latest twelve month period, April-21 to March-22, there have been 143 leavers throughout the Trust. This is in relation to a headcount in post of 1658, as at 31st March 2022.
The staff groups with turnover above target are; Estates and Ancillary - 11.26%, Nursing and Midwifery - 10.60%, Add Prof Scientific - 10.53%, Additional Clinic - 8.46%, Administrative and Clinical - 8.26%

Following a recent action, additional analysis has been undertaken to review the reasons for leaving. The top three reasons (that accounts for 60.84%) at Trust level were:
* Retirement age 44 / 30.77%
* Voluntary Resignation - Other/Not Known - 27 / 18.88%
* Voluntary Resignation - Promotion - 16 / 11.19%
This is based on the leaving reasons listed on termination form/ESR. There are three categories for Retirement - Age, ill health and flexi retirement. The total for these three categories was 53 leavers in the last twelve months. Of the 53 leaving due to retirement, 26 returned in some capacity (44%).

Actions

Following an action last month, the Information Workforce Team have provided some further data to the People Business Partners giving a demographic view of the Trust workforce. The People Business Partners will now carry out some analysis of this and based on their findings, agree a suitable approach to take this forward.

In line with the NHS People Plan, the Trust is proactively promoting and supporting staff with agile/flexible working with the recent release of an updated Trust policy and communications highlighting this.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
6%	7%	7%	7%	7%	7%	7%	7%	8%	8%	8%	8%	8%

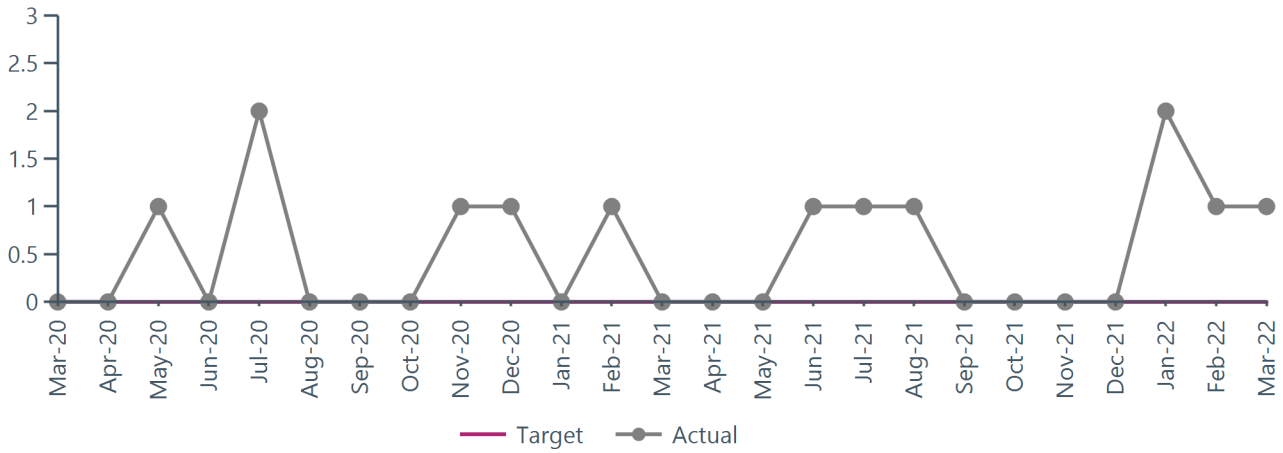
- Staff - Patients - Finances -

Serious Incidents

Number of Serious Incidents reported in month 211160

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

There was one serious incident reported in March. A patient developed a VTE following surgery and there was a deviation from policy. The reporting of this serious incident was following a complaint that was received in February-22 regarding health issues that followed original surgery in June 2020.

Actions

The VTE Policy has been reviewed and updated, with approval by the Quality and Safety Committee. The updated policy has been disseminated to all Clinical Leads.

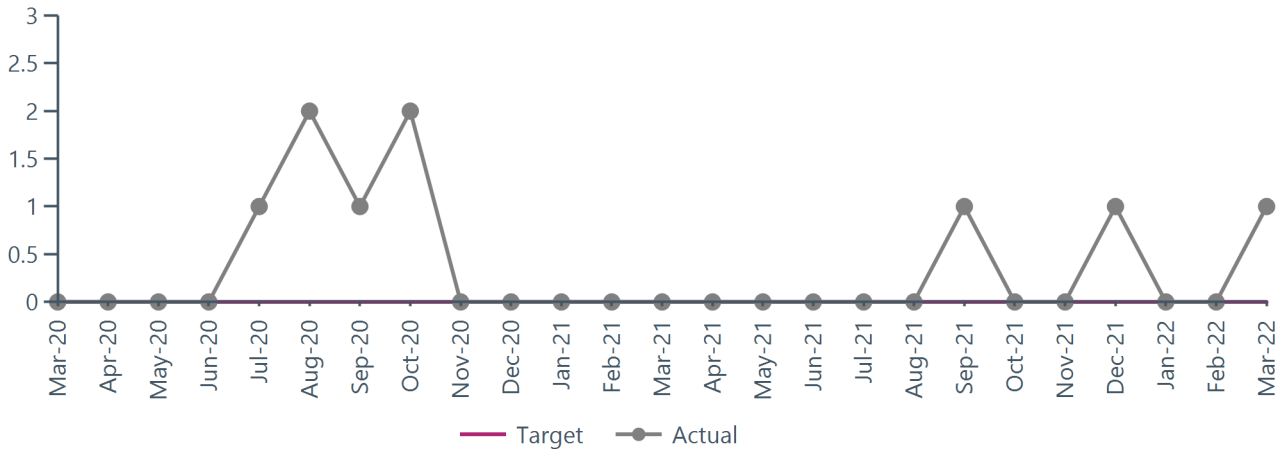
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
0	0	0	1	1	1	0	0	0	0	2	1	1

RJAH Acquired E. Coli Bacteraemia

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

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

There was one RJAH acquired E.coli Bacteraemia reported in March. There have been three infections throughout this financial year, below the annual tolerance set by the CCG.

Actions

As at 6th April, a post infection review meeting is scheduled to take place on 19th April.

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

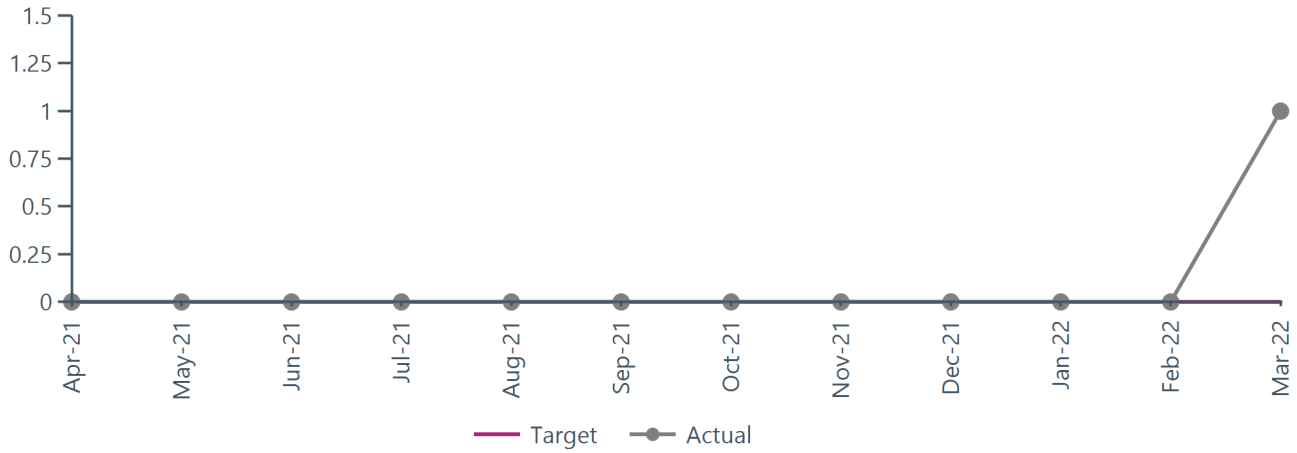
- Staff - Patients - Finances -

RJAH Acquired Klebsiella spp

RJAH Acquired Klebsiella spp 217635

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

There was one RJAH acquired Klebsiella spp reported in March.

Actions

As at 6th April, a post infection review meeting is scheduled to take place on 12th April.

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

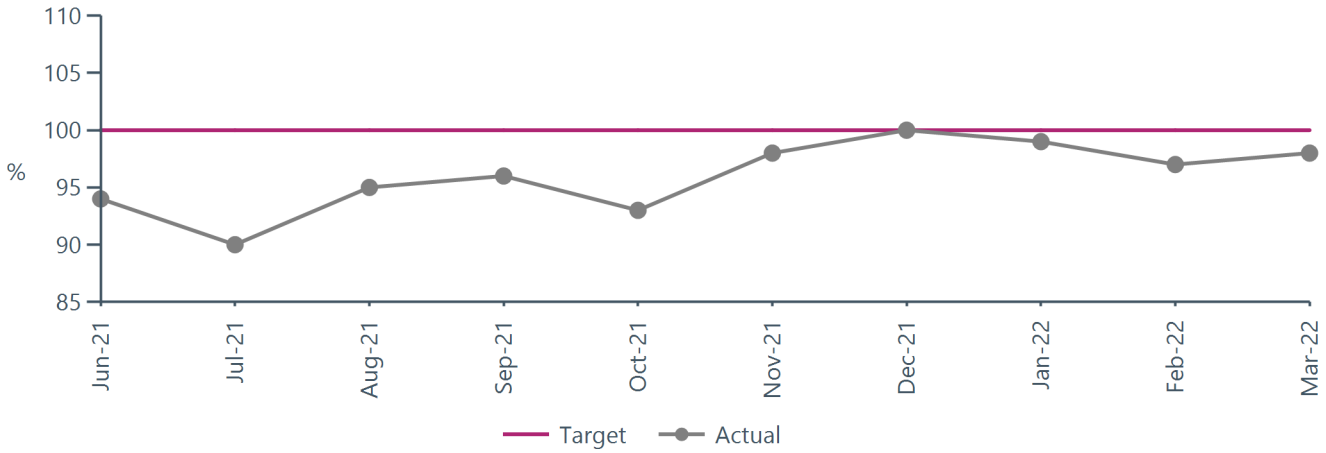
- Staff - Patients - Finances -

WHO Documentation Audit - % Compliance

% of sticker compliance for steps one to five of WHO documentation 217718

Exec Lead:
Chief Medical Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
100%	98%	N/A to SPC	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

The WHO Documentation Audit - % Compliance in March is reporting 98%.
A total of 40 paper documentation audits were undertaken by the Recovery team, where staff were checking for stickers evidencing adherence to each of the WHO five steps, result of which showed:

* There was no sticker present on a sample in the first March audit which affected all 5 Steps and resulted in 90% compliance for this audit
* The remaining four audits achieved 100% compliance

The aim of the audit is to ascertain how well the team are recording compliance in patients' notes. A full and complete record of the background evidence of the audit is retained by Theatres and the outcomes of the audit are being reviewed for common themes and, where appropriate, actions to improve. As a result of COVID-19 sickness related absence amongst Registered Nurses these audits were not recorded in the Tendable App (formerly known as Perfect Ward).

Actions

Documentation audit results and observations have been shared with the Matron, Assistant Chief Nurse and the Chief Medical Officer, and the detail behind the audit results and actions to improve compliance will be discussed at the fortnightly Theatre User Group meeting. A recommendation in relation to the 100% target compliance level will be brought to Patient Safety Committee by the Assistant Chief Nurse.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
			94%	90%	95%	96%	93%	98%	100%	99%	97%	98%

- Staff - Patients - Finances -

6 Week Wait for Diagnostics - English Patients

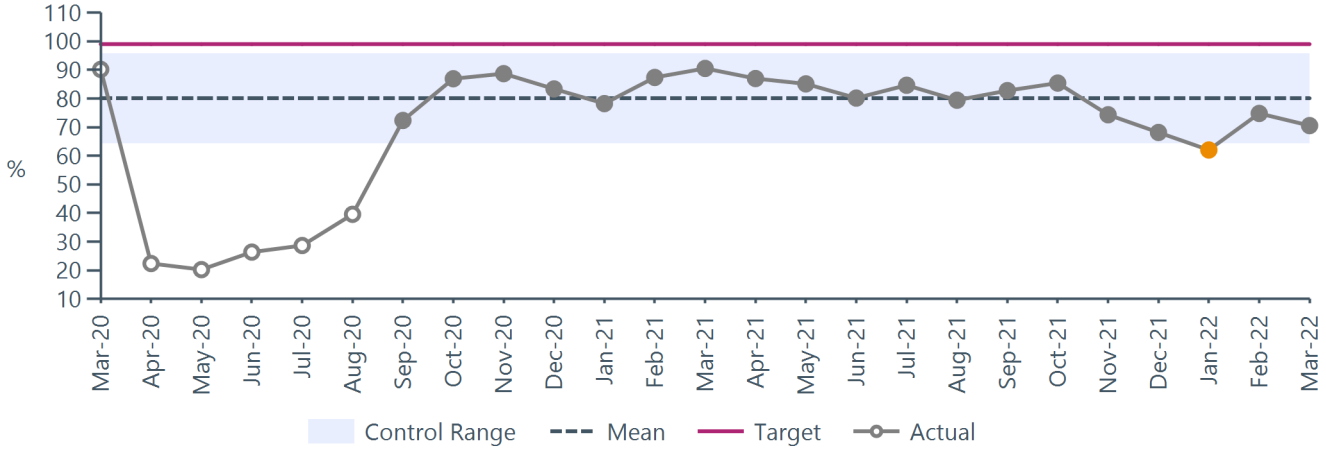
% of English patients currently waiting less than 6 weeks for diagnostics 211026

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	70.56%		F

Trajectory/Plan (H1&H2)

Actual
Trajectory



What these graphs are telling us

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

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 70.56%. This equates to 436 patients who waited beyond 6 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 62.08% D2 (Urgent - 0-2 weeks) - 4 with 3 dated, D3 (Routine - 4-6 weeks) - 3 dated, D4 (Routine - 6-12 weeks) - 387 with 170 dated
- CT - 86.81% D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 11 with 7 dated
- Ultrasound - 91.20% D4 (Routine - 6-12 weeks) - 30 dated

Number of MRI patients breaching is increasing due to referrals returning to normal levels during January after Christmas. MRI activity has also been affected in March due to the arrival of the mobile scanner whilst the static MRI scanner is being installed. There was also an increase in the number of Ultrasound patients breaching in March; this is due to the increase in the Ultrasound waiting list. Furthermore, the trust continues to treat by clinical priority, the D2 (Urgent - 2 weeks) breaches were changed from routine to urgent.

Actions

Actions include:
- Extended weekend working to be implemented and retraining of staff to support modalities under pressure with an increase in activity expected from October 2022
- Currently reviewing skill mix within Diagnostics to train and then utilise established staff across multiple modalities

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

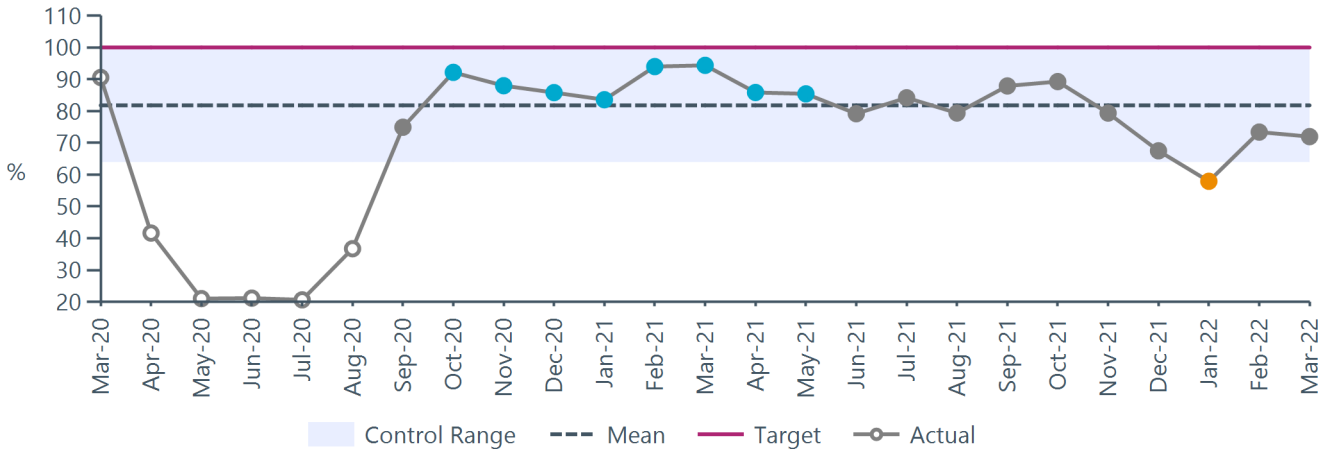
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
90.53%	86.99%	85.13%	80.17%	84.66%	79.43%	82.78%	85.42%	74.35%	68.16%	62.04%	74.81%	70.56%

8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	71.98%		F



Trajectory/Plan (H1&H2)

Actual
Trajectory

What these graphs are telling us

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Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 71.98%. This equates to 190 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
- MRI - 67.94% - D4 (Routine 6-12 weeks) -184 with 84 dated
- CT - 88.46% - D4 (Routine - 6-12 weeks) - 3 dated
- Ultrasound - 96.15% - D4 (Routine - 6-12 weeks) - 3 dated

Number of MRI patients breaching is increasing due to referrals returning to normal levels during January after Christmas. MRI activity has also been affected in March due to the arrival of the mobile scanner whilst the static MRI scanner is being installed.

Actions

Actions include:
- Extended weekend working to be implemented and retraining of staff to support modalities under pressure with an increase in activity expected from October 2022
- Currently reviewing skill mix within Diagnostics to train and then utilise established staff across multiple modalities

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

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
94.40%	85.86%	85.43%	79.18%	84.19%	79.39%	87.91%	89.28%	79.38%	67.51%	57.94%	73.41%	71.98%

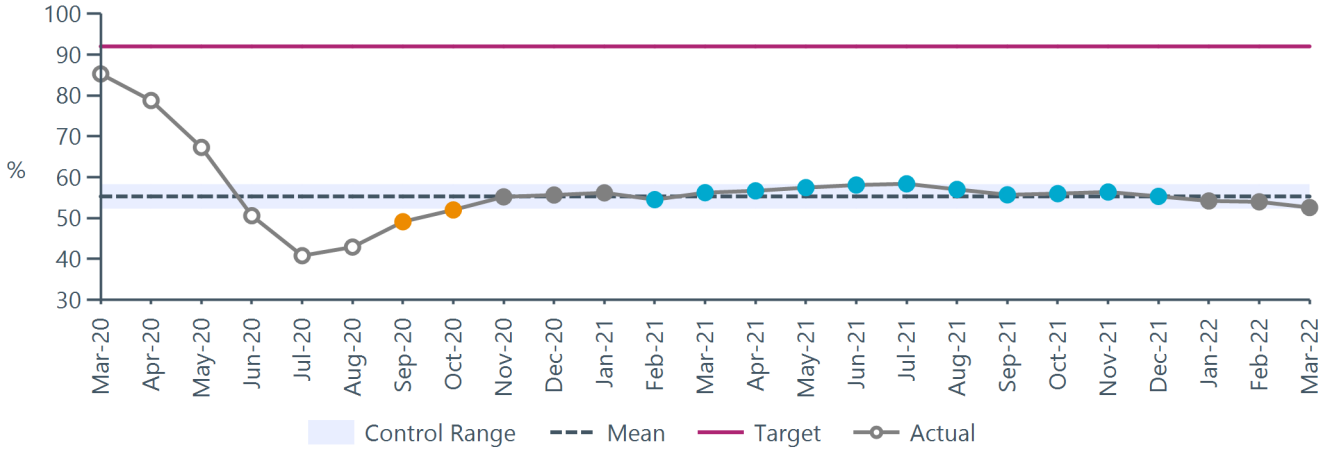
18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	52.60%		F

Trajectory/Plan (H1&H2)



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Narrative

Our March performance was 52.60% against the 92% open pathway performance for patients waiting 18 weeks or less to start their treatment. The performance breakdown by milestone is as follows:
* MS1 - 7532 patients waiting of which 2179 are breaches
* MS2 - 1265 patients waiting of which 803 are breaches
* MS3 - 4763 patients waiting of which 3445 are breaches

Actions

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

Despite this, we anticipate an impact on RTT performance as a result of reductions in planned activity due to recent pandemic pressures and more recently, the Trust supporting the system's critical incident.

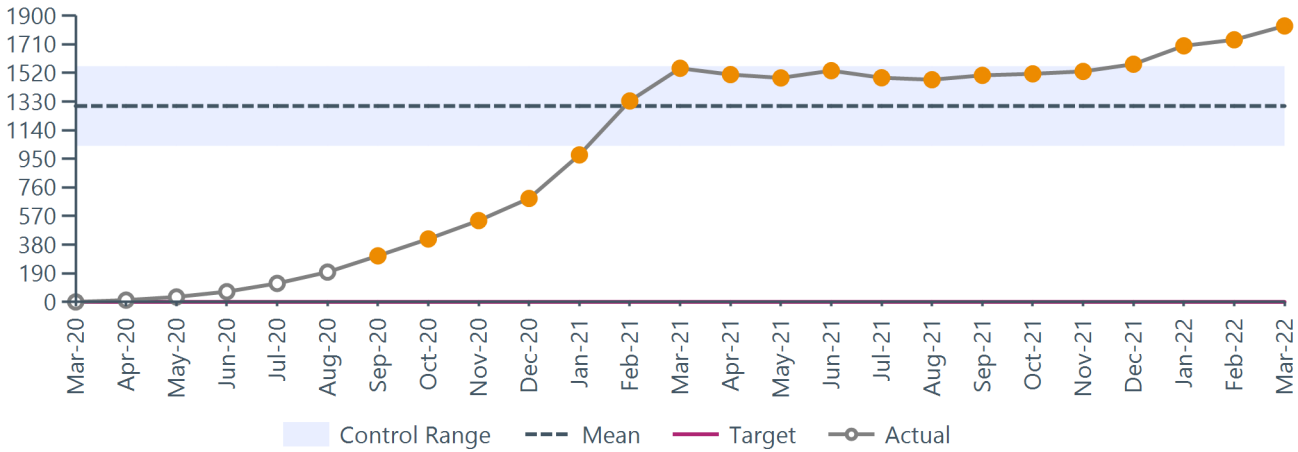
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
56.23%	56.68%	57.46%	58.10%	58.40%	57.02%	55.71%	55.99%	56.39%	55.33%	54.21%	53.99%	52.60%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1,832	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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Narrative

At the end of March there were 1832 English patients waiting over 52 weeks; below our trajectory figure of 1972 by 140.

The patients are under the care of the following sub-specialities; Spinal Disorders (956), Knee & Sports Injuries (335), Arthroplasty (232), Upper Limb (130), Foot & Ankle (81), Spinal Injuries (65), Metabolic Medicine (13), Paediatric Orthopaedics (10), Tumour (8), Neurology (1) and Geriatrics (1).

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 1306 patients
- >78 to <=95 weeks - 349 patients
- >95 to <=104 weeks - 71 patients
- >104 weeks - 106 patients

Actions

H2 planning guidance stipulated that Trusts should hold, or where possible, reduce the number of patients waiting over 52 weeks. The submitted plans have been reflected in the trajectory line above. The trajectory for future months will be updated once the 22/23 operational plans are approved and submitted. Planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

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

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust provides support to the system's critical incident.

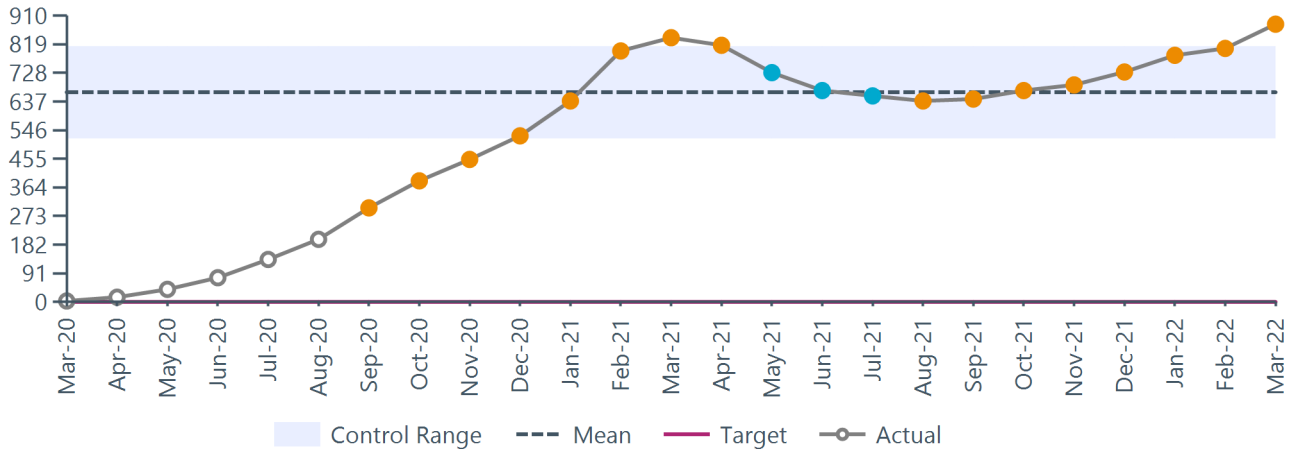
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1551	1509	1487	1535	1488	1475	1504	1514	1530	1578	1700	1740	1832

Patients Waiting Over 52 Weeks – Welsh

Number of RJAH Welsh RTT patients waiting 52 weeks or more at month end 211140

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	883	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

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

Narrative

At the end of March there were 883 Welsh patients waiting over 52 weeks; below our trajectory figure of 1134 by 251. The patients are under the care of the following sub specialties; Spinal Disorders (558), Knee & Sports Injuries (111), Arthroplasty (92), Upper Limb (59), Foot & Ankle (30), Spinal Injuries (16), Metabolic Medicine (5), Paediatric Orthopaedics (5), Tumour (4), Neurology (2) and Physiotherapy (1).

The patients are under the care of the following commissioners; BCU (473), Powys (394), Hywel Dda (12), Aneurin Bevan (2), Abertawe Bro Morgannwg (1) and Cardiff & Vale (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 631 patients
- >78 to <=95 weeks - 137 patients
- >95 to <=104 weeks - 29 patients
- >104 weeks - 86 patients

Actions

H2 planning guidance stipulated that Trusts should hold, or where possible, reduce the number of patients waiting over 52 weeks. The submitted plans have been reflected in the trajectory line above. The trajectory for future months will be updated once the 22/23 operational plans are approved and submitted. Planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

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

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust provides support to the system's critical incident.

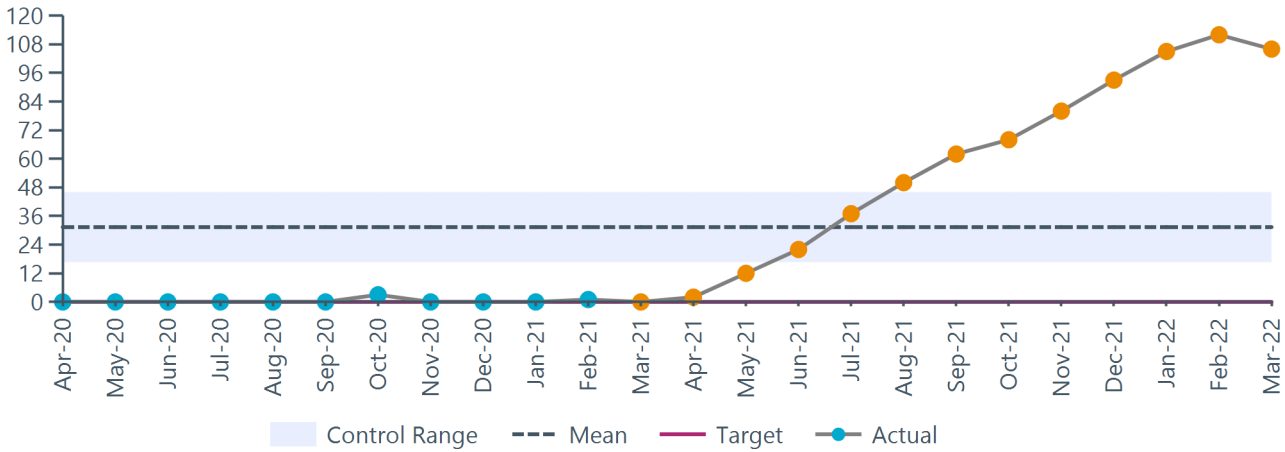
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
840	816	729	672	655	639	645	672	690	731	784	806	883

Patients Waiting Over 104 Weeks - English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	106	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

At the end of March there were 106 English patients waiting over 104 weeks, below our trajectory figure of 167 by 61. The patients are under the care of the following sub-specialities, with further details on the volume by priority;

- Spinal Disorders (96) - P2 (2), P3 (22), P4 (57), P6 (7), Not on Elective WL yet so no priority (8)
- Arthroplasty (4) - P2 (1), P3 (1), P6 (2)
- Knee & Sports Injuries (3) - P6 (2), Not on Elective WL yet so no priority (1)
- Foot & Ankle (1 - P6)
- Upper Limb (1 - P3)
- Spinal Injuries (1 - P6)

Actions

H2 planning guidance stated that the Trust should eliminate non-spinal 104+ week waits by March 2022. Latest planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

The Trust expects spinal disorders 104+ weeks to still be present . This is due to national pressures for this specialist service and continued demand. Mutual aid discussions are in progress with the independent sector who can provide us with some capacity. We are currently identifying patients who are suitable, and agree, to transfer. As acknowledged through the planning guidance, there may also be patients who choose to wait. This formed part of our H2 planning submission and features in the forthcoming plans for 22/23. The trajectory for future months will be updated once the 22/23 operational plans are approved and submitted.

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust has to reduce planned activity due to the support being provided to the system's critical incident but every effort has been made to ensure those patients waiting over 104 weeks are not impacted.

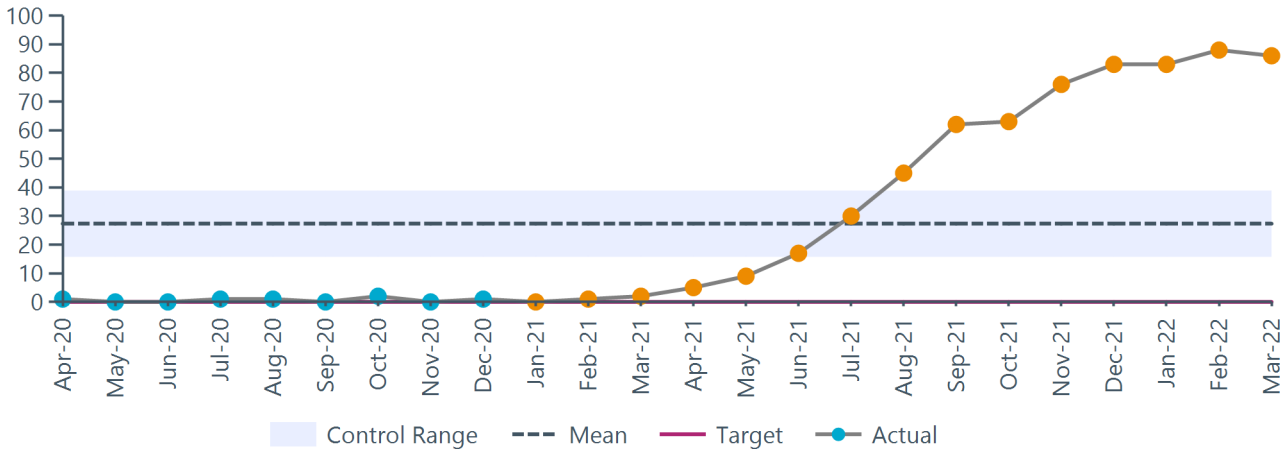
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
0	2	12	22	37	50	62	68	80	93	105	112	106

Patients Waiting Over 104 Weeks - Welsh

Number of RJAH Welsh RTT patients waiting 104 weeks or more at month end 217592

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	86	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

At the end of March there were 86 Welsh patients waiting over 104 weeks, below our trajectory figure of 159 by 73. The patients are under the care of the following sub-specialities, with further details on the volume by priority;

- Spinal Disorders (84) - P2 (4), P3 (23), P4 (49), Not on Elective WL yet so no priority (8)
- Arthroplasty (1 - Not on Elective WL yet so no priority)
- Spinal Injuries (1 - Not on Elective WL yet so no priority)

Actions

H2 planning guidance stated that the Trust should eliminate non-spinal 104+ week waits by March 2022. Latest planning guidance for 22/23 stipulates that Trusts should eliminate 104+ weeks by July 2022 (except for patient choice) and make plans to reduce waits over 52 weeks.

The Trust expects spinal disorders 104+ weeks to still be present . This is due to national pressures for this specialist service and continued demand. Mutual aid discussions are in progress with the independent sector who can provide us with some capacity. We are currently identifying patients who are suitable, and agree, to transfer. As acknowledged through the planning guidance, there may also be patients who choose to wait. This formed part of our H2 planning submission and features in the forthcoming plans for 22/23. The trajectory for future months will be updated once the 22/23 operational plans are approved and submitted.

At present, we do anticipate an impact on the number of patients currently waiting whilst the Trust has to reduce planned activity due to the support being provided to the system's critical incident but every effort has been made to ensure those patients waiting over 104 weeks are not impacted.

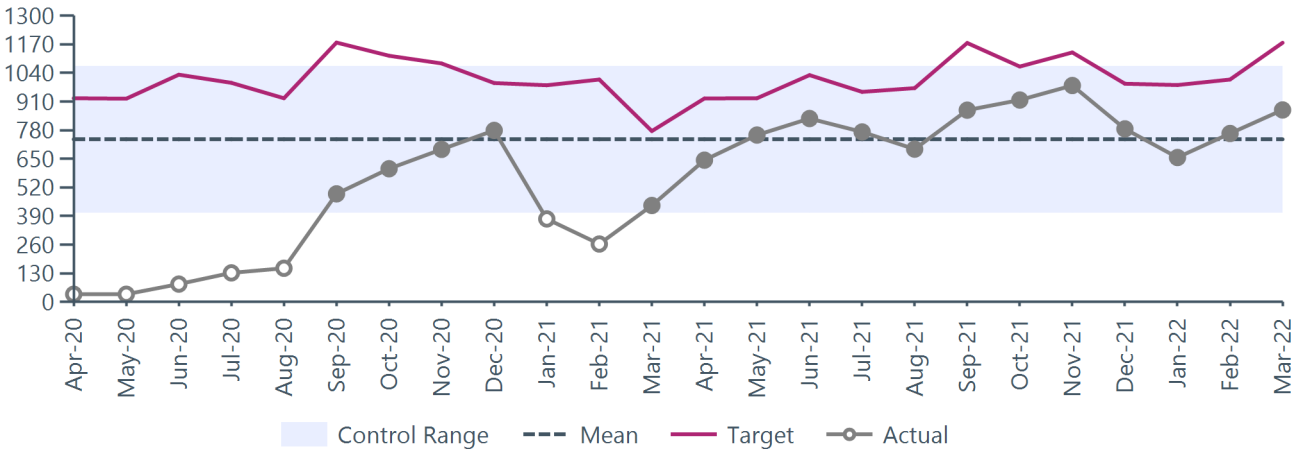
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
2	5	9	17	30	45	62	63	76	83	83	88	86

Total Elective Activity

All elective activity in month rated against 19/20 baseline activity adjusted for working days and the impact of Covid-19 217556

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
1,177	872		Moving Target



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Following guidance from NHS EI we have updated the SPC graphs throughout the IPR to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. To recognise all elective work following the impact of COVID-19 , this new committee measure was added in 21/22 and there is now enough data points to display this in SPC.

Narrative

Total elective activity undertaken in March was 872, behind the H2 plan of 1135 as represented in the trajectory line above. March activity represents 74.1% of the 19/20 baseline figure of 1177; the March target, as set by NHS EI, was to meet 85% of baseline 19/20 activity. The aim of the Trust is to ensure elective activity continues according to plan, to reduce long waits and prevent further lengthening of waiting lists. As of 7th March, elective bookings were reported at 877 against the H2 plan of 1135 - 77.3%. As a result of the continued pressures felt from Covid and its impacts, bookings fell short of the trajectory at the start of the month and did not recover. A high rate of cancellations was seen once again in March due to multiple factors; absence amongst critical and wider Theatre staff accounted for 22 cancellations on the day, and a further 55 ahead of the day cancellations can be attributed to wider staff sickness/shortfall/isolation. The Trust has a known shortfall in Theatre staffing that is currently impacted by vacancies and maternity leave and there is a recruitment plan in place to address this. Mitigations currently include flexibility of current workforce and agency staff on a short-term basis. In March, the Trust achieved 94.9% of its IJP capacity and all core staffed Theatre sessions were utilised. Plans were to further deliver 409 cases via OJP of which the Trust achieved 150 (36.7%) due to current constraints of staffing and mitigations. As of 7th April, elective activity is reported at 641 this month.

Actions

In March there were multiple factors relating felt from continued Covid impacts which led to lost activity:
* Staff absence resulting in Theatre cancellations - see % Cancellations narrative for actions.
* Lost sessions due to predominantly due staff sickness/shortfall/isolation – see % Sessions narrative for actions.
* Essential estates work causing temporary ward closures/loss of ward beds.
* Critical incident declared across the health and care system in Shropshire, Telford, and Wrekin.

Current actions include:
* Actions to improve staffing levels for Theatres and wards is underway
* Use of independent sector capacity is being progressed to support addressing long waiters in Spinal Disorders.

Impacts from staff absence are expected to continue into April performance as community prevalence in Shropshire remains high. Extreme pressures which threatened to overwhelm the system's urgent and emergency services resulted in a critical incident being declared in Shropshire, Telford, and Wrekin. Discussions commenced 28th March where actions were decided to stand down a proportion of non-urgent elective surgical activity and to release some staff to support our urgent care colleagues. This has impacted elective activity in late March and will continue into April.

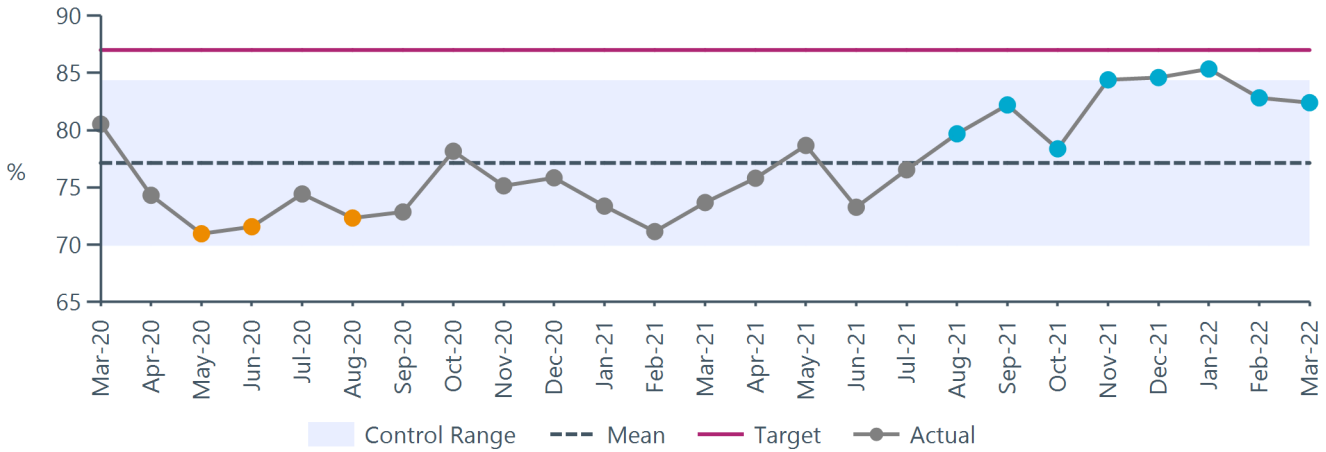
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
438	644	758	833	772	694	871	917	983	786	656	765	872

Bed Occupancy – All Wards – 2pm

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

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	82.40%	H	F



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 82.40% for March and remains shown as special cause variation of an improving nature. Breakdown provided below:
MSK Unit:
- Clwyd - 78.77% - compliment of 22 beds open for majority of month
- Powys - 73.94% - compliment of 22 beds open for majority of month
- Kenyon - 89.22% - compliment of 12 beds open; periods in month where 4 or 10 additional beds opened
- Ludlow - 86.67% - closed for majority of the month

Specialist Unit:
- Alice - 61.54% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 73.86% - compliment of 10 beds open throughout month
- Gladstone - 85.40% - compliment of 29 beds open throughout month
- Wrekin - 89.85% - compliment of 15 beds open with couple of days having 1 bed closed
- Sheldon - 90.82% - compliment of 20 beds open throughout month

It should be noted that 26 beds were closed that are not reflected in the calculation of this KPI.

Actions

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

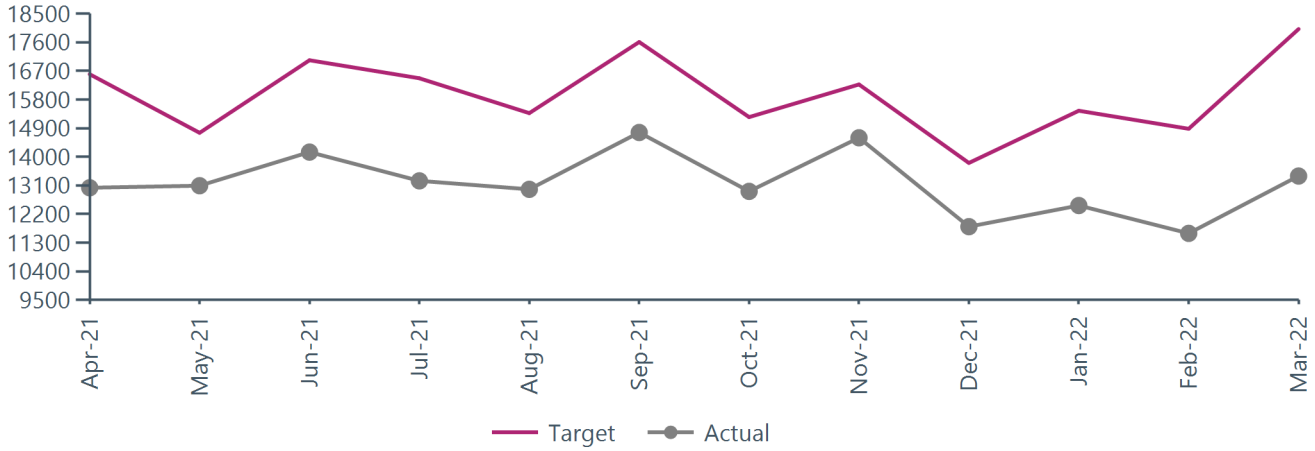
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
73.68%	75.81%	78.67%	73.27%	76.54%	79.68%	82.21%	78.37%	84.40%	84.60%	85.35%	82.82%	82.40%

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (H2), Catchment Based) 217580

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
18,016	13,396	N/A to SPC	Moving Target



Trajectory/Plan (H1&H2)

What these graphs are telling us

Currently this measure is not appropriate to display as SPC. Analysis will improve as more data points are added. It is recommended that 15+ data points are required for robust analysis. This measure has a moving target.

Narrative

The target for Total Outpatient Activity is the 2019/2020 baseline activity delivered by the Trust. NHS England figures for H1 outpatient baseline included unmatched/unbundled activity, however, H2 planning guidance now excludes unbundled/unmatched activity and is reflected in our reported performance figures from October onwards. H2 plan is included as a trajectory in the trajectory graph above. In March the total Outpatient activity undertaken in the Trust was 13396; 2839 cases below our H2 plan. This is broken down as follows:
- Consultant led - 86.38% (10340 against target of 11970)
- Non consultant-led - 71.65% (3056 against target of 4625)

For the March 2020 baseline figures NHS EI made an adjustment as this was the first month hit by Covid, the Trust believes the adjustments were too high for the system and as part of the 2022/23 planning an algorithm adjustment has been made for March 2020 baseline. Outpatient activity was lost in March due to the continuation of covid within patients and staff and a higher number of DNAs and cancellations; still causing significant rework. As at 7th April (5th working day) there were 898 missing outcomes so once administrative actions are taken with these data entries, the March position will alter. Taking into account the missing outcomes, this would mean that the Outpatient activity for March was 14294, 1910 below our H2 plan of 16235. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs.

Actions

Actions include:
- Assess recommendations received from recent review of Outpatient Activity conducted by Meridian.
- Mitigations have now been put in place to reflect job plan changes since 2019/20.

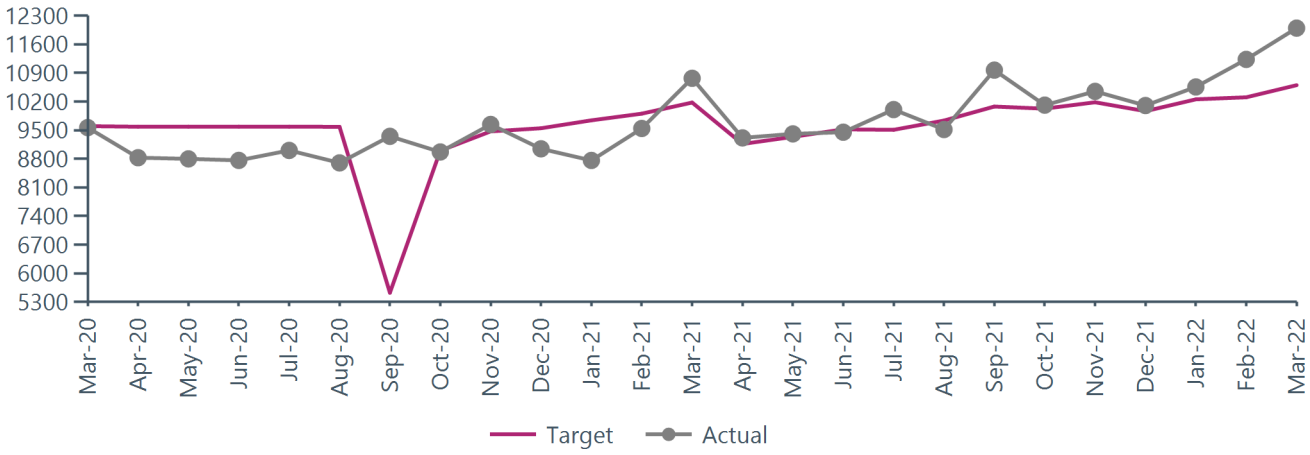
Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
	13027	13091	14148	13244	12978	14765	12914	14599	11804	12469	11593	13396

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
10,600	11,996	N/A to SPC	Moving Target



Trajectory/Plan (H1&H2)

What these graphs are telling us

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

Narrative

Overall £1,396k adverse in month:

Pay £101k adverse
- Pass through costs adverse (Health Education England and Clinical Excellence Awards)
- Increased premium Agency costs partially offset by vacancies

Non Pay £1,295k adverse
- Pass through costs adverse (High Cost Drugs, Digital funding for EPR & Health Education England funding)
- Covid Costs, Estates Works & IPC Audit works adverse
- Partially offset by activity adverse to plan (implants. consumables, OJP)

Actions

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
10769	9311	9409	9451	10004	9517	10969	10113	10449	10103	10557	11231	11996

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

Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	101,699	9,056	9,788	732	101,706	105,010	3,304
System Top Up Funding	4,842	373	373	(0)	4,834	4,842	8
Non NHS income support	1,537	110	110	0	1,537	1,537	0
Covid-19 Funding	2,822	228	228	(0)	2,822	2,822	0
Private Patient income	4,101	343	351	8	4,101	6,593	2,492
Other income	6,365	558	4,607	4,049	6,365	10,950	4,586
Pay	(71,131)	(6,197)	(9,392)	(3,196)	(71,131)	(75,103)	(3,972)
Non-pay	(40,925)	(3,856)	(5,483)	(1,627)	(40,925)	(44,798)	(3,873)
EBITDA	9,308	615	581	(34)	9,308	11,853	2,544
Finance Costs	(6,616)	(547)	(502)	45	(6,616)	(6,591)	24
Capital Donations	4,750	628	506	(122)	4,750	2,940	(1,810)
Operational Surplus	7,443	696	586	(110)	7,443	8,201	758
Remove Capital Donations	(4,750)	(628)	(506)	122	(4,750)	(2,940)	1,810
Add Back Donated Dep'n	540	45	49	3	540	562	23
Add Back Centrally Procured PPE	0	0	73	73	0	73	73
Control Total	3,232	113	201	88	3,232	5,897	2,665
EBITDA margin	8.0%	5.8%	3.8%	-2.0%	7.7%	9.0%	1.3%

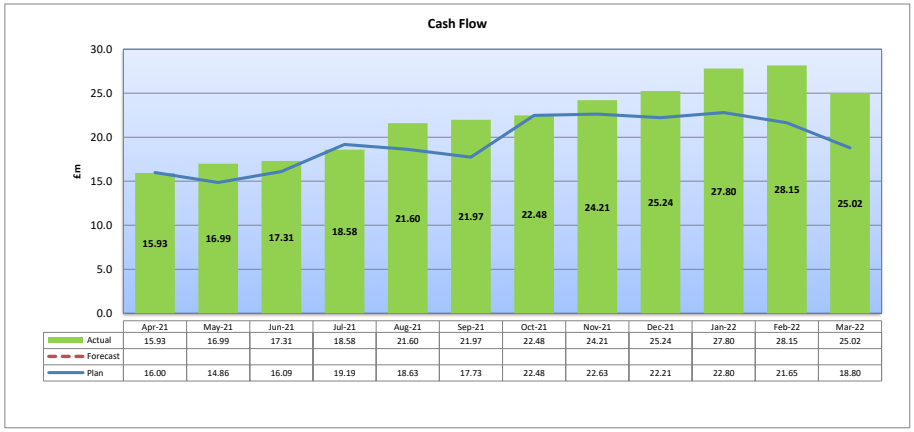
Statement of Financial Position £'000s				
Category	Feb	Mar	Movement	Drivers
Fixed Assets	84,823	87,999	3,176	Additions less depreciation
Non current receivables	1,177	1,321	144	
Total Non Current Assets	86,000	89,320	3,320	
Inventories (Stocks)	1,424	1,335	(89)	
Receivables (Debtors)	4,900	4,462	(438)	Year end settlement of invoices
Cash at Bank and in hand	28,155	25,024	(3,131)	Capital, PDC and annual prepayments
Total Current Assets	34,479	30,821	(3,658)	
Payables (Creditors)	(18,581)	(17,342)	1,239	Decrease in deferred income and accrued payables
Borrowings	(1,317)	(1,461)	(144)	
Current Provisions	(290)	(333)	(43)	
Total Current Liabilities (< 1 year)	(20,188)	(19,136)	1,052	
Total Assets less Current Liabilities	100,291	101,005	714	
Non Current Borrowings	(3,465)	(3,327)	138	
Non Current Provisions	(952)	(1,062)	(110)	
Non Current Liabilities (> 1 year)	(4,417)	(4,389)	28	
Total Assets Employed	95,874	96,616	742	
Public Dividend Capital	(36,108)	(36,354)	(246)	PDC received to fund capital schemes
Retained Earnings	(22,396)	(22,396)	0	
Revenue Position	(7,614)	(8,202)	(588)	Current period surplus
Revaluation Reserve	(29,756)	(29,664)	92	
Total Taxpayers Equity	(95,874)	(96,616)	(742)	

Sustainability (Recurrent) Plan 2021/22						
Category	In Month Position (£'000)			Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	8,764	8,763	(1)	105,167	105,166	(1)
System Top Up Funding	0	0	0	0	0	0
Non NHS income Support	0	0	0	0	0	0
Covid-19 Funding	0	0	0	0	0	0
Private Patient income	240	240	0	5,228	5,228	(0)
Other income	553	549	(4)	6,637	6,616	(21)
Pay	(5,972)	(5,972)	0	(71,910)	(71,910)	0
Non-pay	(3,053)	(3,053)	0	(41,467)	(41,481)	(14)
EBITDA	**533**	**529**	**(5)**	**3,655**	**3,619**	**(36)**
Finance Costs	(561)	(557)	4	(6,739)	(6,735)	4
Operational Surplus	**(28)**	**(28)**	**(1)**	**(3,084)**	**(3,116)**	**(32)**
Add Back Donated Dep'n	45	49	4	539	562	23
Control Total	**17**	**21**	**3**	**(2,545)**	**(2,554)**	**(9)**

Draft Finance Metrics (New Single Oversight Framework)

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

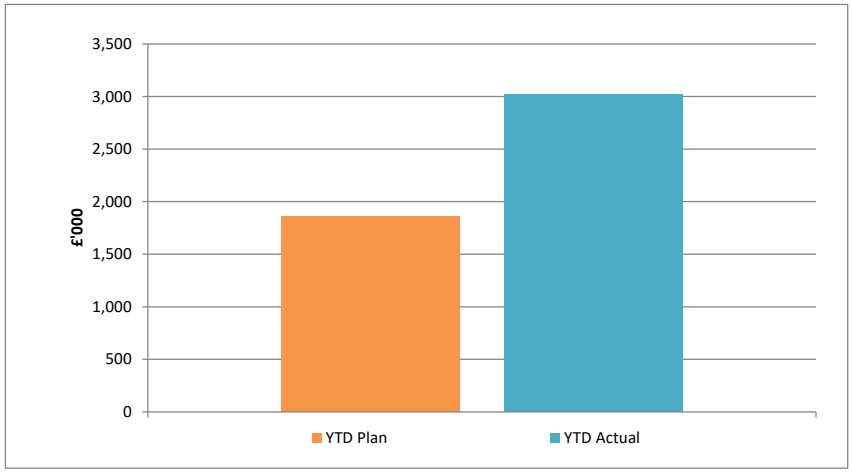
	YTD
Debtor Days	9
Creditor Days	34



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

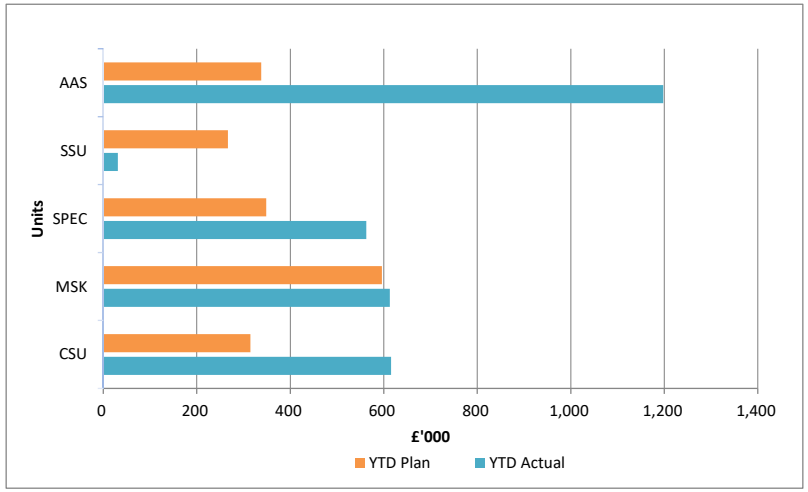
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



YTD Efficiencies

YTD Efficiencies Achievement £000's



Capital

Position as at	2122-12	Capital Programme 2021-22					
Project	Annual Plan £000s	In Month Plan £000s	In Month Complete d £000s	In Month Variance £000s	YTD Plan £000s	YTD Complete d £000s	YTD Variance £000s
Backlog maintenance	600	17	297	-280	600	754	-154
I/T investment & replacement	300	80	189	-109	300	300	0
Capital project management	100	9	9	-0	100	117	-17
Equipment replacement	500	50	1	49	500	525	-25
Diagnostic equipment replacement	1,701	901	2,053	-1,152	1,701	2,277	-576
Diagnostic equipment replacement (PDC)	99	99	116	-17	99	116	-17
Diagnostic digital capability (PDC)	0	0	31	-31	0	143	-143
Contingency	500	100	530	-430	500	1,000	-500
EPR planning & implementation	2,000	600	0	600	2,000	0	2,000
Invest to save	200	50	0	50	200	25	175
Donated medical equipment	200	25	46	-21	200	281	-81
Veterans' centre	4,500	485	458	27	4,500	2,658	1,842
Total Capital Funding	10,700	2,416	3,730	-1,314	10,700	8,196	2,504
Donated medical equipment	-200	-25	-46	21	-200	-281	81
Veteran's facility	-4,500	-485	-458	-27	-4,500	-2,658	-1,842
Capital Funding (NHS only)	6,000	1,906	3,227	-1,321	6,000	5,256	744

Chair's Assurance Report
Extra-Ordinary Finance, Planning and Digital Committee

0. Reference Information

Author:	Amber Scott, Executive Assistant	**Paper date:**	04/05/2022
Executive Sponsor:	Sarfraz Nawaz, Chair of the FPD Committee	**Paper written on:**	28/04/2022
Paper Reviewed by:	N/A	**Paper Category:**	Governance
Forum submitted to:	Board of Directors	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This paper presents a summary of the Extra-Ordinary Finance, Planning and Digital meeting held on Thursday 28th April 2022 to sign off the Trust's Operational and Financial Plan. The Board of Directors is asked to consider the assurances provided and whether any additional assurances are required.

2. Executive Summary

2.1 Context

The Extra-ordinary Finance, Planning and Digital Committee met to review and approve the Operational Plan and Financial Plan prior to submission.

2.2 Summary

- The meeting was attended by two Non-Executive Directors, Chief Finance & Planning Officer, Head of Planning and Operational Director of Finance.
- The Operational and Financial Plans for 2022/23 were considered and approved by the Committee.

2.3. Conclusion

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

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board of Directors from the Extra-ordinary Finance, Planning and Digital Committee which met on Thursday 28th April 2022. The meeting was quorate with two Non-Executive Directors and the Chief Finance & Planning Officer in attendance. A full list of the attendance is outlined below:

Chair/ Attendance:	
Sarfraz Nawaz	Non-Executive Director (Chair)
Chris Beacock	Non-Executive Director
Craig Macbeth	Chief Finance & Planning Officer
Nia Jones	Head of Planning
Mark Salisbury	Operational Director of Finance
Amber Scott	Executive Assistant (minute secretary)
Apologies:	
David Gilburt	Associate Non-Executive Director
Paul Kingston	Non-Executive Director

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. Operational Plan 2022/23		
The Trust informed the Committee that both the Operational Plan and Financial Plan were discussed in detail at Finance, Planning and Digital Committee earlier in the week, but due to quoracy the plans were not approved, hence the meeting today. The Chair of the Finance, Planning and Digital Committee confirmed that by way of a briefing note, good assurance was provided outside of the meeting. The key area for noting is the risk assessment, and ensuring those risks are monitored and tracked by the correct Committee to achieve delivery of the plan. Discussion were held in relation to what extent the plan has been driven by the dictates of the Regulators and NHSE/I and is the plan truly deliverable. It was noted that not all requests from the Regulator have been met, and the plan is driven by the capacity of the Trust and a series of improvement measures identified. It is of importance that these improvement measures remain in the line of sight through the various assurance Committees with risks regularly reviewed and updated. It was noted that the plan requires balance of ambition with realism and pragmatism, acknowledging the risks involved and	Yes	

being aware this may not hit everything the Regulator requests, confirming this process has been undertaken and assurance has been received on the purpose of the plan for the Trust. Further to this the planning guidance assumes no impact of COVID in terms of restoration targets, yet the Trust have seen, through the current month, the huge impact from COVID with the Mutual Aid supporting SaTH in terms of the urgent care pressures. Therefore, the reduced activity is reflected in the submission. This led the Committee discussing the risk, assuming no further impact of COVID for the next 11 months, with this being unknown the impact of this is articulated on the deliverability of this plan. The second significant concern is the new guidance published for interpretation on a relaxation of the COVID infection control measures. It was confirmed that the Chief Nurse and IPC Team are currently working through that to interpret what changes with an aim to see some upsides in outpatient activity because of that. The Trust are acknowledging risks in the submission so that there is transparency adding that these risks are not only reflecting internally but are recognised externally also.		
2. Financial Plan 2022/23		
The changes made to the plan following the meeting on Tuesday due to the conclusion of some outstanding matters. ▪ The COVID cost reduction was confirmed and improved the I&E position by £0.7m as income was retained by RJAH. ▪ The deficit position had therefore moved from the £2.3m that we presented on Tuesday to £1.6m. ▪ Elective Recovery funding of £3.2 was also now confirmed but was still subject to delivery of the system plan. Due to this high risk, the Non-Executives questioned how viable it is felt that System partners will deliver plans, enabling the Trust to receive the ERF. The Trust confirmed there was potential exposure for the Trust, with a need to agree on how this would be transacted should System partners not deliver but the spirit of the Electric Recovery Fund is to enable organizations to maximise waiting list clearance and delivery of activity so we should not be penalized. Furthermore, the Trust raised the point that a couple of business cases are in the pipeline aiming to be presented at FPD in May 2022. ▪ Increasing Theatre Capacity (with potential to access National Funds to grow capacity) ▪ Diagnostics (with potential to access Diagnostic Capacity Growth fund, contributing to the developments of a North Shropshire Locality Diagnostic Hub)	Yes	

3.4 Approvals

Approval Sought	Outcome
Formal agreement and approval of the Operational Plan and Financial Plan	The FPD agreed to approve the plan submission on behalf of the Board on the basis that deliverability risks receive ongoing oversight throughout the year.

3.6 Risks to be Escalated

Risks identified to be assigned to appropriate Committee for ongoing oversight.

4. Conclusion

The Board of Directors is asked to note the approval of the Operational plan by FPD.

Operational Plan 2022/23

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

Activity Restoration

- **Elective inpatients – Restoration of 101% (target 110%)**
  - COVID impact 2% (April actual – no further COVID disruption planned)
  - Cases per session reduced by 5% (case mix driven)
  - Additional Theatre sessions included
  - Independent Sector capacity supporting
  - Business case for additional capacity from targeted investment fund being worked up

- **Outpatients – Restoration of 91% (target 110%)**
  - Pathway IPC restrictions under review (currently reducing productivity by 10%)
  - Further Outpatient productivity opportunities being explored

- **Diagnostics MRI restoration of 101%, Ultrasound 108%, CT 110% (targets 110%)**
  - Business case for additional capacity being worked up as part of Community Diagnostic Hub initiative

Waiting times

- 104 week waiters – 96 remaining by end of June (target zero)
- 78 week waiters – 247 remaining at end of March 2023 (target zero)
  - COVID impact experienced for April incorporated (Targets assume no COVID)
  - Mutual aid from other providers being explored with a view to further reduce
  - Complex spinal unable to be accommodated in Independent Sector

Delivery trajectory (Theatre sessions)

19/20	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
NHS	392	451	424	447	432	495	503	473	388	482	443	288	5,214
PP	34	37	35	29	23	28	40	43	21	41	29	17	374
Dental	2	5	3	2	4	3	4	7	3	4	6	4	47
Total	428	493	461	478	459	526	546	523	412	526	477	309	5,635

22/23 Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
NHS	215	417	394	460	485	479	514	529	423	515	494	573	5,499
PP	33	33	37	27	23	31	36	45	22	35	28	30	380
Dental/CT	10	13	11	10	13	12	12	16	11	12	14	13	148
Total	258	464	442	498	521	521	563	590	456	563	536	616	6,027

Gap	- 169	- 29	- 19	20	63	- 4	17	67	44	37	59	308	393

19/20 adjusted for working days	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
IJP	238	293	268	245	282	343	298	296	235	303	255	277	3,333
OJP	134	158	156	163	171	175	161	200	153	157	188	173	1,989
Total NHS	372	451	424	408	453	518	459	496	388	460	443	450	5,322

22/23 Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
IJP	188	355	300	284	258	341	334	382	264	332	336	373	3,747
OJP	27	62	95	176	228	138	180	147	159	183	158	200	1,753
Total NHS	215	417	395	460	486	479	514	529	423	515	494	573	5,500

- Plan is to deliver 5,500 sessions compared to 5322 in 2019/20
- Increased in job plan capacity linked to recruitment plans – 2 step changes (July and October)
- PP remains proportionate to baseline

Delivery Trajectory – Outpatients

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
19/20 Baseline working day adj	14,664	15,426	14,593	14,747	15,260	16,671	15,490	16,513	13,288	16,444	15,079	17,158	185,333
Physio Pool and Classes	- 247	- 262	- 251	- 258	- 280	- 237	- 242	- 238	- 139	- 214	- 199	- 135	-2,702
Revised technical Baseline	14,417	15,164	14,342	14,489	14,980	16,434	15,248	16,275	13,149	16,230	14,880	17,023	182,631
Plan	11,577	12,607	12,144	12,323	12,506	13,953	13,721	15,065	11,970	13,744	12,987	14,461	150,893
% Restoration	80%	83%	85%	85%	83%	85%	90%	93%	91%	85%	87%	85%	83%
Transformation - Locum						38	36	38	35	36	35	40	258
Transformation - STIG	10	10	20	20	20								80
Transformation - ORLAU							20	20	20	10	20	20	110
Transformation - Physio Gym Class	80	76	88	88	84	88	84	88	84	80	80	92	1,012
Recruitment								85	85	85	85	85	425
Underutilisation LLP Clinics				50	50	50	50	50	50	50	50	50	450
Cancellation pre 48 hours	88	103	91	88	71	100	97	110	79	100	93	106	1,126
Lost PA's MSK Recruitment							174	183	166	174	166	191	1,054
Additional OJP to align with 19/20	241	258	192	371	401	454	251	385	394	843	282	-40	4,032
DNA reduction 1.9% improvement	34	43	36	37	27	39	39	44	32	41	35	41	448
Plan inc transformation	12,030	13,097	12,571	12,977	13,159	14,722	14,472	16,068	12,915	15,163	13,833	15,046	166,053
% Restoration	83%	86%	88%	90%	88%	90%	95%	99%	98%	93%	93%	88%	91%

- Numerous interventions agreed to support restoration
- IPC guideline changes still to be determined

Delivery trajectory - Diagnostics

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

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

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

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

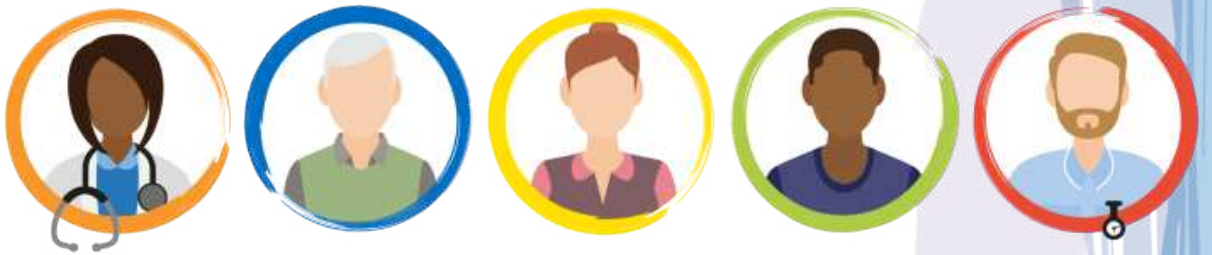
Risks to delivery

Risk Description	Consequence	Likelihood	Risk score	Risk owner	Mitigating actions
Spinal Disorders capacity risk with reliance on independent sector provision	4	4	16	Specialist Delivery Unit	The operational plan delivers proportionately higher spinal disorders activity, impacting on cases per session, however prioritising longest waiters and high risk patients. Independent sector contract for 2022/23 for 450 spinal disorders capacity, risk to delivery of 104 weeks in June. Additional mutual aid capacity being sought from NHS Providers.
System pressures necessitating further mutual aid support	4	4	16	MSK and Specialist Units	Impact seen in Month 1 with activity reduction through provision of mutual aid. Protected services and delivery of activity for patients over 90 weeks to be maintained during mutual aid support.
Staff covid isolation: - increased cancellations could impact on delivery as seen in 2021/22.	4	4	16	MSK, Specialist Clinical Support Units	Ensure ongoing compliance with IPC and testing guidelines to ensure impact is in line with other providers.

Risks to delivery

Risk Description	Consequence	Likelihood	Risk score	Risk owner	Mitigating actions
WLIs reliant on uptake and availability of staff from targeted specialties	4	3	12	MSK and Specialist Units	Delivery of the plan is based on 31% OJP rate for Electives and 10% OJP rates for outpatients. 6-4-2 meetings monitoring allocation uptake and monthly LLP meetings to review delivery against this level.
Workforce recruitment dependencies and ongoing reliance on flexible workforce	4	3	12	MSK and Specialist Units	Sustainability plans through consultant recruitment 6.5 WTE consultant recruitment planned in 2022/23.
104 weeks and 78 weeks to be balanced with clinical priority	4	3	12	MSK and Specialist Units	Currently non compliant with national standards for 0 104 at the end of June 2022 and 0 over 78 weeks at the end of March 2023. Trust processes in place to ensure clinical prioritisation in line with national guidelines. Additional capacity for long waiters sought through independent sector for spinal disorders. Further discussions taking place with regards to additional mutual aid support.
Inability to secure the necessary ERF funding, to implement the required interventions.	3	4	12	MSK, Specialist Clinical Support Units	The Operational plan is not impacted by the ERF requirements, however, our ability to restore further is dependant on securing the necessary ERF schemes, in particular, Independent sector provision, Diagnostic MRI capacity and Elective hub revenue. Ongoing review by system with escalation through DOF meetings to ensure conclusion and appropriate areas prioritised as a system for investment.
Bed occupancy reliant on improvements in length of stay	4	3	12	MSK	The operational plan requires improvements in length of stay to commence from September 2022. The implementation of the enhanced recovery programme is planned for 2022/23 to improve length of stay.
Welsh demand – Welsh demand that also requires management within system capacity with NHS England emphasis on English only activity.	3	3	9	MSK and Specialist Units	Planning assumptions are based on maintaining 19.20 apportionment of activity to ensure as a Trust we maintain equitable services. Monthly meetings with Welsh providers to ensure Welsh standards are understood and that the Trust responds to competing demands equitably.
Small number of cancer cases places risk on month on month delivery where complex pathways arise	4	2	8	Specialist Units	PTL reviews and ongoing monitoring and escalation processes in place. Complex pathways to be monitored and escalation as appropriate. If clinically appropriate, cases may ned additional diagnostics and/or complex treatment. All cases will have a harms assessment completed if over target in line with national guidance.

Financial Plan 2022/23



The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

Plan Headlines

Overall ICS deficit of £38.1m against break even requirement :

- All uncommitted cost pressures excluded - £18.6m to be re- prioritised through Investment Panel
- Elective Recovery Funding of £16.3m (subject to achieving 104%)
- COVID exceptional costs removed from June onwards
- Transformational savings of £14m from Big Ticket items
- Organisation level efficiencies of 1.6%
- Unfunded inflationary pressures of £11m

RJAH deficit of £1.6m

- Domestics business case excluded £0.2m (requires system investment panel approval)
- Elective Recovery funding of £3.2m secured to support restoration (subject to delivery of activity)
- COVID costs stepped reduction from Q2 onwards
- Transformational savings of £0.7m from MSK pathways
- Core efficiencies of 1.6%
- Inflation pressures of £0.7m

RJAH Financial Plan

Category	22/23 Plan	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income	£ 125,988	£ 8,511	£ 9,778	£ 9,503	£ 10,470	£ 10,628	£ 11,018	£ 11,132	£ 11,664	£ 9,596	£ 11,207	£ 10,436	£ 12,045
Pay	-£ 76,207	-£ 6,284	-£ 6,296	-£ 6,300	-£ 6,368	-£ 6,347	-£ 6,326	-£ 6,387	-£ 6,376	-£ 6,353	-£ 6,389	-£ 6,378	-£ 6,404
Non Pay	-£ 44,016	-£ 2,802	-£ 3,360	-£ 3,362	-£ 3,648	-£ 3,716	-£ 3,688	-£ 3,947	-£ 4,010	-£ 3,625	-£ 4,021	-£ 3,779	-£ 4,058
EBITDA	£ 5,765	-£ 574	£ 123	-£ 159	£ 454	£ 565	£ 1,005	£ 799	£ 1,278	-£ 383	£ 796	£ 279	£ 1,583
Finance Costs	-£ 7,995	-£ 644	-£ 644	-£ 644	-£ 665	-£ 663	-£ 664	-£ 666	-£ 665	-£ 666	-£ 691	-£ 690	-£ 691
Capital Donations	£ 3,300	£ 493	£ 493	£ 517	£ 484	£ 479	£ 784	£ -	£ -	£ 25	£ -	£ -	£ 25
Operational Surplus / (Deficit)	£ 1,070	-£ 725	-£ 29	-£ 286	£ 273	£ 380	£ 1,125	£ 132	£ 613	-£ 1,024	£ 105	-£ 411	£ 917
Remove Capital Donations	-£ 3,300	-£ 493	-£ 493	-£ 517	-£ 484	-£ 479	-£ 784	£ -	£ -	-£ 25	£ -	£ -	-£ 25
Add Back Donated Dep'n	£ 632	£ 50	£ 50	£ 50	£ 51	£ 52	£ 52	£ 52	£ 53	£ 53	£ 56	£ 56	£ 56
Adjusted Surplus / (Deficit)	-£ 1,598	-£ 1,168	-£ 472	-£ 753	-£ 160	-£ 47	£ 393	£ 184	£ 666	-£ 996	£ 161	-£ 355	£ 948

RJAH Capital Plan

Capital Plan	2022/23 £'m
Trust Funded Investments:	
Business Continuity	
Backlog estates maintenance	0.35
IT investment & replacement	0.30
Capital project management	0.13
Equipment replacement	0.75
Diagnostic equipment replacement plan	0.92
IPC & safety compliance	0.36
Contingency	0.50
Sub Total Business Continuity	**3.31**
Developments	
EPR planning & implementation	4.50
Invest to Save	0.20
Enhanced staff facilities	0.50
Additional Theatres x4 (For Barns Replacement)	3.00
Sub Total Developments	**8.20**
Total Trust Funded Investments	**11.51**
Externally Funded	
Donated equipment	0.10
Veterans facility	3.20
Total Externally Funded	**3.30**
Total Capital Programme	**14.81**

- The RJAH capital plan has been agreed from within a system delegated expenditure limit
- EPR funding of £4.5m ringfenced based on NHSI/E submitted business case.
- Any further funded national allocations e.g. Targeted Investment Fund, Community Diagnostic Hub, will be added to plan once confirmed.
- The plan requires investment of £3.5m of RJAH cash reserves

Cash Projection

Project Cash Balances 2022/23	£m
Opening cash balance	25.0
Impact of 22/23 Deficit	-1.6
Loan repayment	-1.5
Cash investment in capital programme	-2.0
Working capital movements	-0.7
Closing Cash Balances	19.2

- Above table shows the cash plan for the full year with opening and closing balances
- Shows continued strong cash balances despite deficit position and investment in capital programme

Risks to the Financial Plan

Risk Description	Consequence	Likelihood	Risk Score	Risk Owner	Mitigating Actions
ERF regime is complex, earnings may not cover costs	4	4	16	Finance	Favourable plan casemix against baseline should offer benefit to calculations. Costs can be influenced if needed to manage against envelope. Close dialogue with system partners to monitor system position and likelihood of funding clawback. Welsh regime TBC, may offer mitigation if additional ERF available.
Ongoing Covid costs impact – funding reduced by 75%	4	4	16	Delivery Units	Clear forecast position with step down plans for pay costs. SLG oversight of plans on a quarterly basis. IPC guidance changes reducing requirement for direct intervention.
Inflationary pressures	4	4	16	Finance	Inflationary pressures submitted to regulator – may offer financial redress or at least recognition of variances. Multiyear contracts protected from inflationary rises i.e. implants. Inflation reserve held centrally to address in year pressures.
Variable income performance pbr linked to activity delivery	4	3	12	Delivery Units	Operational plan risk mitigations address adverse performance concerns. Favourable activity performance in areas will attract additional income potentially offsetting areas of shortfall. Block income from STW & LVA agreements protects downside on 44% of overall activity levels.
Efficiency programme shortfall	4	3	12	Delivery Units	Identification of 20% contingency to manage slippage.
Workforce recruitment dependencies - slippage will drive premium backfill or adverse activity consequence	4	3	12	Delivery Units	Recruitment plans in place for nursing and consultant workforce monitored through People Committee.
Non NHS (commercial and other) income recovery to pre-pandemic levels	4	3	12	Delivery Units	Commercial activity built into operational plans. Financial plans recognise risk of full recovery on activities which require direct footfall i.e. Denbigh's.
Plan does not include contingency at organisation or system level	3	4	12	Finance	Identification of additional efficiencies. Benefits taken back to reserves in month to manage in year pressures i.e. higher than expected vacancies.

RJAH Corporate Objective 2022/23

A Reminder of our Strategy 2018-2023

Our Mission - Caring for . . . (how)

Strategic Context

NHS

Patients

Staff

Finances

Aspiring to deliver world class patient care

Our Vision

Strategic Context

NHS

To deliver world class patient care

Our Strategy (what)

Strategic Context

NHS

Specialist Orthopaedic

- Explore new markets
- Leading work to develop a chain
- National voice on our areas of expertise
- Maintain & secure our position as an excellent educator.
- Adoption of innovation & research into clinical practice
- We share learning for the benefit of the patient.

Operational Excellence

- Focus on operational detail using good data.
- Embed & standardise safe processes.
- Define data enabled transformation schemes.
- Focus on unwarranted variation & waste, drive efficiency & value to ensure sustainability.
- Be as safe as we can,
- We organise ourselves to have real operational grip.

Local MSK Services

- Not relevant to relevant.
- Divorced from the system to part of the system.
- Consumer of resources to management of demand.
- Exclusive specialist to underwriter of quality of care in the system.
- Ad hoc private to long term contractual model.
- Short term Welsh fixer to long term expert & partner.
- Orthopaedic to MSK/Orthopaedic
- Stayed to innovation & creative.

Culture and Leadership

- We are an extraordinary place to work.
- We develop our people to realise their potential.
- Clinically led organisation.
- Rebuilding relationships.
- Structured team development.
- Investing in leaders and aspiring leaders.
- Focused support for first line management.
- Refine service improvement method & capability

ss patient care

Corporate Objectives 2022/23

Strategic Context

NHS

Aspiring to deliver world class patient care

Key Strategic Priorities

The Trust's overarching corporate objectives for 2022/23 are:

- Develop and maintain safe services
- Further develop the veterans service to ensure it is established as a centre of Excellence
- Support MSK integration across the system
- Optimise the potential of digital technologies to transform the care of patients and their outcomes
- Maintaining statutory and regulatory compliance

Each overarching corporate objective is underpinned by further, more detailed objectives and description of how success will be measured. The objectives will be monitored through a quarterly update to Board, together with the alignment of our key performance indicators within the integrated performance report, which is reported monthly to the Board. Assurance is managed through the board assurance framework.

1. Developing and Maintaining Safe Services

Our mission	How we will do it	Measure
Caring for Patients	Undertake full service reviews to include specialised commissioning to ensure we have the right services to serve our patients	• Service Review programme agreed by the end of Q1. • Delivery of 2022/23 service reviews in line with agreed service review programme.
	Development of a specialist revision knee service	• Service specification and resource requirements presented to FPD. • Implementation of the service specification requirements agreed by March 2023.
	Securing robust and sustainable microbiology support	• Service specification agreed with service provider. • Trust membership on the N8 pathology network
	Further developing equality and inclusion initiatives for patients	• Delivery of Inclusion Action Plan
Caring for staff	Recruiting and retaining staff to ensure we have the right staff, in the right place at the right time	Delivery of key KPIs in our 2022/23 workforce plan: • Nursing vacancy rate: 7.2% • Medical vacancy rate: 2.5% • HCSW vacancy rate: 0% • Staff Turnover: 8%
	Further developing equality and inclusion initiatives for staff	• Delivery of Inclusion Action Plan • Staff survey results
Caring for Finances	Review of funding models and service line reporting to ensure robust financial management	• Service line reports presented to FPD Committee.

2 Develop our Veterans service to ensure it is established as a centre of excellence

Our mission	How we will do it	Measure
Caring for Patients	Develop a communications, marketing and branding strategy aimed at enhancing links with key stakeholders	• Communication, Marketing and Branding in place
	Maintain Veteran accreditation and explore other relevant accreditation opportunities	• Veteran accreditation maintained • Additional accreditation application opportunities reviewed and progressed
Caring for staff	Identification and utilisation of key recruitment links for the Veterans service	• Phase 2 business case has supporting recruitment strategy in place
	Roll out of Veterans awareness training	• Staff training to include Veterans awareness training for relevant staff
Caring for finances	Sustainable funding model to be agreed to optimise further investment opportunities	• Business case presented to FPD on phase 2 for the Veterans service
	Programme of review to ensure best use of resource	• Deliver to agreed timescales and budget

3 Support MSK integration across the system

Our mission	How we will do it	Measure
Caring for patients	Leading the MSK Transformation Board and contributing to the delivery of the transformation programme	• MSK transformation Board Chair's reports presented to FPD committee
	Standardising pathways and access for patients Levelling up of outcomes for patients across all providers	• Standardised pathways to be implemented in line with MSK Transformation board implementation programme • NJR outcomes • PROMs • GIRFT metrics • Model Hospital data • Agreed MSK OD strategy in place for system providers
Caring for staff	Integrated OD solution for MSK providers in the system	
	Enhancement of non-medical roles	• Standardised pathways for integrated care. • Introduction of enhanced roles and new non-medical roles into MSK services.
Caring for Finances	Delivery of efficiencies outlined in the ICS plan	• Transformation programme delivered to timescales. • Achievement of 2022/23 efficiency target

4 Optimise the potential of digital technologies to transform the care of patients and their outcomes

Our mission	How we will do it	Measure
Caring for Patients	Continue to develop patient facing apps to optimise patient outcomes and explore the use of artificial intelligence (AI).	• Roll out of My Recovery app to agreed clinical pathways • Complete review of new technologies • Business cases for investments presented to FPD as appropriate
Caring for Staff	Programme of education for staff on digital awareness	• Development of appropriate training & awareness programme and demonstrate staff uptake and compliance
Caring for Finances	Commence delivery of the next stages of the EPR programme, ensuring processes are reviewed to improve workflows and outcomes	• Deliver to agreed timescales and budget. • Reports and oversight through FPD Committee

5 Maintaining statutory and regulatory compliance

Our mission	How we will do it	Measure
Caring for Patients	Progress towards full compliance with accessible information standard to coincide with EPR programme	• Accessible information standards compliance included in ERP implementation programme.
	Maintaining CQC rating	• Trust CQC Action plan and preparedness plans monitored through Quality and Safety Committee • Trust CQC rating
	Delivery of IPC Improvement Programme	• Delivery of IPC Improvement plan to agreed timescales • Monitored through internal IPCC, IPC Quality Assurance Committee with system oversight at the STW System Quality Group
	Compliance with ED&I requirements	• Compliance with Regulatory requirements evidenced through Trust regulatory submissions and declarations reported to Trust Board.
Caring for Staff	Compliance with ED&I requirements	• Compliance with Regulatory requirements evidenced through Trust regulatory submissions and declarations reported to Trust Board.
Caring for Finances	Delivery of Financial Plan	• Deliver Trust financial plan budget by 31st March 2023 • Deliver Trust efficiency programme • Ensure activity delivery plan is managed within available sources of funding
	Improve System Oversight Framework rating from SOF3 to SOF2.	• Trust improvement plan in place and delivering to agreed timescales.

Risk Appetite and Tolerance

0. Reference Information

Author:	Shelley Ramtuhul, Trust Secretary	Paper date:	4 May 2022
Executive Sponsor:	Stacey Keegan, Interim Chief Executive	Paper Category:	Governance
Paper Reviewed by:	Audit and Risk Committee – 11/10/2021	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board is asked to consider the risk appetite and tolerance which was considered by the Audit and Risk Committee in October 2021.

2. Executive Summary

2.1. Context

The Board considers its risk appetite and tolerance on an annual basis to ensure it remains up to date and aligned to the Trust's requirements.

2.2 Summary

This paper presents the risk appetite and tolerance as agreed by the Board last year and there are no recommendations to alter these for the year ahead.

2.3. Conclusion

The Board is asked to consider and approve the risk appetite and tolerance statements for the organisation.

Risk Appetite and Tolerance

3. Main Report

3.1. Risk Appetite

Risk appetite is defined by the Institute of Risk Management as 'the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives'.

It is recognised best practice for organisations to clearly define their risk appetite to ensure there is an appropriate balance between uncontrolled innovation and excessive caution. It can serve as a guide to staff on the level of risk permitted and encourage consistency of approach.

The appetite agreed in October 2021 is set out at Appendix One. This is a nationally recognised risk appetite matrix published by the Good Governance Institute and adopted across a large number of NHS organisations.

The recommendation is for the appetite to remain unchanged at this time.

3.2 Risk Tolerance

Risk tolerance is the level of risk that is acceptable to the Trust once a risk has been identified. It is equally important that this is clearly defined for staff as it then prevents resources from being spent on further reducing risks that are already an acceptable level to the organisation

The table below outlines the risk tolerance agreed in October 2021. It should be noted that the types of risk cited align to those outlined in the risk appetite matrix with the exception of the innovation and quality risks. In 2018 it was decided that these should be separated out as the tolerance for innovation risk was higher than that for risks to quality and this remains in place.

It is proposed that all tolerances remain unchanged and that the split of tolerance for compliance / regulation risks remains. This is in recognition that the Trust should have a low tolerance for non-compliance but that instances could arise in the current restoration climate where clinical safety and prioritisation may result in a conscious non-compliance. In such circumstances a moderate tolerance could be adopted provided the Trust's usual governance has been followed in accepting the non-compliance e.g treatment of patient in order of clinical priority result in non-compliance with referral to treatment targets. This is covered in the proposed footnote to the tolerance table.

Type of Risk	Risk Score	Rationale
Financial Risk / VfM	Low	Achieving the financial balance of the Trust is both a strategic priority and a statutory duty. Therefore the Trust will rarely accept any risk that (if realised) will threaten this.
Value for Money	Low	The Trust has a statutory duty to ensure that public resources are safeguarded and its expenditure is in accordance with due process. The Trust can therefore only accept low risk in relation to this.
Compliance / Regulation	Low/Moderate	The Trust will comply with all applicable legislation and will rarely accept any risk which (if realised) would result in non-compliance*.
Innovation	Moderate	The Trust encourages a culture of innovation and is willing to accept risks associated with this approach

Risk Appetite and Tolerance

		where they do not threaten areas that the Trust is not prepared to accept (as defined in this table).
Quality / Outcomes	Very Low	We hold patient and staff safety in the highest regard and will not accept any risks that threaten this. The Trust will provide high quality services for our patients. We will not accept risks which threaten that goal.
Reputation	Low	The Trust will maintain high standards of conduct and will rarely accept risks that may cause reputational harm because it could undermine public and stakeholder confidence.

*A moderate tolerance can only be accepted where the non-compliance arises from a clinical safety risk and the non-compliance is approved through the Trust's governance routes

3.2. Conclusion

The Board is asked to consider and approve the risk appetite and tolerance statements for the organisation.

Risk Appetite and Tolerance

Appendix One: Assessment of Trust's Risk Appetite Against the 'Risk Appetite for NHS Organisations Matrix

Key Elements ↓	Risk Levels					
	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a key organisational objective	**Minimal** As little risk as possible. Preference for ultra-safe delivery options with low degree of risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and response systems are robust
Financial / Value for Money (VfM)	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of limited financial loss. VfM still the primary concern but will consider other benefits of constraints. Resources generally restricted to existing commitments.	**Recommended** Prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits considered. Resources allocated to capitalise opportunities.	Investing in best possible return and accept the possibility of financial loss (with controls in place). Resources allocated without guarantee of return – 'investment capital' type approach	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself
Compliance / Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances	**Recommended** Limited tolerance for sticking neck out. Want to be reasonably sure we would win any challenge	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
Innovation / Quality / Outcomes	Defensive approach to objectives – aim to maintain/protect, rather than create or innovate. Tight management controls and oversight / limited devolved decision taking authority. General avoidance of systems / technology developments	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority is held by senior management. Only essential systems / technology developments to protect current operations	Tendency to stick to the status quo, innovations in practice avoided unless necessary. Decision making authority held by senior management. Systems / technology developments limited to protection of current operations.	**Recommended** Innovation supported, with demonstration of commensurate management control improvements. Systems / technology developments used to enable operational delivery. Responsibility for non-critical decisions may be devolved	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control	Innovation the priority – consistently 'breaking the mould' / challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust not tight control is standard.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation is viewed as a concern	Tolerance for risk taking limited to events where there is no chance of significant repercussions. Senior management distant from chance of exposure to attention	Tolerance for risk taking limited to events where there is no chance of significant repercussions. Should there be failure. Mitigations in place for undue interest	**Recommended** Appetite to take decisions with potential to expose the Trust to additional scrutiny/interest. Prospective management of organisations reputation	Willingness to take decisions likely to bring scrutiny but where potential benefits outweigh risks. New ideas seen as potentially enhancing reputation	Track record / investment in communications has built public, press and politician confidence that difficult decisions will be taken following benefits / risk analysis