The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors (Public) 23.09.2021

MEETING
23 September 2021 09:30

PUBLISHED
21 September 2021

Agenda

Location	*Date*	*Owner*	*Time*
Teams	23/09/21		09:30
1. Part One - Public Meeting			09:30
1.1. Declarations of Interest		Chair	
1.2. Minutes of the Previous Meeting (July 2021)		Chair	
1.3. Matters Arising		Chair	
2. Presentations			
2.1. Patient Story		Chief Nurse and Patient Safety Officer	09:35
2.2. Staff Story - The vital role of Specialist doctors in the NHS		Chief Medical Officer	09:45
3. Chief Executive Update (verbal)		Chief Executive	09:55
4. Quality & Safety			
4.1. Chair Report: Quality and Safety Committee		Non Executive Director	10:05
4.2. Infection Control Annual Report		Chief Nurse and Patient Safety Officer	10:10
5. People Update			
5.1. Chair Report: People Committee		Non Executive Director	10:20
5.2. Guardian of Safe Working Hours Update		Chief Medical Officer	10:25
5.3. Freedom to Speak Up Annual Report		Chief People Officer	10:30

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Teams	23/09/21		09:30
6. Performance & Governance			
6.1. Chair Report: Extra Ordinary Audit Committee		Non Executive Director	10:35
6.2. Chair Report: Finance, Planning and Digital Committee		Non Executive Director	10:40
6.3. Performance Report		Chief Performance, Improvement and OD Officer	10:45
6.4. System Oversight Framework		Chief Performance, Improvement and OD Officer	10:55
6.5. Well Led Review		Trust Secretary/Director of Governance	11:00
6.6. Governors Update (verbal)		Trust Secretary/Director of Governance	11:10
7. Any Other Business		All	11:15
7.1. Questions from the Public			
8. Next meeting: 28th October 2021			

Contents

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust
Frank Collins ☎ 4358
Chairman

BOARD OF DIRECTORS – PUBLIC BOARD
29 JULY 2021
MINUTES OF MEETING

Present:

Frank Collins	Chairman	FC
Mark Brandreth	Chief Executive Officer	MB
Stacey-Lea Keegan	Chief Nurse and Patient Safety Officer	SK
Craig Macbeth	Chief Finance and Planning Officer	CM
Ibrahim Roushdi	Associate Chief Medical Officer	IR
Kerry Robinson	Chief Improvement, Performance and OD Officer	KR
Rachel Hopwood	Non-Executive Director	RH
Paul Kingston	Non-Executive Director	PK
Chris Beacock	Non-Executive Director	CB
David Gilburt	Non-Executive Director	DG

In Attendance:

Shelley Ramtuhul	Trust Secretary	SR
Sarah Sheppard	Chief People Officer	SS
Hilary Pepler	Board Advisor	HP
Sara Ellis Anderson	Chief of Professions	SEA

FC welcomed everyone to the meeting.

MINUTE NO	TITLE
29/07/1.0	**APOLOGIES** Harry Turner, Non-Executive Director and Ruth Longfellow, Chief Medical Officer. FC welcomed the following attendees: • Ibs Roushdi, Associate Medical Officer who attended the meeting on behalf of Ruth Longfellow. • Sara Ellis Anderson, Chief of Professions who will be joining the Board of Directors as Interim Chief Nurse and Patient Safety Officer as of August 2021.
29/07/2.0	**MINUTES OF PREVIOUS MEETING** The minutes of the previous meeting were agreed as an accurate reflection of the meeting.
29/07/3.0	**MATTERS ARISING** None to note – all matters were tabled for discussion throughout the meeting.
29/07/4.0	**DECLARATIONS OF INTEREST** PK informed the Board that he has accepted the position of Interim Independent Chair for the Richmond and Wandsworth for their Safeguarding Partnership.
29/07/5.0	**STAFF STORY – COVID-19 MURAL** SK introduced and welcomed Caroline Stewart, Clinical Engineer and ORLAU Manger who has joined the meeting to present the work completed in the earlier stages of the pandemic relating to staff experience both at work and home. Caroline's presentation highlighted the following: • Shared a quote from Lord Kelvin which initiated the purpose of capturing staff feedback • 15 staff members kept a diary of living with Covid-19 and was prompted to share experiences following questions • The feedback was processed formally and anonymised as the diary entries were kept confidential

	• Thematic analysis was used which uses emotions, opinions, and observations to recognise themes and patterns • Inequalities, stress, ethics, guilt, identity, and communication were just some of the key areas • A mural was created and developed by the project group – this is found in the main corridor • Caroline's personal reflections included the need to be flexible, methodologies exist without number/figures, the importance of storytelling and understanding boundaries FC thanked Caroline for the presentation and the work completed to portray staff experiences. It has highlighted key areas for the Board consideration relating to the ways of working and supporting staff. SS thanked Caroline for the presentation and explained that as one of the 15 staff members who participating in the project, had found the experience therapeutic. SS highlighted that the experience at the beginning of Covid-19 is different to today. It was noted that SS thought there was a richness to the feedback which cannot be portrayed through the regular staff survey and suggested if there is a way of using this method to support a change in culture. Caroline agreed that non structure story telling is powerful and highlighted the importance of confidentiality to ensure people feel safe when sharing their experience. KR thanked the project team for allowing her to be part of the project. KR informed the Board that the Trust is looking into new ways of receiving feedback from staff including focus groups and forums. FC encouraged the project team to publish the findings to publications wider than the organisation. PK suggested that the Trust consider poets/artist in residence to illuminate staff stories. The feedback from the assurance committees and the Trust has emphasised the value of the project. FC asked Caroline to share thanks from the board to all who contributed into the project.
29/07/6.0	**ARTHROPLASTY OUTCOMES** MB introduced and welcomed Geraint Thomas who joined the meeting to present information on outcomes on total hip replacements (THR). Geraint's' presentation highlighted the following: • Shared the three results which matter the most to patients, these include relief of pain, improved function/mobility, and restored quality of life • Shropshire is in the higher quartile of the delivering improvement • The Trust is a positive outlier in comparison to other Orthopaedics Hospitals • Shared funnel charts to show the average primary THR score change • A total of 6 surgeries are within the top 0.2% of the country • Length of stay data reports the Trust as average against other hospitals • Readmission's data reports the Trust as below average against other hospitals • Geraint shared some personal data • Results are outstanding for the Trusts • Rapid Recovery is safe, effective and requires support MB queried the reduced length of stay data and questioned the difference between surgical technique and anaesthetic intervention. Geraint highlighted the importance of preparing the patients and understanding their expectations of their operation and care.

	Overall, there are no changes for operational technique as there is no known significant techniques compared to others in the Trust. Geraint suggested there having a regular anaesthetic and consultant has supported the length of stay. CB thanked Geraint for the presentation and noted the point relating to a team approach is key to a patient's recovery. CB questioned whether the approach could be rolled out to other areas to include total knee replacements. Geraint informed the Board that the average length of stay for a total knee patient is 4.1 days and a hip is 3.9 days which he believes can be reduced. FC noted the fascinating presentation and questioned whether volume was a variable within the data. Geraint explained the confidence interval decreases within the lower volumes which are reported. Those who are reported as a lower volume is due to being newer to the Trust and not having as much data recorded. The average volume of hips completed and reported to NHS nationally is 69 compared to the average within the Trust is 169. Geraint asked the Board for support in embedding the rapid recovery across the organisation and within other sub-specialities. FC thanked Geraint for his time and welcomed another presentation in the future.
29/07/7.0	**CHIEF EXECUTIVE UPDATE** Firstly, MB welcomed and congratulated Sir Neil Mckay who has been appointed as the Chair of STW ICS. MB recognised the pressure the NHS is under with still living with Covid-19. There has been a noted increase within mental health services, A&E, ambulances, and primary care. The Trust continue to support partners within the system and continue to lead all orthopaedics work within the system MB thanked colleagues for their continued support and involvement with regards to the sustainability within the system, another workshop is scheduled for September. The vaccination programme continues, it has been noted that the patients who are admitted to hospital are usually those who have either not had the vaccine or only received one injection. The Trusts vaccination centre continues to offer walk in clinics. It is anticipated that there will be a requirement to vaccinate staff with a booster injection in the autumn. MB thanked patients and staff for their support following the relaxation of the rules on the 19th July. The Trust is a green site and MB highlighted the importance of following the guidelines in order to keep our patients and staff safe. MB acknowledged the few occasions when staff have breached the PPE whilst onsite. MB assured the Board each occasion had been dealt with immediately and is noted as accidental. MB and FC attended the long service awards at the Lion Quays where staff members celebrated their 30 years' service within the NHS. A health hero lunch was arranged for all the past health hero winners. MB encouraged the Board to watch the Marie Carter Presentation on the history of the Hospital. The presentation will be circulated via social media. Lastly, MB thanked the League of Friends for arranging the festival on the field and the ice cream van which is due on site this afternoon.
29/07/8.0	**CHAIR REPORT - QUALITY AND SAFETY COMMITTEE** CB presented the Quality and Safety Assurance Report and highlighted the following:

	• Since the last board meeting, the Quality and Safety accepted and considered the Quality Account which will be submitted and thanked the staff for their hard work at a difficult time • There have been 2 recent audits on pressure ulcers, and it was agreed a combined action plan will be created • There has been concerns relating to the harms review and process. CB confirmed there is a robust policy now in place which provides significant assurance • A quality report was received from specialised support services and MSK unit – no concerns were raised The Board noted the assurance report.
29/07/9.0	**LEARNING FROM DEATHS** IR informed the Board that there have been zero deaths recorded within quarter one. The team are looking into ways of sharing learning within the system. FC highlighted the importance of the paper which often reports no deaths. The Board noted the report.
29/07/10.0	**CONTROLLED DRUG AND ACCOUNTABLE OFFICER ANNUAL REPORT** SK presented the annual report for 2020/21 which has been reviewed by the Quality and Safety Committee earlier in the month. The report provides assurance to the Board that the Trust manages controlled drugs inline with the CQC, controlled drug intelligence and Department of Health legislation. Its was noted there are no concerns to be raised. The Board noted the annual report.
29/07/11.0	**SAFEGUARDING ANNUAL REPORT** SK presented the annual report for 2020/21 which has been reviewed by the Quality and Safety Committee earlier in the month. The report provides an overview of the work undertaken in relation to children and young people safeguarding. SK highlighted the following key areas: • Non-compliance with reporting with level 3 adult safeguarding training – there has been a lack of e-learning platform nationally. There are mitigations in place to ensure there is always a level 3 complaint staff member working within the Trust. It was noted that 57% of staff completed some level 3 training within the past 12 months. A new provided has been established • Excellent progress has been noted in relation to relation to associate policies in safeguarding • Resources of the safeguarding team including the skill set within the team • Mental health resilience and learning disability & autism work has commenced The Board commented on the disappointing training compliance and noted the annual report.
29/07/12.0	**CHAIR REPORT – PEOPLE COMMITTEE** PK presented the People Assurance Report and highlighted the following: • The meeting was well attended and quorate • Considered the Committee self-assessment and annual report ahead of presentation at the Audit Committee • Reviewed an update on the consultant capacity which is a continues project • A total of 3 policies were approved • There were no concerns raised The Board noted the assurance report.
29/07/13.0	**DIGITAL TRANSFORMATION – STRATEGY UPDATE**

	SA provided an update following the Strategy Board in June. In summary there was a main discussion relating to the shared consensuses that digital isn't just about technology but the interaction with people and the importance of engagement when creating the digital strategy. The Board noted the report.
29/07/14.0	**CHAIR REPORT – AUDIT COMMITTEE** DG presented the Audit Assurance Report and highlighted the following: • Two joint audit and quality and safety committees were held in June • The committee received the head of internal audit opinion – moderate assurance was reported. • Approved the internal audit annual report, annual governance statement and the letter of representation • The Trust is awaiting the values for money report which is to be presented by external audit – due to be completed by the end of the month. An extra-ordinary meeting will be scheduled for August to receive the report The Board noted the assurance report.
29/07/15.0	**AUDIT AND RISK COMMITTEE AMALGAMATION** SR presented the paper which sets out the rationale for the decision to amalgamate the Audit and Risk Management Committee. SR confirmed that both Committees have approved the proposal. FC thanked SR for the update and noted the discussions which have been held in other forums. The Board approved the proposal to amalgamate the Audit and Risk Management Committees.
29/07/16.0	**CHAIR REPORT – FINANCE, PLANNING AND DIGITAL COMMITTEE** RH presented the Finance, Planning and Digital Assurance Report and highlighted the following: • Received the financial system recovery plan • Restoration update was received an going forward will be incorporated into the performance report • Received an update on net zero emission target and encourage colleagues to read the paper • Continue the Unit deep dives with a presentation from the MSK unit The Board noted the assurance report.
29/07/17.0	**PERFORMANCE REPORT – MONTH 3** KR confirmed that the assurance committee have received and approved their remit of the report along with any actions. Following from the recent development session with NHSE/I, the following amendment have been incorporated: • the finance information will be presented in line graphs • the control range of those KPIs that have been affected by Covid-19 have been adjusted, with a step change being introduced • the data quality ratings have been updated following an audit KR explained that as per previous months, the statutory targets of 18, 52, 6 and 8 weeks will continue not to be met due to pausing elective services through Covid-19. The Trust is meeting the regulatory target of 80% across all points of delivery. Therefore, assurance can be provided on meeting the activity targets and actions in place.

	It was noted there were no exception reporting with the People KPIs. SK informed the Board that there was one serious incident reported in June – an unexpected patient deterioration during surgery. The patient continues to recover well at home. SK reminded the Board the incident will be investigated following the usual governance process. A formal report will be presented to the Quality and Safety Committee. SK also highlighted the increase in complaints, there were a total of 17 formal complaints received throughout June. It was noted that there has been an increase in patients' complaints relating to waiting times. The patient experience committee are reviewing communication links. CM gave an overview of the Trusts finance performance report and highlighted the following: • H1 plan – the Trust is above plan and £600k ahead of target • The Trust achieved the 1% delivery efficiency • Forecasting £1m – further information relating to the elective recovery is to be received • The sustainability plan remains a key focus – a 3% efficiency target is required DF gave a summary of the overall performance: • Cancer Pathways - Met all cancer targets • 18/52 RTT weeks - Performance was recorded at 58.10% against the 92% open pathways • Continue to balance patients between the clinical prioritisation with the long waiters • Continue to review the priority of patients and harms assessments as appropriate • Continue to provide mutal aid to local providers • Spinal disorders patients are a large portion of the 52+week patients • Bed occupancy rate was reported at 73.7% - a new model is being developed • MRI activity has continued to increase in month • Significant improvement in CT and ultrasound with no breaches • 6 newly recruited radiographers will be in post by the end of September • CT mutal aid with SaTH has commenced – a total of 60 patients have been transferred to RJAH • The 80% NHSE/I target was met across all delivery points within core capacity • The percentage of long waiters continue to reduce FC queried the bed occupancy in the month of June, KR explained an extra 12 beds were opened – this is under review. MB acknowledged the in-job plan activity which in Q1 which will not be expected going forward due to annual leave. SS agreed with MBs comment and explained the managing directors continue to work closely to the consultant to monitor. FC thanked the Trust for the update and the Board noted the report.
29/07/18.0	**BOARD ASSURANCE FRAMEWORK** SR presented the Board Assurance Framework which has been reviewed by the relevant committee. SR highlighted the two risks which have reduced, these relate to the capital programme and EPRR. The Board approved the Board Assurance Framework.
29/07/19.0	**GOVERNORS UPDATE** SR provided an overview on the Governors activity since May, highlighting the following:

	• Re-started the Governor surgery • Involvement in the recruitment of a Non-Executive Director and an associate Non-Executive Director • Involved in the recruitment process for the CEO and Chair FC thanked SR for the update.
29/07/20.0	**ITEMS TO NOTE** The Board noted the following items: • Performance Report (Month 2)
29/07/21.0	**ANY OTHER BUSINESS** *CEO Recruitment* FC advised the Board that there was a decision not to appoint following the formal CEO interviews and thanked those all involved. A new process of recruitment will begin in October. *Attendance* It was acknowledged that it is last meeting for Jan Greasley as Lead Governor and William Greenwood will commence his role. FC welcomed Simon Jones, Collete Gribble and Phil White as newly elected Governors. *Farewell to Mark Brandreth* FC and the Board acknowledged the time and contribution MB has given over the past 5 years. A farewell presentation is scheduled for this afternoon.
29/07/22.0	**QUESTIONS FROM THE PUBLIC** None to note
	DATE OF NEXT MEETING IN PUBLIC: Thursday 23rd September at 9:30am via Teams
	CHAIRMAN'S CLOSING REMARKS FC thanked everyone for their contribution and closed the meeting.

29 JULY 2021

SUMMARY OF KEY ACTIONS

Outstanding Actions from Previous Meetings	Lead Responsibility	Progress
Actions from Last Meeting	**Lead Responsibility**	**Progress**

Role of SAS doctors

Dr Prasanth Kandepalli

23/09/2021

SAS Doctors

- **S**taff grade, **A**ssociate specialist and **S**pecialty doctors
- At least **four** years of postgraduate training - two of which are in a relevant specialty
- Diverse group with individual and often highly specialised skills
- Essential part of the medical workforce
- Focus predominantly on providing direct patient care and less on the non-clinical responsibilities
- Teaching, service development, research, management and leadership

SAS doctors

- SAS doctors are confident and competent healthcare professionals delivering clinical services in partnership with consultants and other health care workers

- We also provide significant contributions in areas of leadership, research and governance

SAS Doctors

- work more flexibly to service needs
- work in a specific geographical location without having to rotate to different units
- work in a subspecialty which suits us
- optimise our work-life balance, as the hours may be more regular than for trainees or consultants

SAS Doctors

Historically SAS doctors' role and expertise have been under recognised and undervalued

However our trust has been helpful in supporting our training and CPD (Continuous professional development) needs

We work at a level commensurate with our competence and experience, seeking assistance where appropriate

We have been receiving supervision and support with our clinical supervisor on a continuous basis

Our trust contracts of employment have adhered to national terms

Trust role in supporting professional activities

- Allocated sessions for

  -education

  -audit

  -appraisal

  -teaching

- Frequent and very easy access to our clinical lead, Dr Ho

- Study leave budget

- Our role is acknowledged and respected by all colleagues in the trust

SAS doctors Oncall rota at RJAH

3 Specialty doctors and 3 Associate Specialists

2 x 12 hour shifts per day – 7 days a week

GP trainee covers one day oncall (Tuesday 9am-9pm) a week

Rest of the oncalls are split between 6 SAS doctors

2 SAS doctors participate as 1 person in the oncall rota

Hence a total of 5 SAS doctors participate in the oncall rota

Oncall rota

1 of the SAS doctors (who has retired and come back after retirement but does full oncall rota) has opted only to do day oncalls only. Rest of the other SAS doctors share this doctor's night shifts

We cover perioperative wards oncall from 9am to 9am. From 7pm till 9am, we also cover Sheldon and Spinal injuries rehab units in addition to perioperative wards

3 SAS doctors cover weekly OP clinic on a prospective basis

My journey

- MBBS (1995) (India)
- MD (General Medicine) (2000) (India)
- Cardiology (2000-2003) (India)
- Renal Medicine (2003 -2006) - On arrival to the UK – Renal SHO and Registrar
- MRCP (2005) (UK)
- Now presently working in Geriatric Medicine and perioperative medicine as an Associate Specialist.

My role

Chair weekly medical teaching meetings

Participate in committee meetings

- Multidisciplinary Audit Committee
- Local Negotiating Committee
- Its Just Cricket Network (previously BAME)
- Equality, Diversity & Inclusion Sub-Committee

Formulate hospital protocols for common medical conditions

Thank you

Any questions?

Chair Assurance Report
Quality and Safety Committee – 16 September 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	23 September 2021
Director Sponsor:	Chris Beacock, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper provides an outline of the Quality and Safety Committee Agenda for the meeting of 16th September 2021. This will support the verbal report provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1 Context

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

2.2 Summary

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

2.3. Conclusion

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

Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	16/09/21		14:00
1. Introduction			14:00
1.1. Apologies		All	
1.2. Minutes from the previous meeting		Chris Beacock	
1.3. Action Log / Matters Arising		Chris Beacock	
1.4. Declaration of Interests		All	
2. Caring for Patients			
2.1. Serious Incidents, Never Events & Learning from Incidents		Ash Donohoe-Harrison	14:05
2.2. Harms Review Presentation		Alyson Jordan	14:10
2.3. 104+ Weeks and Clinical Prioritisation Balance		Alyson Jordan	14:15
2.4. PROMS Report		Ibs Roushdi	14:25
2.5. Infection Control MRSA Outbreak Action Plan		Sara Ellis Anderson	14:30
3. Governance			
3.1. Infection Control Board Assurance Framework		Sara Ellis Anderson	14:40
3.2. Infection Control Governance Review		Shelley Ramtuhul	14:45
3.3. Board Assurance Framework		Shelley Ramtuhul	14:50
3.4. Performance Report M5 (verbal)		Sara Ellis Anderson	14:55
3.5. Specialist Services Quality Report		Nicki Bellinger	15:00
3.6. WHO Process (verbal)		Ibs Roushdi	15:10
4. Internal Audit			
4.1. Pressure Ulcer Report		Julie Beaumont	15:15

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Agenda

Location	*Date*	*Owner*	*Time*
Teams Meeting	16/09/21		14:00

5. Policy/Strategy		
5.1. Food and Hydration Strategy	Sian Langford	15:20
5.2. Claims Policy	Ash Donohoe-Harrison	15:25
6. Annual Reports		
6.1. Infection Control	Sue Sayles	15:30
6.2. Drugs and Therapeutics Committee	Huw Jones	15:35
7. Items to Note:		15:40
7.1. Performance Report M4	Sara Ellis Anderson	
7.2. Chair Report		
7.2.1. Clinical Effectiveness Committee	Ibs Roushdi	
7.2.2. Patient Safety Committee	Sara Ellis Anderson	
7.2.3. Research Committee	Claire Wright	
7.2.4. Infection Control Committee	Sara Ellis Anderson	
7.2.5. Trust Improvement and OD Committee	Sara Ellis Anderson	
7.3. Review of the Work Plan	Shelley Ramtuhul	
7.3.1. Attendance Matrix		
8. Any Other Business		
8.1. Next Meeting: 14th October 2021		

Infection Prevention & Control & Cleanliness Annual Report 2020/21

0.0 Reference Information

Author:	Sue Sayles, Infection Control Nurse Phil Davies, Head of Estates and Facilities	Paper date:	23 September 2021
Executive Sponsor:	Sara Ellis Anderson, Interim Chief Nurse and Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	Quality and Safety Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?
The Infection Control Annual Report is presented to the Board of Directors for assureance purposed following consideration and noting at the Quality and Safety Committee on 16th September 2021.

2. Executive Summary

2.1. Context

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

2.2. Summary

Despite the impact of dealing with the global pandemic of COVID-19 2020/21 was another year of improvements in the continuing campaign to reduce avoidable Health Care Associated Infections (HCAI) at the RJAH Orthopaedic NHS Foundation Trust (See Figure 1).

Successes included:

- The prevention and control of COVID-19
- Meeting our MRSA bacteraemia target of zero for the fifteenth year.
- No cases of C.*difficile* infection.
- 33.3% Reduction in HCAI reportable infections
- 30% Reduction in needle stick injuries

The increased flu vaccination uptake of 82.96% from 66.38% during 2020/21 against a national target of 90%, demonstrated the hard work of our lead Practice Nurse Facilitator to raise awareness of the benefits of the flu vaccination whilst working alongside Team Prevent and additional nurse vaccinators, improving the accessibility and availability of the flu vaccine to all staff.

The work of the IPC Team was significantly impacted by the COVID-19 pandemic from mid March 2020. RJAH implemented and responsded to national guidance and recommendations in ceasing elective work reconfiguring acute services with orthopaedic trauma capacity.

2.3. Conclusion

The Board is asked to:

(a) To note the report

(b) To discuss and determine actions as appropriate

Figure 1

3. The Main Report

3.1. Introduction

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

Health & Social Care Act Code of Practice

The Robert Jones & Agnes Hunt Orthopaedic Hospital has registered with the Care Quality Commission and have acknowledged full compliance with the Health and Social Care Act (2008) Code of Practice (commonly known as the Hygiene Code).

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

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

IPC Structure

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

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

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

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

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

The ICD reports to the DIPC on IPC matters.

The Infection Prevention and Control Team (IPCT)

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

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

- Infection Prevention and Control (IP&C) Lead Nurse: (1 WTE) Band 7
- Infection Prevention & Control Nurse Specialist: (1 WTE) Band 6
- Surgical Site Surveillance Nurse: (0.4 WTE) Band 5
- Surgical Site Surveillance Nurse: (0.6 WTE) Band 5 (Current vacancy)
- Infection Control Analyst (0.8 WTE): Band 4
- The Infection Control Doctor (0.4 WTE)
- Infection Prevention & Control Modern Apprenice (1 WTE)

A successful business case resulted in the appointment of an additional band 6 Infection Control Nurse Speacilist, a band 5 Surgical Site Surveillance Nurse and a full time Infection Control Administration Apprentice

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

The Antimicrobial Pharmacist

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

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

Infection Prevention Control Committee

The RJAH Infection Prevention & Control Committee (IPCC) is a multidisciplinary Trust committee with outside representation from Public Health England and the CCG. The IPCC oversees the activity of the IPCT and supervises the implementation of the infection control programme of work. The IPCC met every 3 months during 2020/2021. Extra ordinary meetings were arranged in May 2020 and January 2021 in response to changes in guidance for managing COVID-19.

Attendance at IPCC

	Apr 2020	*July 2020*	*Oct 2020*	*Jan 2021*
DIPC	✓	✓	✓	✓
ICD	✓	✓	✓	✓
IPCN	✓	✓	✓	✓
Ass. DON	✓	✓	✓	*apol*
Antimicrobial Pharmacist	✓	*apol*	*apol*	✓
Facilities Manager (Estates & Facilities Representation)	✓	✓	✓	✓
Matron (Medicine)	✓	✓	*apol*	*apol*
Matron (Surgery)	✓	✓	*apol*	✓
Matron (Theatre & OPD)	✓	✓	✓	*apol*
Theatre Manager	*apol*	*apol*	*apol*	*apol*
Head of IPC SCCG & TWCCG	✓	✓	*apol*	✓
Clinician Rep	*apol*	✓	✓	✓
TSSU Rep	*apol*	*apol*	*apol*	*apol*

The IPC Programme of Work

The IPC programme of work 2018-21 was specifically designed to focus on achieving full compliance with the standards identified in the Code of Practice, and the achievement of national and local infection related targets, using a template set by the Shropshire & Telford & Wrekin IPC Lead. The Trust has achieved full compliance on all the standards with the exception of having a fit-for-purpose IT system to support surveillance activity. The identification of a most cost-effective solution utilising internal systems and exploring local solutions continues to be required. SaTH progressed IC Net through their business case with a view of wider local health economy purchase. This has been highlighted and reported on the Risk Register.

Infection Prevention and Control Working Group

The working group meets bi-monthly and continues to improve communications between Infection Control, operational areas and Estates & Facilities by identifying and resolving issues in line with Trust priorities. This group reports to the Infection Prevention & Control and Cleanliness Committee.

IPC Link Staff System

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

Link Nurse Attendance

There was a reduction in face to face meetings within the Trust due to the requirement for social distancing, however meetings did take place on MS Teams, and if it was not possible to hold a link meeting on MS Teams, an IPC update was disseminated. Attendance has been highlighted to the Senior Nurse Allied Healthcare Professionals (SNAHP) meeting.

Ward	*April 20*	*June 20*	*Aug 20*	*Oct 20*	*Feb 21*
Ludlow					
OPD	✓			✓	
POAU	✓				
Powys	✓				
Clwyd					
HDU					
Theatres		✓			✓
Anaesthetics					
Recovery		✓		✓	
Oswald	✓				
Radiology					

TSSU					
Gladstone			✓		
Wrekin			✓		
SIU OPD			✓		
Kenyon	✓			✓	
Alice					
Sheldon	✓	✓	✓	✓	
Therapies	✓				
Baschurch		✓			
ORLAU		✓	✓		✓
Library personal	✓		✓		✓
Orthotics				✓	✓

CQC Assessment/ Board Assurance Framework

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

Version 1 of the BAF was presented to the CQC in June 2020 in which the Trust had provided the required evidence of the 10 Key Lines of Enquiry.

The BAF has been regularly monitored and updated to reflect the changes in national guidance. Version 2 was updated in December 2020 and version 3 in February 2021, with all updates presented at the Infection Prevention and Control Committee ,Quality and Safety Committee and subsequently presented to the Board .

The Trust has undertaken a thorough assessment of infection prevention control across all services, since the pandemic of Covid-19 was declared.

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

COVID-19 IPC Coronavirus Reponse

The work of the IPC Team was significantly impacted by the COVID-19 pandemic from mid March 2020.

The IPC Team took a leading role in screening, isolating and cohorting patients.
Infection and Prevention and Control measures included:

- Early recognition/reporting of cases
- Early assessment/triaging of cases
- Maintaining separation in space and/or time between suspected and confirmed COVID-19 patients

- Educating staff and patients about Standard Infection Control Precautions (SICPs)
- Prompt implementation of Transmission Based Precautions (TBPs) including the appropriate use of Personal Protective equipment (PPE) to limit transmission.
- Restricting access of visitors to the trust.
- Participation in the planning and implementation of strategies for surge capacity.

An IPC COVID-19 working group was set up in April, chaired by a Consultant Anaethetist. The group met on a weekly basis to discuss operational issues and guidance and had representatives from all areas within the Trust and fed through to the Silver/Gold command structure in line with the Major Incident Plan Policy. The group continued to meet weekly until October when it was reduced to a monthly basis once local systems had been implemented.

Following the release of national guidance the Trust was divided into green, amber and red zones and an isolation ward was identified for positive/suspected cases of COVID-19. As the guidance was updated the Trust introduced patient green, amber and red pathways. Close collaboration with Estates and Facilities was maintained throughout the pandemic to ensure the ongoing provision of a clean, safe environment.

The following road map shows a detailed timeline for the Trusts journey throughout the COVID-19 pandemic:

RJAH COVID-19 Road Map

March 20
- Public Health England published IPC guidance to incorporate PPE requirements
- Trust ceased its elective surgery to acccept trauma patients from SaTH
- Trust reported its first COVID positive patient.
- Introduction of Microsoft Team to allow meetings to be undertaken virtually.
- Restricted visiting was introduced.
- External company was commissioned to perform fit testing for staff.
- COVID-19 Swabbing commenced for admissions.
- Working from home commenced.
- Staff sheilding

April 20
- PHE released further updates the IPC guidance to include clarity on PPE use for different clinical scenarios.
- The Trust took part in a Point prevalence Survey for asymptomatic carriage for staff and patients.
- First COVID-19 outbreak declared on Sheldon Ward Reported as a serious incident.
- The Trust introduced PPE champions to provide face to face training and support across the wards and departments.
- B6 Theatre Sister redeployed to IPC team for additional support
- NHS supply chain began to take lead on the supply of PPE
- IPC COVID-19 meeting was set up to discuss operational issues and guidance and chaired by a Consultant Anaesthetist. This group fed into Silver Command and continued to meet on a weekly basis until October when it was reduced to monthly once local systems had been implemented.
- Absence reporting line for staff commenced.

May 20
- Beds removed to ensure 2m distancing in bays.
- Estates & Facilities took on the management of PPE and an electronic system was introduced to monitor supplies from the national chain.
- Two Healthcare Assistants became Infection Control, Train the Trainers for Care Homes across Shropshire, Telford & Wrekin.
- Hand Hygiene and Bare Below the Elbow audit tool adapted to include Personal Protective Equipment (PPE) to capture compliancy throughout the Trust,
- PHE issued a Board Assurance Framework with key lines of enquires relating to COVID-19.

June 20
- Nominated staff members received comprehensive Fit Testing training to allow testing to be undertaken in-house. (Train the Trainer).
- Antibody testing commenced for staff.
- COVID-19 and Social Distancing checklists introduced to monitor issues relating to PPE and social distancing in all areas.
- Front door manned with temperature checks and reminder to wear mask/face covering when entering the Trust
- Introduction of surgical masks to be worn by clinical staff within the Trust.

July 20
- CQC visit to assess the IPC Board Assurance Framework and associated evidence relating to COVID-19.
- Introduction of Social Distancing Observational Tool
- Coronavirus Policy Introduced in line with new guidance released by PHE: Introduction of the COVID 19 rapid guideline: arranging planned care in hospitals and diagnostic services.
- Limited patient visiting introduced.

August 20
- Updated PHE guidance changed from zones to red/amber/green care pathways.
- Trauma returned to SaTH
- Business case agreed to expand the IPC Team.
- Staff returned from sheilding

September 20
- Recommenced elective surgery
- Patients were required to wear surgical masks on Amber & Red pathways.
- All staff clinical/non clinical required to wear a surgical mask.

October 20
- COVID-19 Outbreak on Pre Op Assessment Unit
- Band 6 Infection Control Nurse Specilaist appointed.

November 20
- Lateral Flow Tests introduced for all staff
- COVID-19 Outbreak Outpatients
- COVID-19 Outbreak on Powys Ward& HDU
- Sheilding for extremely vulnerable staff members

December 20
- COVID-19 Outbreak on MCSI (resettlement)
- COVID-19 Outbreak TSSU
- COVID-19 Outbreak Outpatients 2
- COVID-19 Outbreak Radiology
- IPCN took part in 'Drive it down for Christmas' campaign for Shropshire Council
- Staff returned from Sheilding

January 21
- COVID-19 Outbreak on Sheldon
- COVID-19 Outbreak MCSI
- Set up of the Vaccination Centre First vaccination administered to a member of public 7th January.
- COVID-19 Outbreak on Sheldon Ward
- Introduction to patients wearing surgical masks if tolerated.
- Restricted patient visiting reintroduced.
- Clinically extremely vulnerable staff shelding

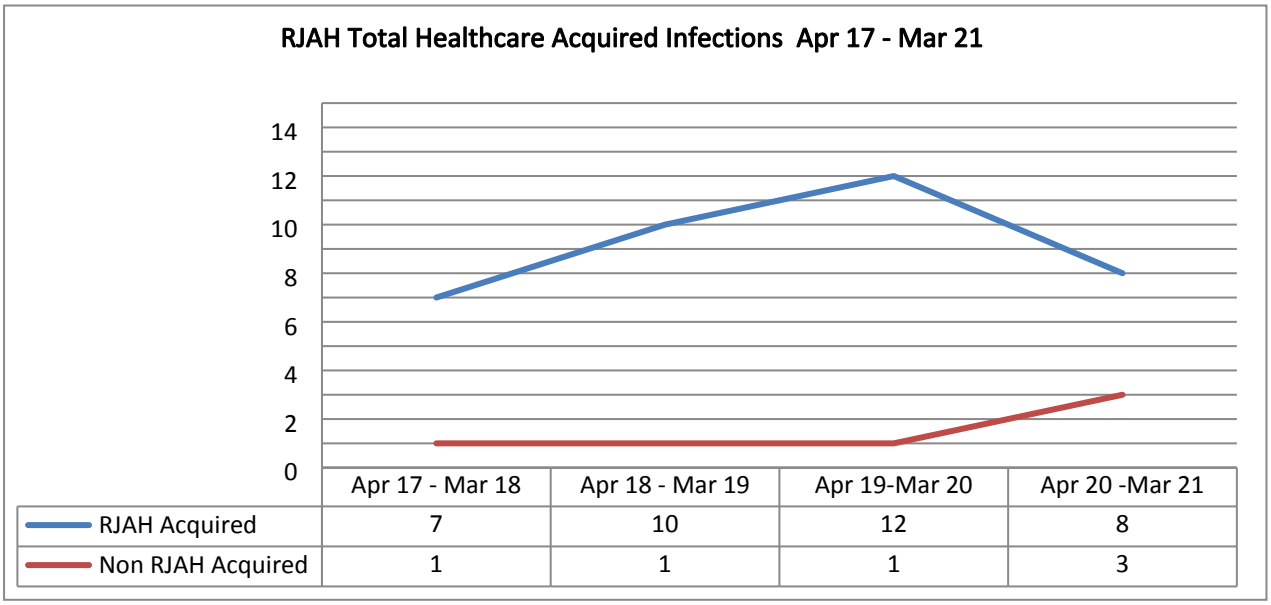
February 21
- IPC Modern Apprentice was appointed.
- Additional hand hygiene training device was purchased.

March 21
- Limited patient visiting resumed.
- IPC Team updated the Hand Hygiene video.
- Staff returned from Sheilding

Mandatory Surveillance

Healthcare Associated Infections

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



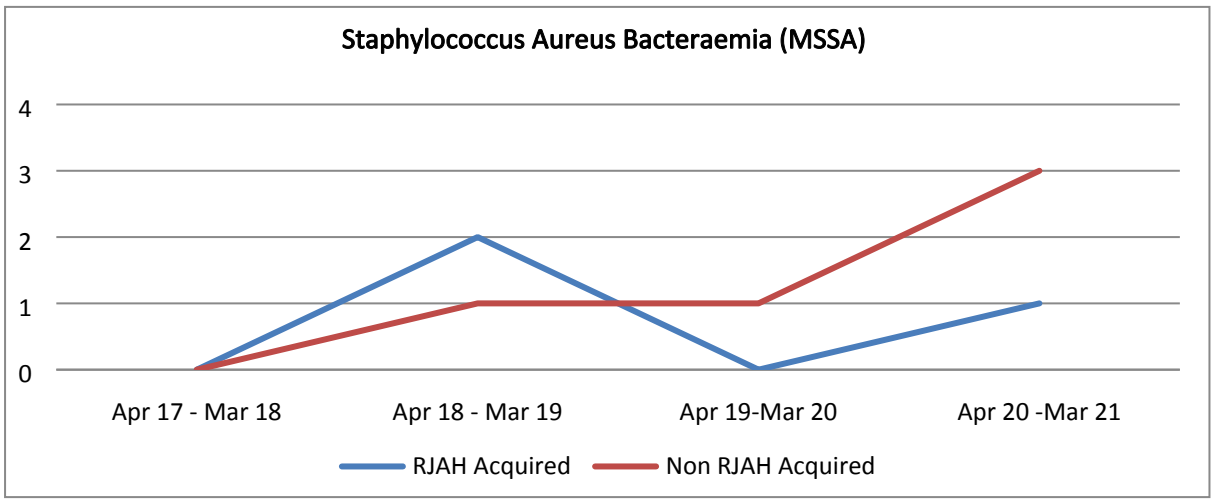
	Apr 17 - Mar 18	Apr 18 - Mar 19	Apr 19-Mar 20	Apr 20 -Mar 21
RJAH Acquired	7	10	12	8
Non RJAH Acquired	1	1	1	3

The graph above shows a 33.4% reduction in the total number of RJAH acquired Healthcare Associated Infections for 2020/21 from the previous year. It should be noted that there was a significant reduction in elective surgical activity due the response to the COVID-19 pandemic.

Methicillin Resistant Staphylococcus Aureus Bacteraemia (MRSA)

The Trust is in its 15th year of reporting zero cases of MRSA bacteraemia and continues to comply to the governments 'zero tolerance' strategy set out in the NHS England Planning Guidance released in 2013 and provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA have significantly reduced.

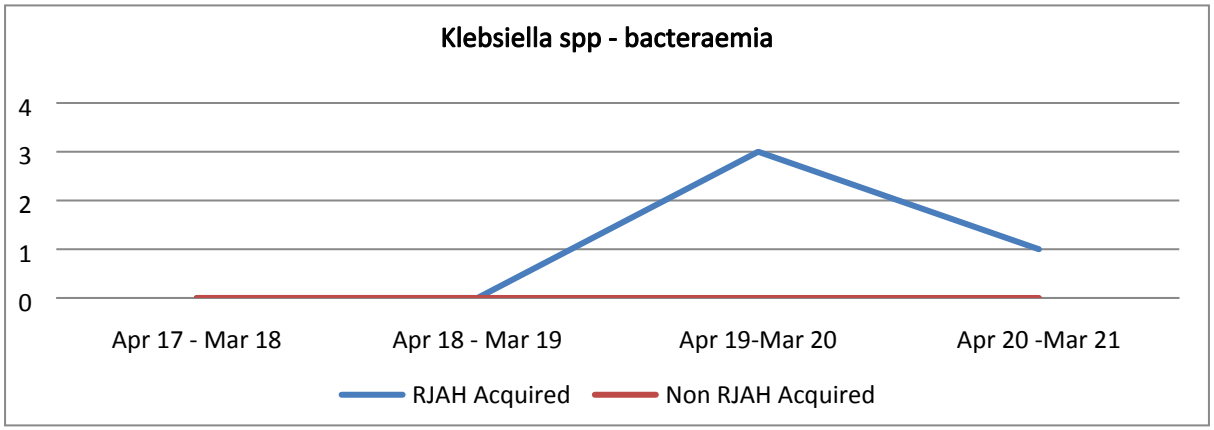
Methicillin Sensitive Staphylococcus Aureus (MSSA)



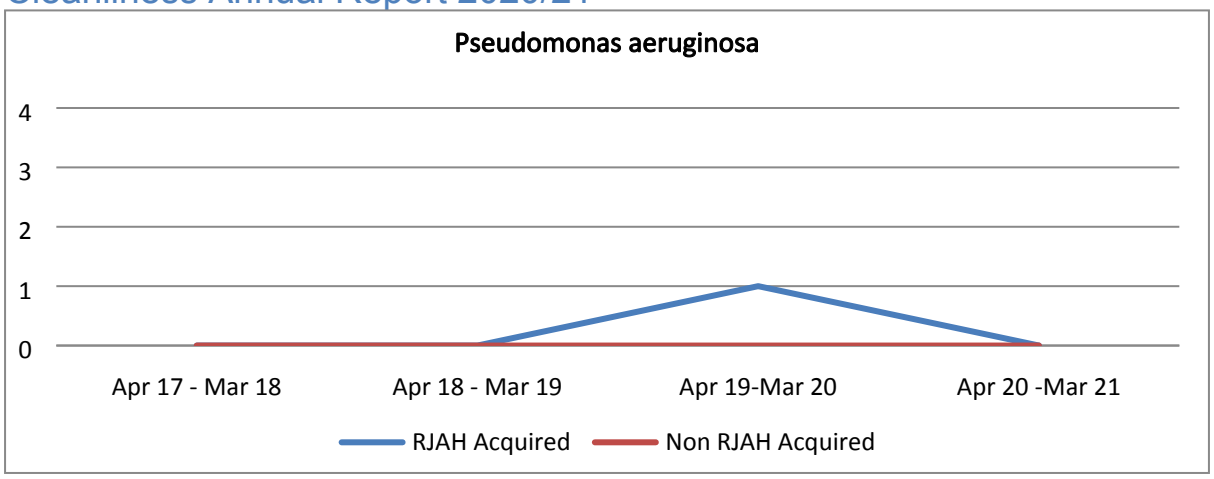
In 2020-2021 the trust reported 4 cases of MSSA bacteraemia, only one of these was RJAH acquired. This patient had a positive MSSA bloodstream infection at RSH following bladder surgery and subsequently developed staphylococcal infections in a spinal abscess, shoulder joint and total knee replacement. The patient was transferred to RJAH for drainage of the spinal abscess and a repeat blood culture was taken. This is a continuing episode of MSSA infection. The patient has been reviewed by the consultant microbiologist and treated with multiple surgical washouts and intravenous antibiotics.

Gram-Negative Blood Stream Infections

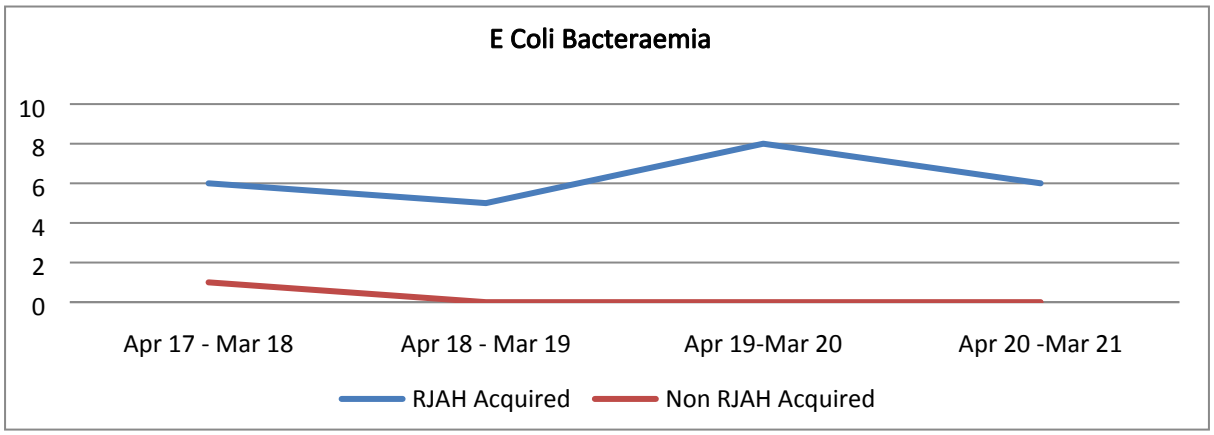
Gram-negative blood stream infections (BSIs) are a healthcare safety issue and from April 2017 there has been an NHS ambition to reduce the number of healthcare associated Gram –negative BSIs. For this purpose the gram-negative organisms are Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)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



In 2020/21 there was 1 Klebsiella sps case apportioned to the Trust, compared to 3 in 2019/20. This is a reduction of 2 cases on last year.



In 2020/21 there were no positive BSI samples for Pseudomonas aeruginosa.



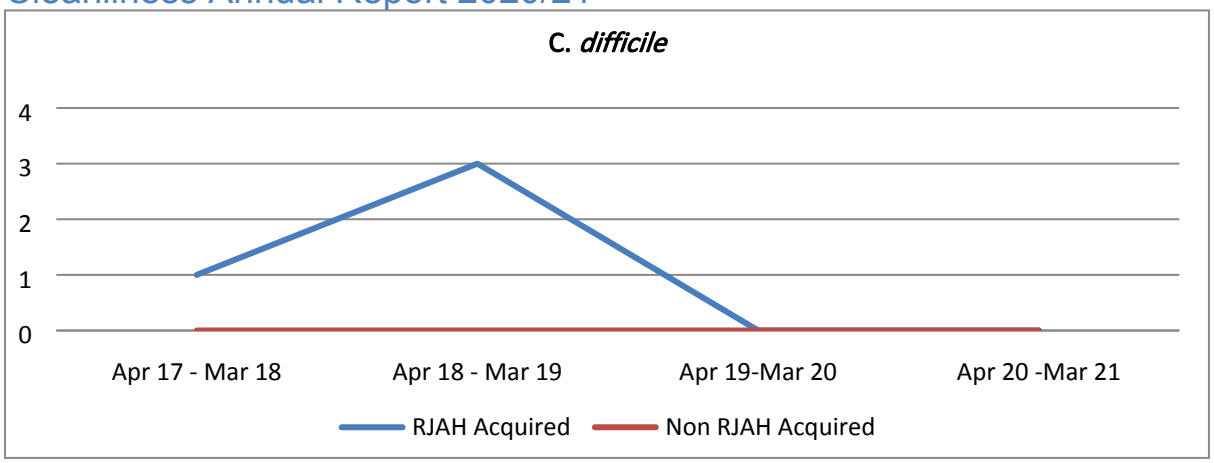
In 2020/21 we had 6 trust apportioned E.coli cases, compared to 8 in 2019/20. This is a reduction of 2 cases on last year.

Since 2018/19 there has been a continued focus on using the Health Economy approach to reduce Escherichia coli bloodstream infections as they represented 55% of all Gram-negative bloodstream infections nationally.

The Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015. We know GNBSI cases can occur in hospitals however, half of all community onset cases have had some healthcare interventions either from Acute, Primary or Community Care. Therefore, a Health economy approach is required to achieve the reductions

A post-infection review was undertaken for all RJAH acquired bloodstream infections in order to identify the root causes and any actions required. All lessons learned were fed to the link nurses and at SNAHP meetings.

Clostridium Difficile Infection (CDI)



The Trust continues to report zero cases of C.*difficile* since January 2019.

Carbapenemase–Producing Enterobacteriaceae cases (CPE)

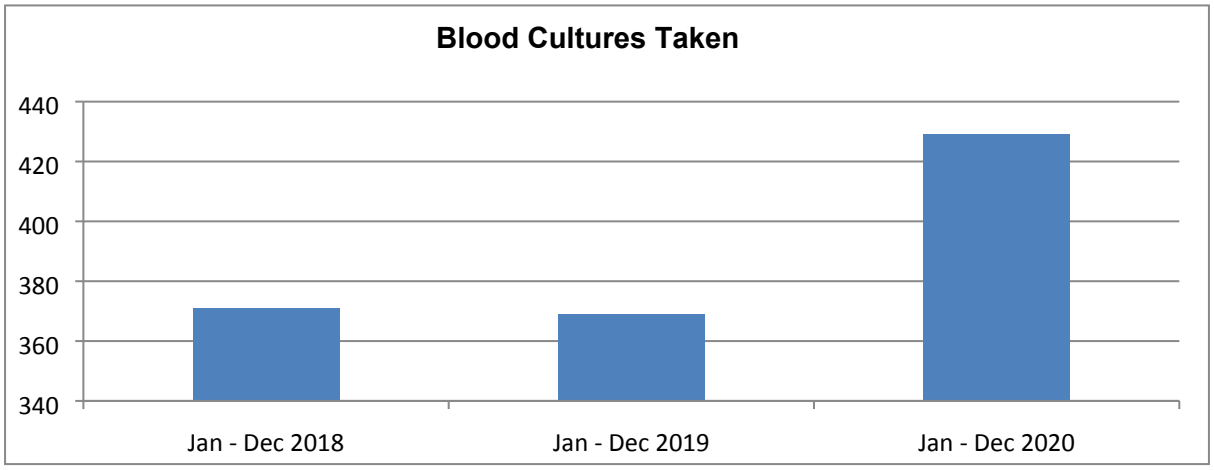
In 2020/21 the Trust reported no cases of CPE

Blood cultures

There has been a significant increase the number of blood cultures taken since 2019/20 due to the Trust's response to the diagnosis and management of sepsis.

Even with the rise in blood cultures taken, the Trust is continuing to meet national targets for the overall reduction in HCAI cases.

The Trust reported a 42% reduction to its Gram-negative bacteraemia blood stream infections for 20/21 from 2019/20. Taking into account the data as a whole, the Trust achieved a 33% reduction on its HCAIs for 2020/21.



The Trust reported a 42% reduction specifically to its gram-negative bacteraemia blood stream infections for 20/21 from 2019/20. Taking into account the data as a whole, the Trust achieved a 33% reduction on its HCAIs for 2020/21.

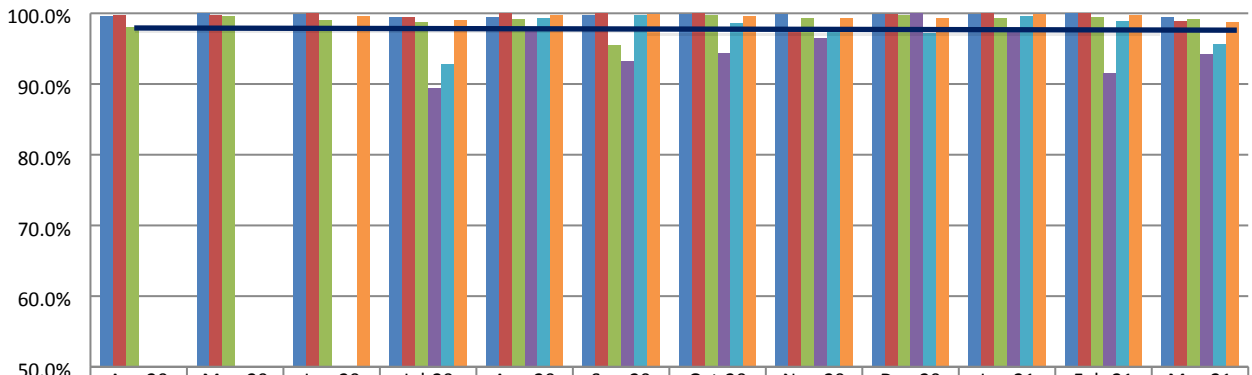
Infection Prevention & Control Ward/Department Audits

Infection Prevention & Control & Cleanliness Annual Report 2020/21

Wards and departments complete a robust package of infection prevention and control audits across the year. The toolkit comprises of environmental auditing, which highlights patterns of non-compliance to be addressed. The Hand Hygiene audit tool includes Bare Below the Elbows (BBE) and an additonal Personal Protective Equipment (PPE) element was introduced to the hand hygiene and bare below the elbow audit in May 2020 to monitor PPE compliance throughout the Trust. Further COVID-19 checklist and Social Distancing Audits were introduced in July 2020.

The following graph shows the Trust's compliance against each of the individual audits. The results show how the Trust consistently achieved the 95% target in all areas for Bare Below the Elbow, Hand Hygiene and Environmental Audits; but compliance to COVID-19 preventative measures and social distancing has fluctuated throughout the pandemic. Scores are sent to all ward and departmental managers monthly to ensure areas of non compliance are highlighted to allow corrective actions to be taken.

RJAH Trust Infection Prevention & Control Ward/Departmental Audit Compliance
April 20 - March 21

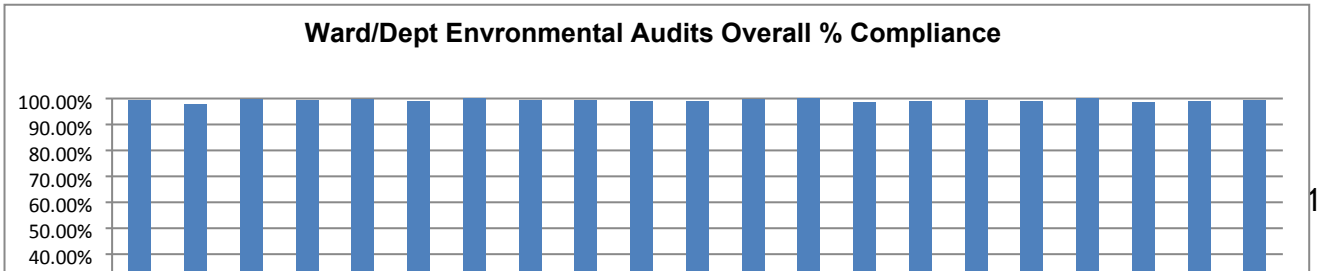


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Bare Below Elbow	99.5%	100.0%	99.8%	99.4%	99.4%	99.8%	99.8%	99.8%	99.9%	99.9%	100.0%	99.4%
Clean Hands	99.7%	99.7%	100.0%	99.4%	100.0%	100.0%	100.0%	97.8%	99.9%	100.0%	100.0%	98.9%
Environment	98.0%	99.6%	99.0%	98.7%	99.1%	95.4%	99.7%	99.3%	99.8%	99.3%	99.4%	99.2%
Social Distance				89.4%	98.0%	93.3%	94.3%	96.5%	100.0%	97.7%	91.5%	94.2%
Covid19 Checklists				92.8%	99.3%	99.8%	98.6%	97.8%	97.2%	99.5%	98.8%	95.7%
PPE			99.6%	99.0%	99.7%	99.8%	99.6%	99.3%	99.3%	99.8%	99.7%	98.8%

An Interactive dashboard was created and is disseminated on a monthly basis to all wards and departmental managers, IPC link staff and senior nurses detailing scores for IPC audits. The dashboard also includes brief detail for areas relating to non compliance and a common themes section to monitor trends. The dashboard was well received by staff within the Trust and therefore will remain following imminent implementation of the Perfect Ward System.

Environmental Audits

Ward/Dept Envronmental Audits Overall % Compliance



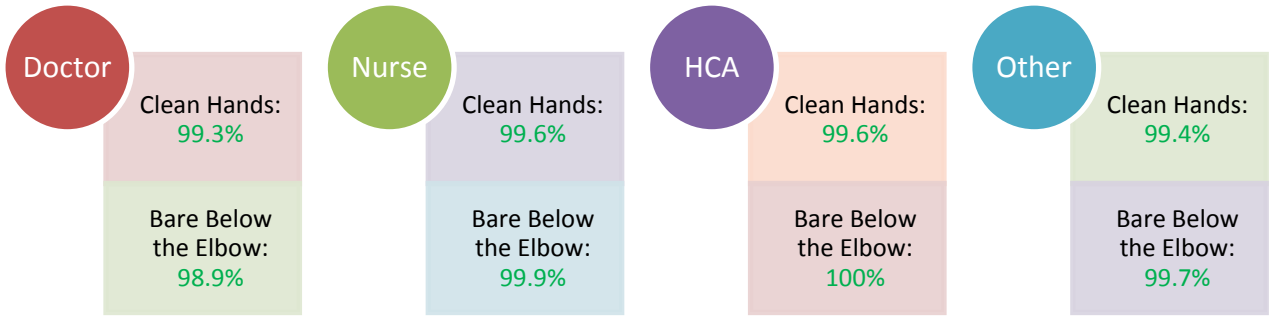
The most common areas of the Environment Audit non-compliance:

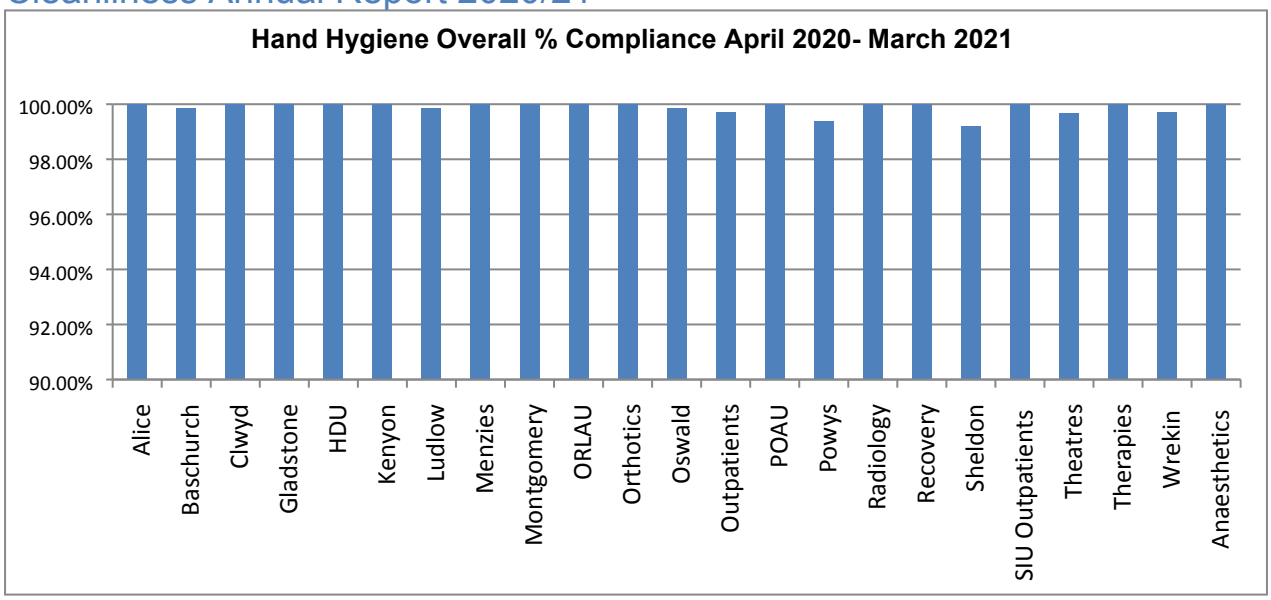
- Floors clean and in good state of repair
- Safer Sharps Devices are in use, or if not a risk assessment has been completed
- High and low surfaces clean & dust free
- Furniture clean and in good state of repair

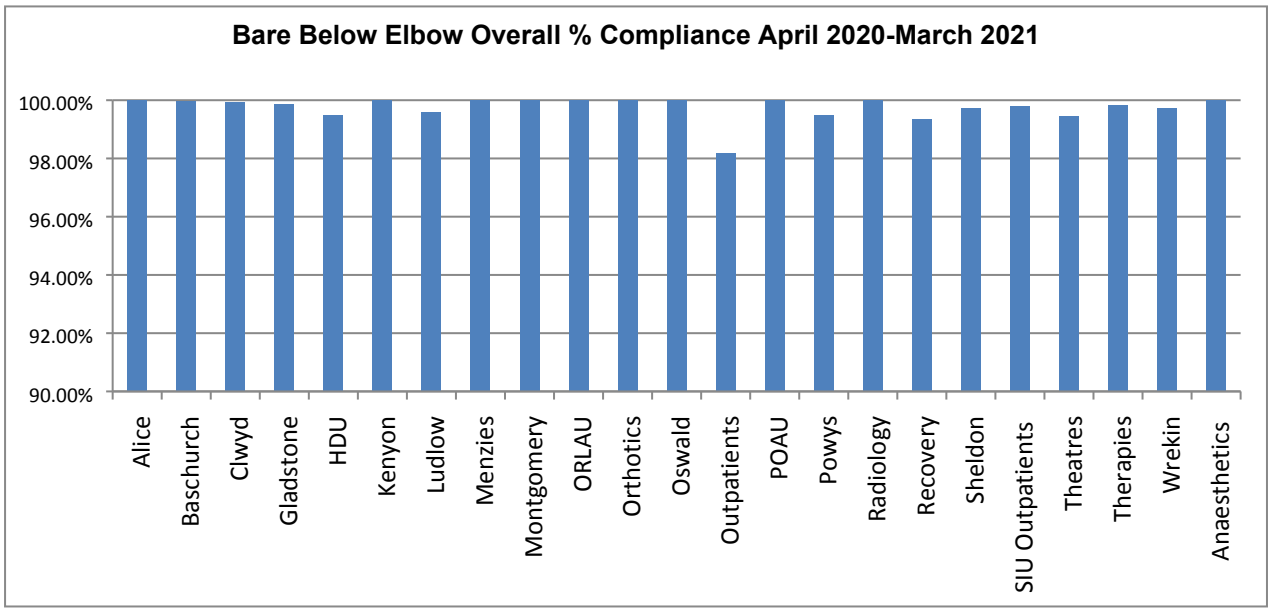
Staff are encouraged to raise requisitions with the Estates department. Waste and sharps awareness sessions have been held at Link meetings to support staff in raising awareness and educate staff within their departments. A rolling programme of backlog maintenance is in place for floor replacements.

Hand Hygiene & Bare Below the Elbows

The image below shows the positive Hand Hygiene and Bare Below the Elbow compliance split by designation. The 'Other' category captures other members of the multi-disciplinary team, such as therapy support, pharmacists and students.







IPC Team Environmental Walkround Audits

Location	Audit date	Issues Identified	Actions Undertaken
Vaccination Centre	March 2021 April 2021	• Patients and some administration staff not adhering to social distancing	• Chairs removed to enable social distancing. • Perspex screen installed between administration desks.

Location	Audit date	Issues Identified	Actions Undertaken
Theatres	March 2021	• Cluttered office spaces and floors unclean. • Staff footwear not always following AfPP guidelines • Build-up of gel residue inside hand gel dispensers • Floor cluttered with items. • cleaning regime required for footwear	• Office spaces decluttered. • Facilities team to source additional hours for cleanliness technicians to be based in Theatres. • Cleaning regime put in place for hand gel dispensers. • Storage identified for warming mattress. • Items relocated to available shelves from the floor.

Location	Audit Date	Issues Identified	Actions Undertaken
Gladstone	March 2021	• Taps heavily tarnished with build-up of lime scale. • Dust inside dani-centres • Build-up of gel residue inside hand gel dispensers • Patient bed spaces cluttered • Macerator over filled • Storage cupboard in sluice room untidy. • No paper towel or soap dispenser in bathrooms. • Shower head and temperature gauge in need of repair.	• Cleaning regime put in place for hand gel dispensers and Dani centres. • E&F have introduced a replacement programme for taps. • Additional storage on order for bays on Gladstone ward to reduce clutter. • Broken items and equipment added to the Estates job plan for repair.

Location	Audit Date	Issues Identified	Actions Undertaken
Wrekin	March 2021	• Taps heavily tarnished with build-up of lime scale. • Dust inside dani-centres • Build-up of gel residue inside hand gel dispensers	• Cleaning regime put in place for hand gel dispensers and dani centres. • Ongoing tap replacement programme put in place.

Location	Audit Date	Issues Identified	Actions Undertaken
Powys	March 2021	• Social distancing in staff for not adhered to. • Taps heavily tarnished with build-up of lime scale • Broken equipment on female shower rooms	• Additional signage added to enforce Social Distancing rules. • Broken equipment reported to E&F job plan for repair.

Location	Audit Date	Issues Identified	Actions Undertaken
TSSU	February 2021	• Lime scale noted on multiple taps • Rusty wheels clogged with hair and dust. • Build-up of gel residue inside hand gel dispensers	• Descaling programme put in place. • Cleaning regime put in place for hand gel dispensers.

		• Vents dirty • Fire exits blocked with trolleys and condemned items.	• Vent cleaning regime put in place. • Wheel replacement programme put in place

Location	Audit Date	Issues Identified	Actions Undertaken
Clwyd	February 2021	• Lime scale build up on some taps • Damaged macerator	• Descaling programme put in place • Broken macerator reported via Qube system.

Location	Audit Date	Issues Identified	Actions Undertaken
HDU	February 2021	• Lime scale build up and tarnishing on taps • Build-up of gel residue inside hand gel dispensers	• Ongoing descalant programme in place • Cleaning regime put in place for hand gel dispensers.

Location	Audit Date	Issues Identified	Actions Undertaken
Ludlow	February 2021	• Dust inside dani-centres • Build-up of gel residue inside hand gel dispensers	• Cleaning regime put in place

Location	Audit Date	Issues Identified	Actions Undertaken
Alice	February 2021	• Damaged macerator in sluice • Build-up of gel residue inside hand gel dispensers • Lime scale build up and tarnishing on taps	• Damaged macerator reported via Qube. • Descalant programme put in place for taps • Cleaning regime put in place for hand gel dispensers.

Location	Audit Date	Issues Identified	Actions Undertaken
Radiology	February 2021	• Damaged concrete flooring outside staff room requires repair or replacement. • Build-up of gel residue inside hand gel dispensers • Lime scale build up on water dispenser and taps.	• Cleaning regime in place and recorded on room cleaning sheets • Repair of the concrete floor is on the Estates job plan. • Ongoing descalant programme put in place

Location	Audit Date	Issues Identified	Actions Undertaken

Oswald	February 2021	• Inappropriate items in sharps bin. • Limescale build up on taps in patient rooms. • Dust found inside Dani-centres • Build-up of gel residue inside hand gel dispensers	• Ongoing descalant programme put in place. • Cleaning regime put in place • Appropriate disposal of sharps

Location	Audit Date	Issues Identified	Actions Undertaken
Outpatients	February 2021	• Storage drawers cluttered. • Inappropriate storage of PPE • Ceiling tiles stained due to roof and window leak. • Lime scale build-up on taps. • Plaster room floor damaged. • Items stored on floor.	• Ongoing tape replacement programme put in place. • Storage drawers de-cluttered • Window leak reported via Qube. • Large box of splints removed from floor • Plaster room floor replacement scheduled for Autumn 2021

Location	Audit Date	Issues Identified	Actions Undertaken
Sheldon	February 2021	• Sealant around base of toilets damaged • No evidence for cleaning of the ice machine • Build-up of gel residue inside hand gel dispensers • Inappropriate items in sharps bin	• Estates replaced seals on all toilets. • Cleaning regime for ice machine in place • Hand gel cleaning regime put in place • Appropriate disposal of sharps

Location	Audit Date	Issues Identified	Actions Undertaken
Baschurch	February 2021	• Lack of storage • Build-up of gel residue inside hand gel dispensers • Lime scale build-up on taps • Dust inside dani centres.	• Further storage located and utilised. • Hand gel and dani centre cleaning regime put in place • Ongoing descalant programme put in place.

Location	Audit Date	Issues Identified	Actions Undertaken
Montgomery	February 2021	• Dust on top of bed space curtain rails • Build-up of gel residue inside hand gel dispensers	•High dusting including curtain rails and examination lights has been incorporated onto the weekly cleaning sheet. •Hand gel dispenser cleaning regime put in place.

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

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

Cleanliness

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

Outcomes for cleaning continued to be monitored internally throughout the year, despite dispensation to pause audit programmes for the duration of the pandemic. External and patient led monitoring, including PLACE assessment, did not take place during this time.

Cleanliness – Deep Cleaning

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

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

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

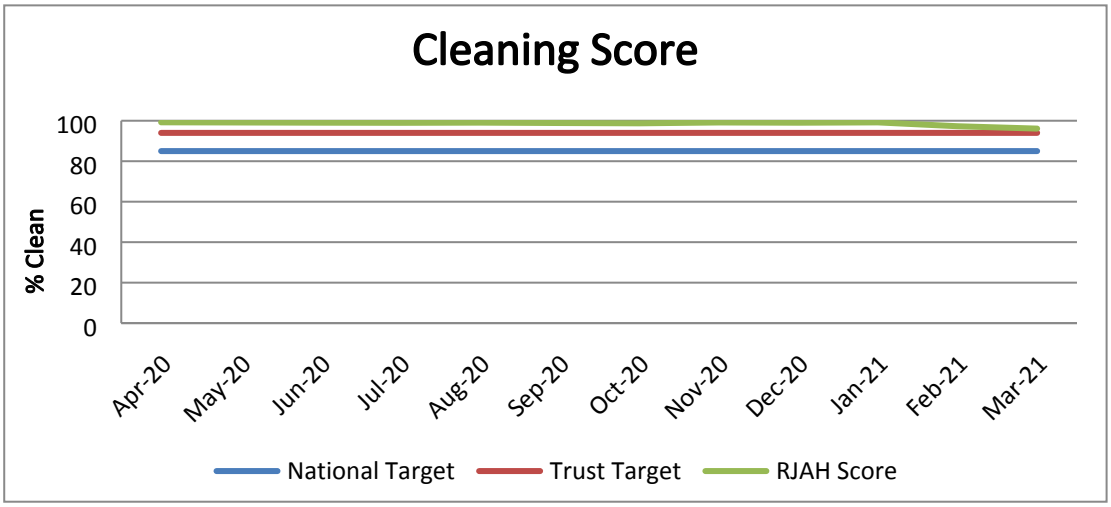
This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

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

12 individual rooms and 4 complete bays have required a red terminal clean in 2020/21; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

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



Internal monitoring is carried out every day, visiting all areas on a rolling programme according to their risk. Very high risk areas are monitored in collaboration with the clinical team to ensure the broadest picture is seen. All required improvements identified by the audits are acted upon by the internal team and the results are reported to the Infection Prevention & Control Committee on a quarterly basis, with specific action plans or failure themes managed through the Infection Prevention & Control Working Group.

A revised approach has been taken to cleanliness monitoring from February 2021, working to a more stringent definition, and with a stenghthended auditing team, which has resulted in a slightly reduced score, seen in the chart, but provides more assurance to site users.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2020/21 the Trust achieved an average score of 98.64%.

Cleanliness and Environment - Kitchen

The Trust kitchen retained its 5 star food hygiene rating at last inspection in February 2020. In response to restrictions during the pandemic, Shropshire Council suspended all site visits in March 2020, with these yet to resume.

The Trust took part in a remote assessment in March 2021, with no concerns raised and now awaits a site visit to confirm a 5 star rating.

Supporting this inspection, the Trust procures a separate externally accredited food safety audit which produces a detailed action plan, undertaken in September 2020 which recommended appropriate measures were in place to retain a 5 star rating.

CQC Inpatient Survey

The CQC Inpatient Survey 2019 results were published in June 2020, with the Trust scoring top in the country under the metric ‘how clean was the hospital room or ward that you were in’ with an average scrore of 9.8 out of 10. The consistently good results achieved through this seurvey are a testament to the dedication and high standards shown by the entire housekeeping team.

PLACE – Patient Led Assessment of the Care Environment

The 2020 National PLACE assessment was cancelled in response to the pandemic.

The Trust anticipates this pause in external patient experience auditing will continue into 2021/22; and therefore a programme of internal 'mini PLACE' audits has been scheduled, to be completed as a multi disciplinary spot check, with actions fed through the Infection Control Working Group. A focus for these inspection will be learning where best practice is already in place, and replicating this where possible in other areas of the Trust.

Linen

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

Following the closure of the Trusts provider, linen services have been provided by an alternative external supplier, who continues to provide assurance to the infection control working group through monthly compliance reporting against HTM (01 04).

Clinical Waste

In 2020/21, the Trust took part in a consortium waste tender alongside Shrewsbury & Telford Hospitals NHS Trust and Shropshire Community NHS Trust. The new contract for clinical waste, effective from April 2021, provides assurance the Trust will continue to maintain its compliance against the relevant HTM (07-01) and retains the ability to flex to National guidance implemented to manage the pandemic.

Estates Department Contribution to the Clean and Appropriate Work Environment

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

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

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

Part A: Design, installation and testing, and

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

Water

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

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

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

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

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

Estates Operational Service continually undertake water tests throughout the Trust estate. This water testing is carried out under legislation and guidance set out by The Health & Safety Executive and the Department of Health. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as legionellosis; it is a method of using qualitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. During April 20 – March 21 a total of 585 water sample tests were undertaken, this is a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

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

The main water storage tanks that were installed in the 1970s supplying potable and softened water to 90% of the estate have been replaced with HTM compliant tanks, with the works being completed and handed over in January 2021.

This year, Estates & Facilities are reviewing water efficiencies in parallel to the implementation of the water storage tanks in Q3 and Q4 and have now significantly reduced water consumption. As a Trust, we have been an outlier amongst our peer Trusts on our water consumption, so we're looking at ways of reducing the amount of water we consume without compromising the service we provide to patients, visitors and staff. We're looking at:

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

These initiatives do not come without risk of proliferation of legionella, however, so we're remaining vigilant by continuing our routine monitoring throughout site.

Decontamination Group

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

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

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

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

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

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

Estates & Facilities COVID19 Response

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

Personal Protective Equipment (PPE)

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

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

Enhanced Cleaning & Ventilation

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

Clinical strategy determined that the HDU unit would be utilised for known Covid-19 patients requiring high flow oxygen, so change of pressure regimes to negative was required because of the possible communication and contamination into the adjacent theatres.

Supporting Social Distancing & Staff Safety

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

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

The team also facilitated removal of non-essential equipment from site – allowing for social distancing and ease of cleaning particularly in clinical areas.

Additional staff shower facilities were installed, and the hydrotherapy pool shower facilities made available to staff for use after their shifts.

Infrastructure

As the Trusts patient population changed during the pandemic response, so too did the requirements of key aspects of the site, including;

- Medical Gases, whereby assurances were sought around resilience of services and continuity of supply given the increased clinical need of COVID patients.
- Medical Devices, whereby the Trusts robust protocols for procurement and management of new medical devices was reiterated when processing the requirements for additional devices (for example, 20 new anaesthetic machines were received during the first wave)

Patient Flow

Ensuring patient's access and route through site was is as safe as possible has seen restrictions to entrances, with all patients signposted to the main entrance and other entrances made staff only using door access controls.

At the main entrance, a screening desk is in place, managed by the Estates & Facilities team with support from volunteers, ensuring that all site users are adhering to both National and Trust level infection control guidance.

When elective surgery returned to the Trust, the department led on the installation of an alternative enrtrance for patients following a specific pathway, feeding directly into Baschurch unit.

Elsewhere on site, ward and departmental access was controlled with additional door access controls at their entrances.

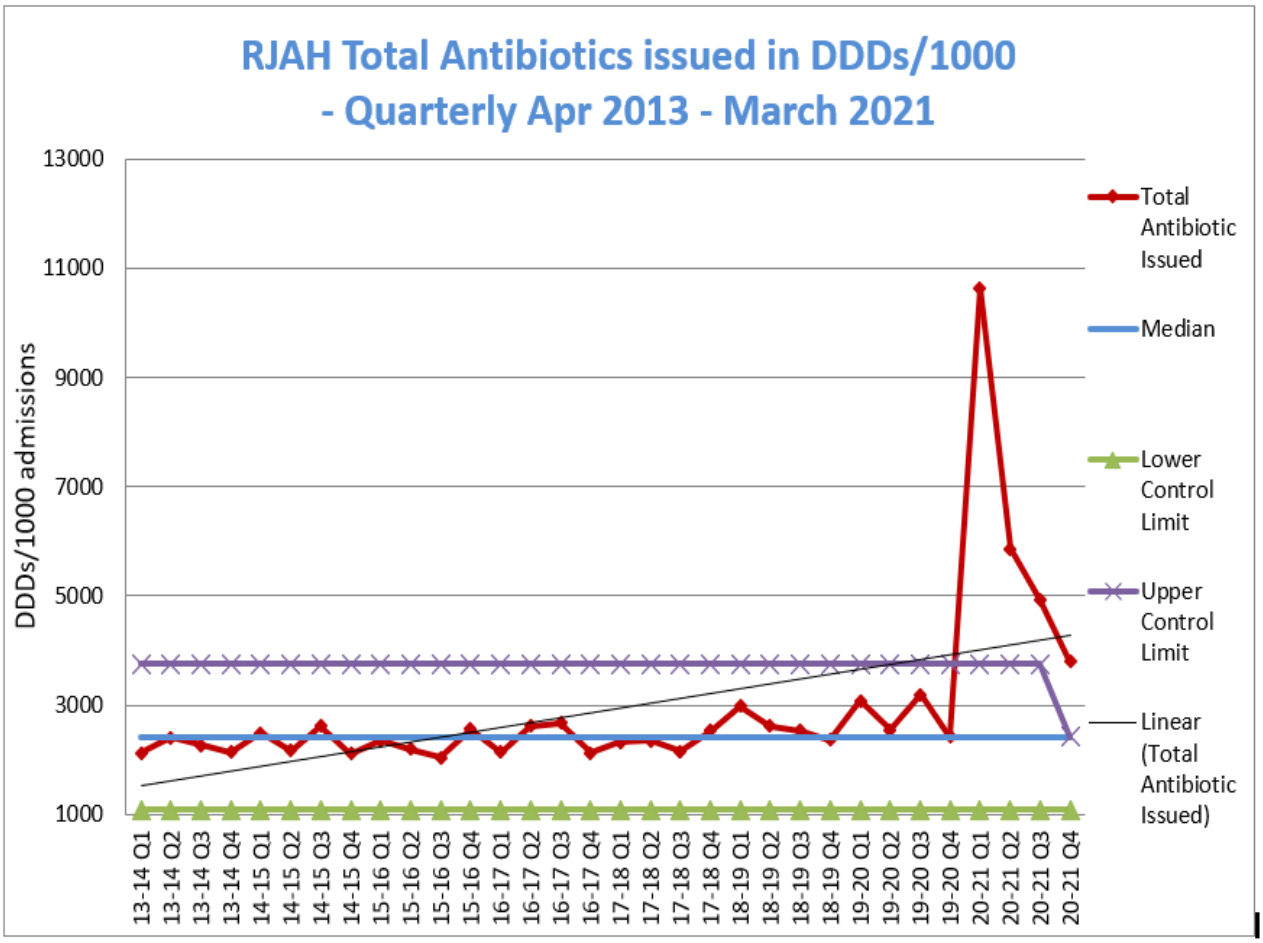
Vaccination Centre

In the last quarter of this year, the Trust hosted a COVID-19 Hospital Hub for vaccinations. Further the Department led on the remodelling of the service to facilitate its conversion to a Vaccination Centre, the first transformation of its kind in the country.Under considerable time constraints, the temporary relocation of maternity services was managed alongside refit and set up of facilities required to facilitate a vaccination service. Advice was given to ensure access, patient flow and infection control risks were considered and mitigated.

3.1.4. Criterion 3: Ensure appropriate antimicrobial use

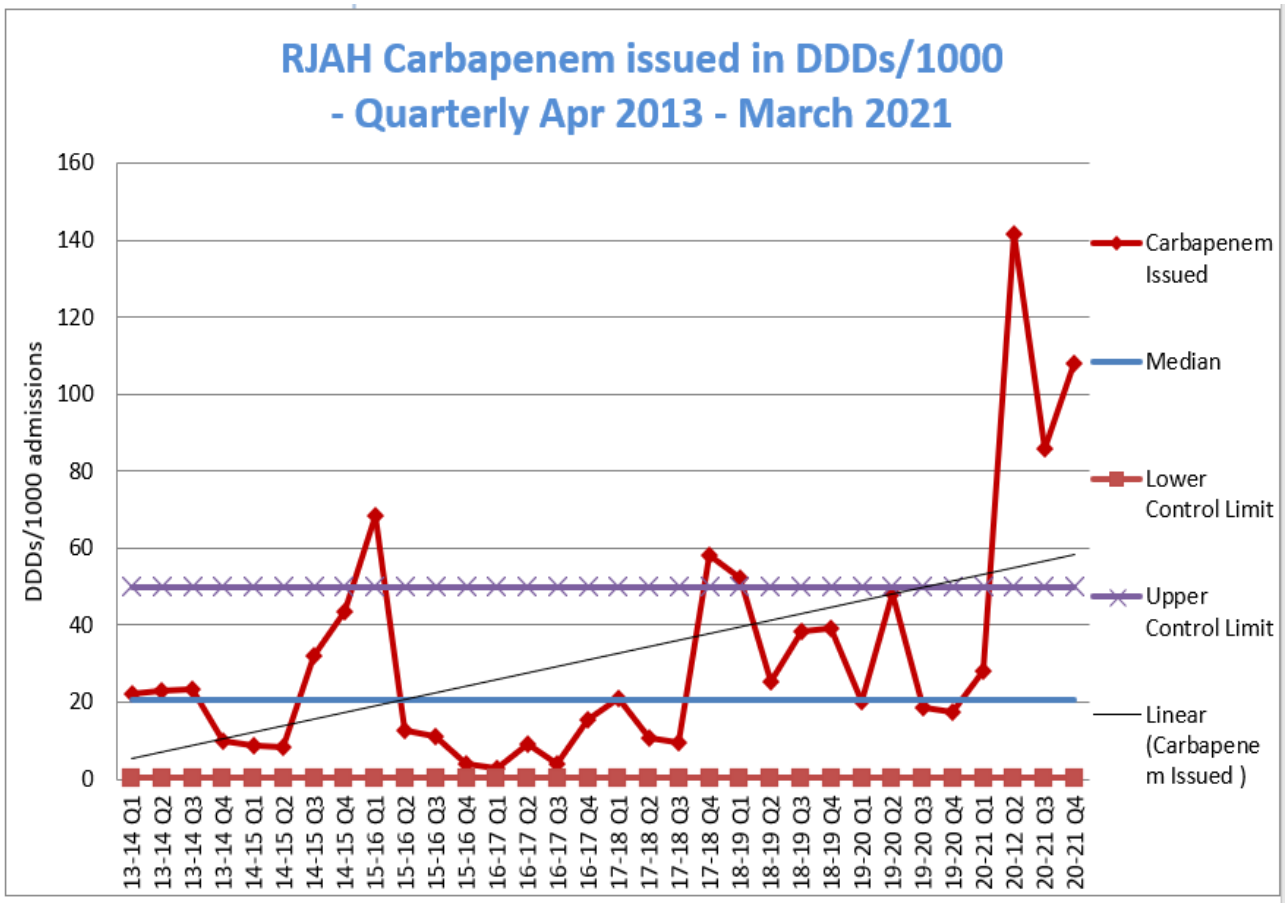
Antimicrobial Stewardship (AMS) The trust antimicrobial management group (AMG) includes representatives from pharmacy, microbiology, nursing and medical staff. This group manages policy with regard to antimicrobial stewardship,formulates policy with regard to antimicrobial stewardship and responds to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

Total antimicrobials



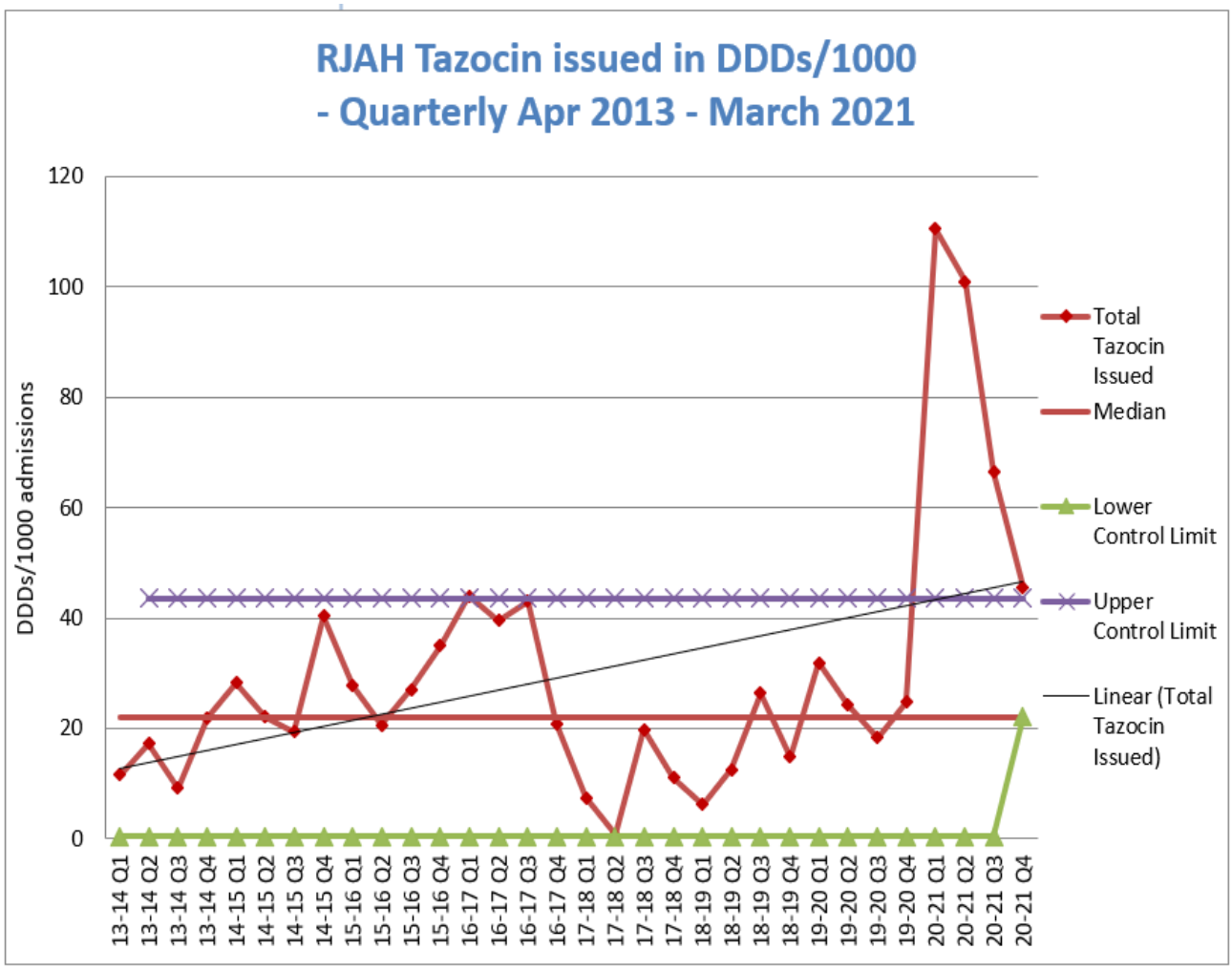
The graph above shows the total antibiotics issued from pharmacy, between April 2013 and March 2021, in DDDs per 1000 admissions. The black line indicates that there is an upward trend in antibiotics issued. The peak seen in Q1 20-21 can be attributed to the hospital becoming a trauma centre during the COVID-19 pandemic, however, it is gradually coming back down as the number of elective surgeries is increasing (i.e. the number of admissions is increasing but the antibiotic usage is decreasing in terms of DDDs/1000 admissions).

Carbapenems



This graph shows the total carbapenems issued from pharmacy, between April 2013 and March 2021, in DDDs per 1000 admissions. There is an upward trend in the amount of carbapenems issued especially in the last year. This is partly due to RJAH becoming a trauma centre, however, a large proportion of carbapenems are issued to long term spinal injuries rehab patients. The latter is often due to pressure sores/osteomyelitis and epidural abscesses for example.

Piperacillin/tazobactam (Tazocin)



This graph shows the total piperacillin/tazobactam issued from pharmacy, between April 2013 and March 2021, in DDDs per 1000 admissions. Again, the overall trend is upwards, but as can be seen by the graph the amount of Tazocin issued increased in Q1 20-21 due to RJAH becoming a trauma centre. This is gradually coming back to the normal range and will continue to be monitored.

The use of carbapenems/ piperacillin/tazobactam (Tazocin) is restricted to the indications specified in the antibiotic policy or as per microbiology advice. Their usage is monitored and they should only be booked out to individual patients and not be given as ward stock. This is so that the prescriptions can be screened by pharmacy prior to being issued to ensure appropriateness. We need to ensure that the use of these antibiotics is tightly controlled as the overuse of broad-spectrum antibiotics can lead to antimicrobial resistance.

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

Communication Programme

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

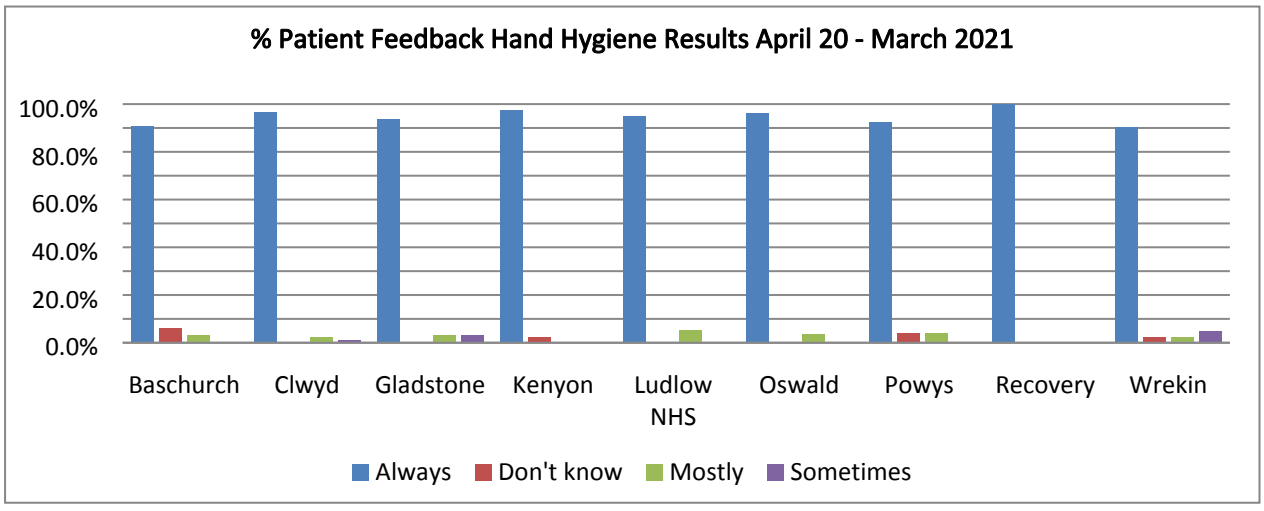
The IPC and Communications Teams work together to:
- Promote IPC events.
- Update the Trust website and intranet.
- Issue media statements during outbreaks.
- Support the annual flu vaccination campaign

Trust Website and Information Leaflets
The Trust website promotes infection prevention issues and guides people to performance information on MRSA, Clostridium difficile and other organisms. The IPT have produced a range of information leaflets on various organisms.
A large number of documents relating to COVID-19 were added during 2020, including information for patients, visitors and staff. This included topics such as volunteering, symptoms of COVID-19, how to keep healthy and avoid infection, how to get tested and visiting. This continues to be updated by the Communications Team with advice from IPC as new information becomes available.

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

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

The patient comment cards were paused at the beginning of COVID-19. The Patient Advice & Liason Service (PALS) Team resumed comment card feedback in December 2020. Feedback received since December 2020 was extracted from the Meridian software to produce the graph below:

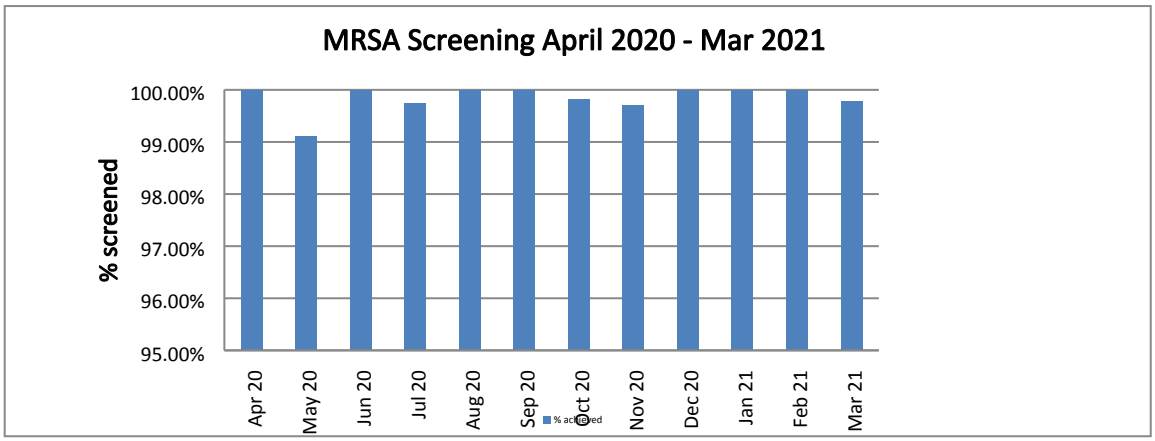


The results are collected from a specific question incorporated on the comment card: "Did the staff practice good hand hygiene" and results provide positive feedback from a patient's perspective.

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

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

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



	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Eligible patients	166	225	269	391	299	519	586	668	788	361	251	460
Screened for MRSA	166	223	269	390	299	519	585	666	788	361	251	459
% achieved	100.00%	99.11%	100.00%	99.74%	100.00%	100.00%	99.83%	99.70%	100.00%	100.00%	100.00%	99.78%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

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

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

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

Surgical Site Surveillance (SSI)

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

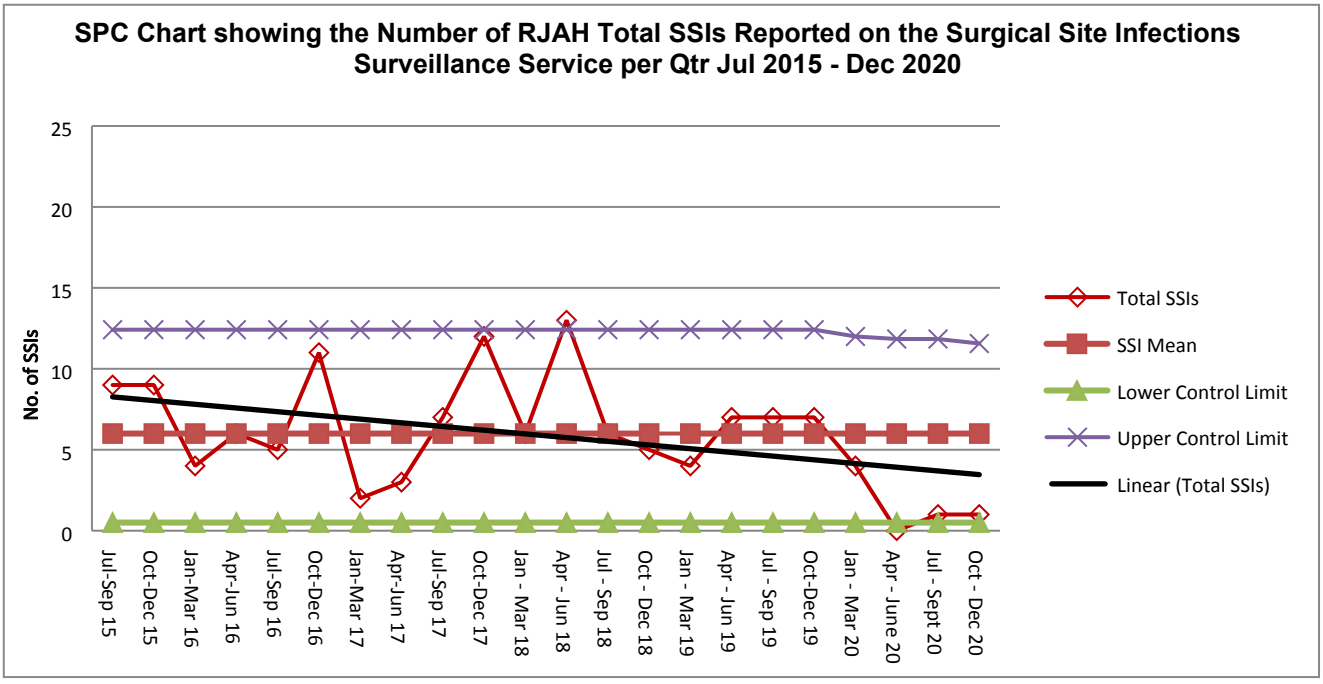
The Trust submits surgical site infection data to the Public Health England (PHE) database on a quarterly basis.

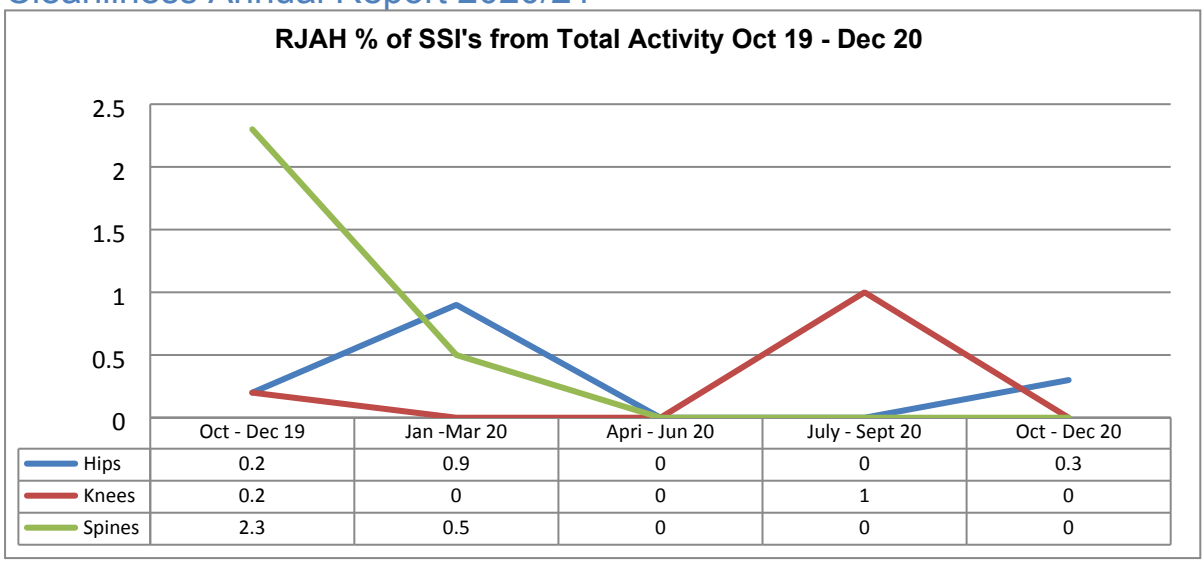
In March 2020, the Trust stopped all elective surgery and supported SaTH by undertaking their trauma service in response to the COVID-19 pandemic.

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

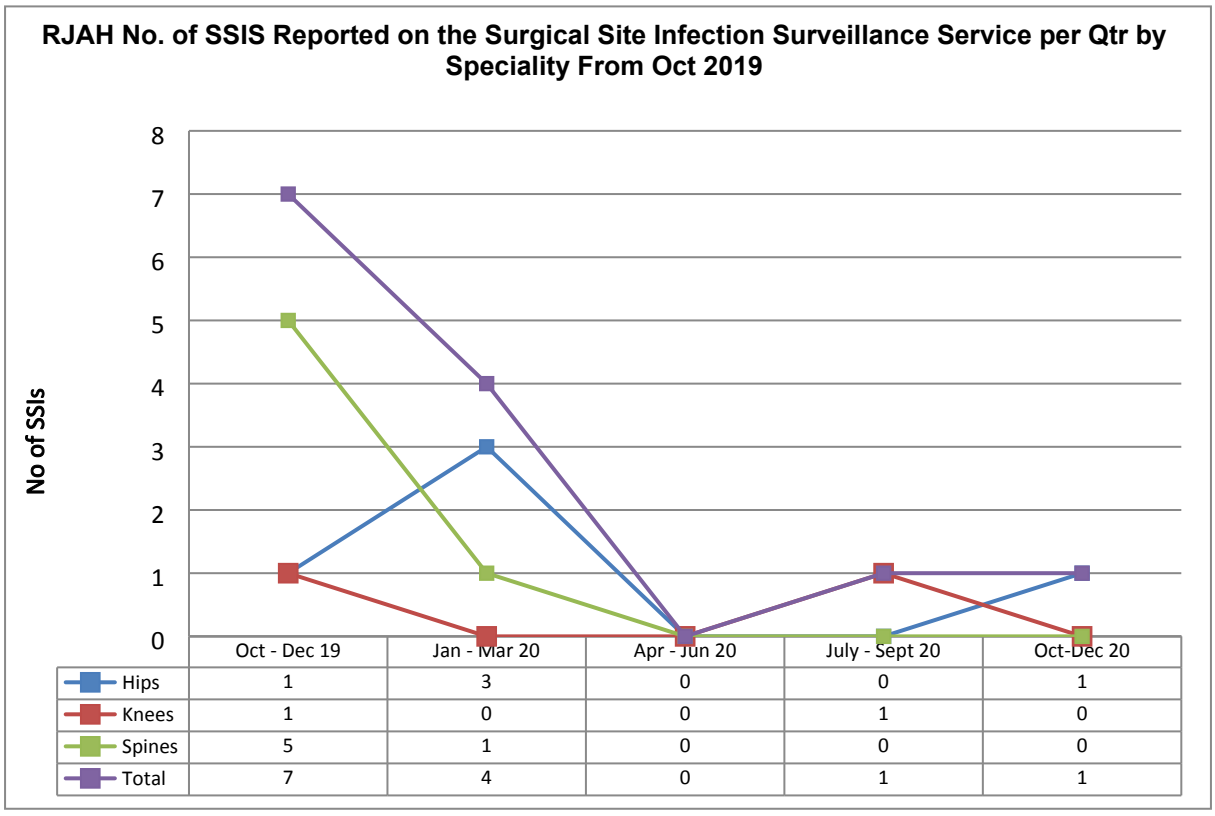
From April 2020 – March 2021, data on 968 operations – 423 Total Hip Replacements (THR), 334 Total Knee Replacements (TKR) and 211 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 2 SSIs reported, 1 THR, 1 TKR, and no spinal surgeries. This compares to a total of 4044 operations with 26 SSI's 11 THR, 4 TKR, 11 Spinal surgeries, reported April 2019 – March 2020.

The following graph shows the trends of the total number of SSIs that have been reported to PHE between January 2015 and December 2020. Reduced activity due to COVID-19 creates low denomanting numbers. The one TKR SSI reported in July – September came in at 1% and took us over the national average of 0.7%. The SSI portal is nationally automated and therefore can not off-set reductions in activity figures. Because of this, the Trust received an outlier letter from PHE

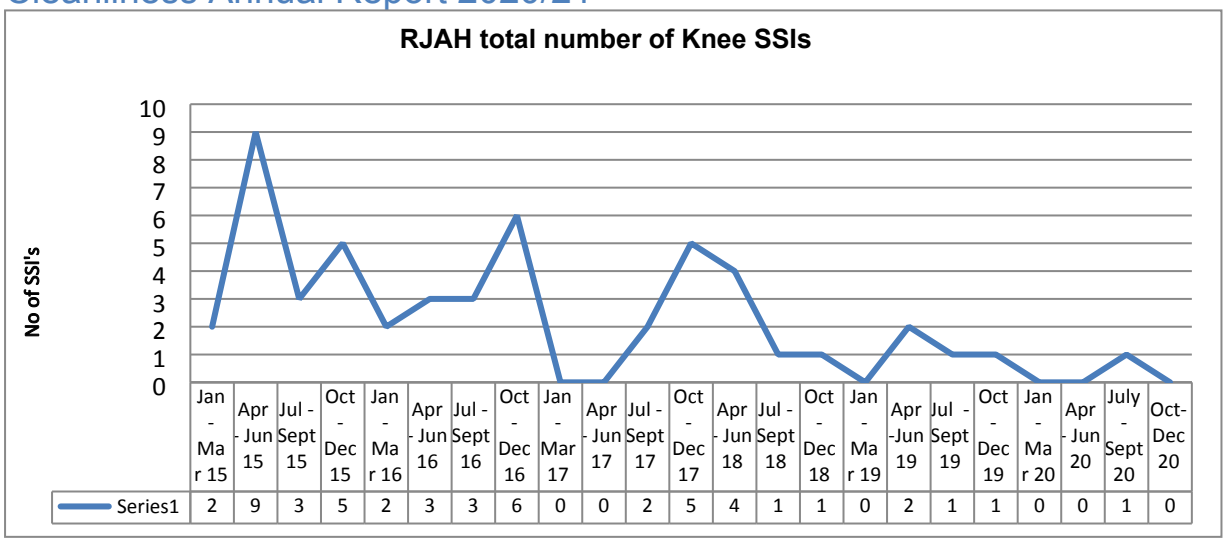


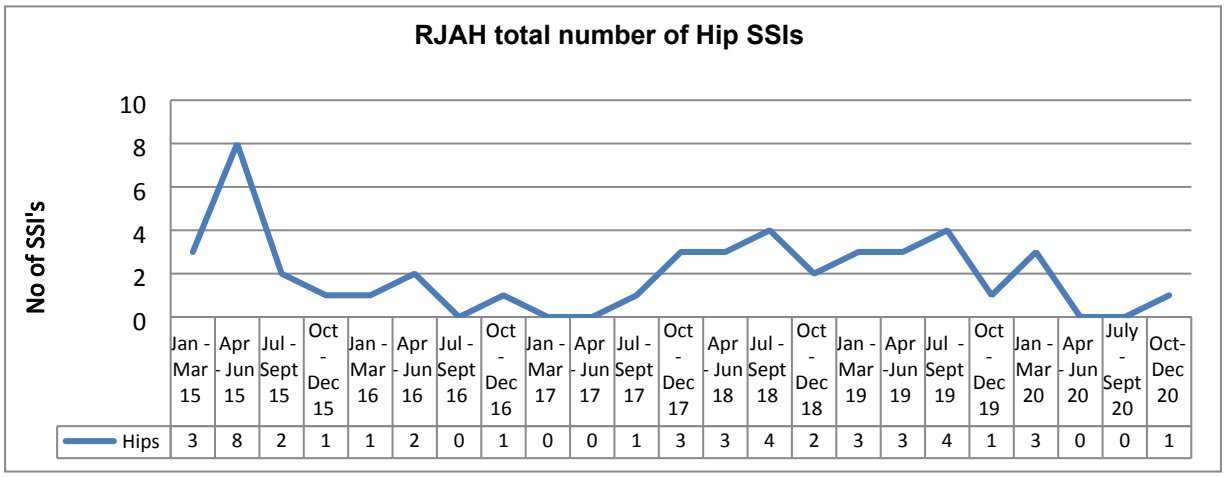


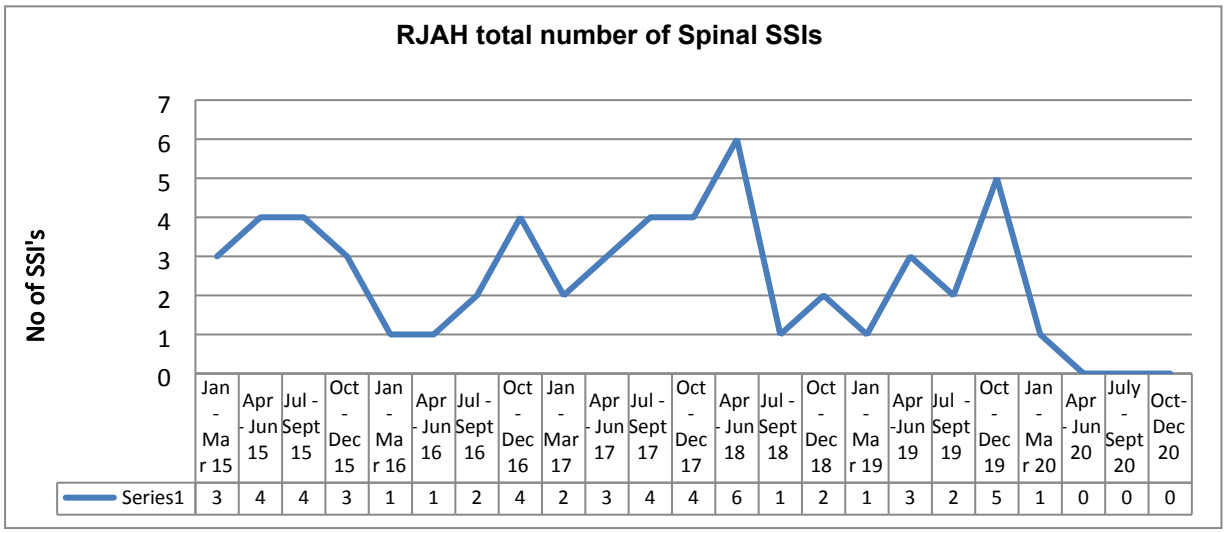
	Oct - Dec 19	Jan -Mar 20	Apri - Jun 20	July - Sept 20	Oct - Dec 20
Hips	0.2	0.9	0	0	0.3
Knees	0.2	0	0	1	0
Spines	2.3	0.5	0	0	0



	Oct - Dec 19	Jan - Mar 20	Apr - Jun 20	July - Sept 20	Oct-Dec 20
Hips	1	3	0	0	1
Knees	1	0	0	1	0
Spines	5	1	0	0	0
Total	7	4	0	1	1







Infection Multi-Disciplinary Team (MDT)

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

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

Outbreaks

There was a total of nine COVID-19 outbreaks across the Trust during 2020/21.

Each outbreak was investigated by the Outbreak Control Team, which consisted of a multi-disciplinary team that reviewed all available evidence, and reported to PHE and the CCG.

The main lessons learned from outbreaks were the non-compliance of social distancing in rest rooms/areas and poor compliance around PPE. Lessons learned were shared with the ward/departmental teams, SNAHP, and any areas of good practice/safety improvements were shared with other teams through the infection control working group and committee.

2020

Dept	Date declared	How many involved (staff and pts)	Themes identified
Pre-op assessment Unit	29/10/2020	3 staff	• Possible link to a patient at POAU
Powys/HDU	02/11/2020	4 patients 8 staff	• PPE compliance • Social Distancing compliance
OPD	26/11/2020	5 staff 1 Company Rep	• PPE compliance • Amber area = Higher risk of transmission
TSSU	8/12/2020	2 staff	• Worked together on one shift but not breaches in PPE. No root cause found
Radiology	15/12/2020	4 staff	• RCA currently being undertaken
OPD2	23/12/2020	3 staff	• Amber area, high volume of staff/patients
MCSI Resettlement	31/12/2020	2 staff	• Environmental clutter

2021

MCSI	18/01/2021	8 patients 5 staff	• Staff member came into work while household member displayed COVID-19 symptoms • Some lapses in PPE usage by staff • Some environmental cleanliness issues
Sheldon Ward	25/01/2021	2 patients	• Patients in same ward at referring Trust – possible transmission

3.2. Serious Incidents/ Periods of Increased Incidence

There were 2 serious incidents reported during 2020/21.

During April 2020 there was an outbreak of COVID-19 involving 4 patients and 2 staff which was reported as a serious incident. Two of the patients were part of the asymptomatic point prevalence trial. A route course analysis was undertaken which identified the root cause being that the patient had moved to multiple bedspaces. Lessons learnt include:

- Limit patient bed space movement within the trust.
- Positive patients to remain in isolation for 14 days as per national guidance.

During November there was an incident in which involved an anaesthetist who had an external PCR swab taken for COVID-19 and was notified of a positive test result. An internal contact tracing investigation as part of the root cause analysis subsequently identified 10 contacts who had breached the Trusts PPE/Social Distancing guidelines. Consequently 11 members of staff from the same department needed to self-isolate for 14 days which impacted on the cancellation of patients.

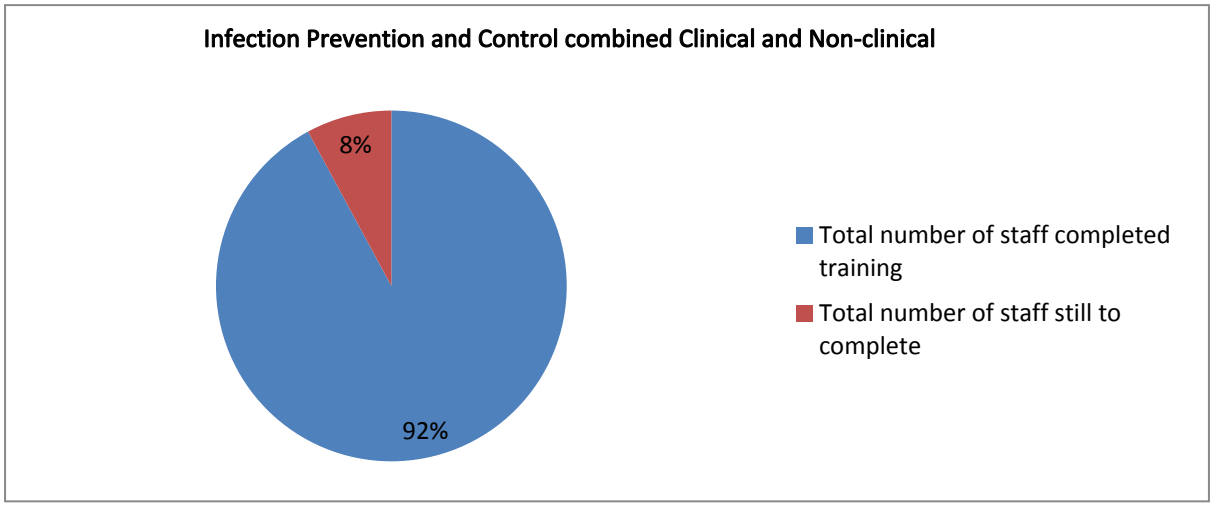
3.2.1. Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

At RJAH infection prevention is included in all job descriptions.

IPC training is delivered via the national 'e-learning for Health' module. The graph below shows the trainng compliance for 2020/21.

Training Compliance

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



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

It was noted that a minority of staff (8%) had not completed Infection Control Training and although work was undertaken to identify reasons for non compliance, this level of detail is not currently captured by the Training Department.

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

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

3.2.2. Criterion 7: Provide or secure adequate isolation facilities

The Trust has always been able to accommodate patient isolation with minimal disruption to the running of the wards. A risk assessment tool is available to help staff in making these decisions and ensuring that practice is consistent.
The IPC team work closely with ward staff and Clinical Site Managers to ensure the most effective use of side rooms according to risk. However, due to the increase of patients carrying antibiotic resistant organisms requiring siderooms for isolation, the installation of additional doors to the bays has been implemented on the spinal injuries unit to enable patients with the same carriage to be cohorted together in an isolated bay with the doors acting as a barrier as well as a reminder for staff to implement standard precautions.

In response to the isolation requirements during the COVID-19 pandemic; an options appraisal has been submitted for the installation of additional doors on bays across the Trust.
During the first wave of COVID-19 Ludlow ward which consist of 14 single siderooms was identified as the isolation area for patients who were displaying symptoms/ confirmed positive.

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

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

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

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

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

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

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

Policies Reviewed Published in 2020- 21	
Coronavirus Policy	HCAI Reporting
Meningococcal Disease	Aseptic Technique
Waste Policy	HCAI Reporting
Varicella Zoster Virus	Clostridium Difficile

The IPC Team made it a priority to review the backlog of policies and procedures for 2020/21. A policy tracker was created to ensure a robust system for the review and update of policies and procedures. A matrix has also been implemented to serve as a working planner and provides dashboard data to the Infection Control & Cleanliness Committee for assurance. The Coronavirus policy is regulary monitored and updated to relect the changes in national guidance.

An Infection Prevention & Control A-Z of Common Infections is available on the Trust's intranet. This significantly enhances the quick location of key infection prevention guidance by our front line staff in regards to infection control common infections. Staff also have a direct link from the intranet to the Royal Marsden polices on nursing procedures.

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

Team Prevent Health Occupational Health and Employee Well-Being

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

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

Blood Bourne Virus Exposure

Blood Borne Virus Exposure incidents or injuries may represent a significant risk to staff working in health care environments.

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

TP Health are responsible for the assessment and follow up of all Blood Borne Virus exposure incidents occurring during departmental opening hours and for the follow up of those exposure incidents occurring out of hours in Emergency Departments.

April 2020 to April 2021 exposure incidents reported to TP Health was a total of 14 which is a reduction since 2019/2020 figures. 7 of the cases were due to a percutaneous injury. The highest number of incidents occurred in theatres.

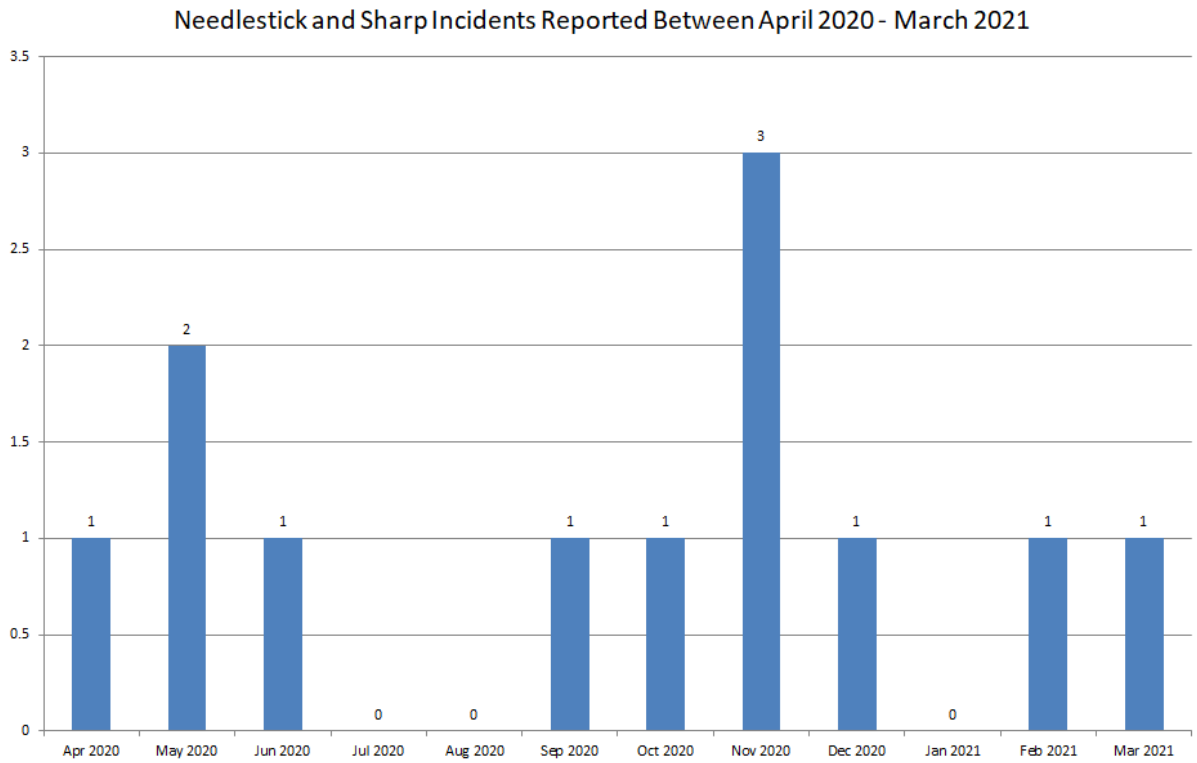
Safer Sharp Regulations

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

Following a review of safer sharps it was highlighted that the Trust was failing to comply with the above regulations. Positive action was taken to return the Trust to compliance which led to a significant reduction in needlestick injuries compared to the 2019/20 reporting year.

There were 33 reported needlestick injuries in 2019/20 compared with 12 in 2020/21.

The graph below is a breakdown of reported Needlestick / Sharps incidents in the last 12 months:



Conclusion

The year 2020/21 was another successful period in meeting the targets set by Public Health England and the Clinical Commissioning Group at RJAH Orthopaedic Hospital.

The Infection Prevention and Control Team have continued to provide an essential service to the Trust encompassing the infection prevention and control service ,surgical site surveillance service,

microbiology ward rounds, post infection review/root cause analysis, education, HCAI surveillance, meetings and audits.

The COVID-19 pandemic has proved a huge challenge for the NHS with a profound impact on Infection Prevention and Control Teams having to comprehend, disseminate and implement the ever changing national guidance.

The Infection Prevention and Control Team and Estates & Facilities have worked together in a united approach to provide a safe environment for patients and staff across the Trust.

9 COVID-19 outbreaks were declared during the second wave ,however the hard work, coloboration and determination of all staff resulted in the prevention and control of the virus across the wards and departments.

COVID-19 has changed the map of infection Control both nationally and internationally highlighting the paramount importance of standard infection control precautions.

The Trust management team have recognised, improved and expanded the IPC team to incorporate new challenges that we will be faced with in the near future.

The biggest challenge for Infection Prevention and Control next year will continue to be the ongoing managemert of the COVID-19 pandemic.

Stacey Keegan: Director of Infection Prevention and Control (DIPC)

Sue Sayles: Infection Prevention and Control Lead Nurse

June 2021

Key Areas of Focus for 21/22

- Achieving PHE National & CCG Infection targets
- PIR of all patients reported with positive blood cultures
- IT Solution for Infection Prevention & Control
- Improve website and intranet
- Collaborative programme for IPC review in satellite clinics
- Introduce a policy tracker system

Appendix 1: Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship Committee
ANTT	Aseptic Non Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CCG	Clinical Commissioning Group
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
E.Coli	Escherichia coli
EPR	Electronic Patient Record
ESBL	Extended Spectrum Beta Lactamase
HCAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
IV	Intravenous
JAC	JAC – Electronic Pharmacy System
KPI's	Key Performance Indicators
MDT	Multi Disciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PALS	Patient Advice and Liason Service
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment

Appendix 1: Acronyms Continued:

RCA	Root Cause Analysis
RSH	Royal Shrewsbury Hospital
SATH	Shrewsbury and Telford Hospitals
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
TSSU	Theatre Sterile Services Unit
WTE	Whole Time Equivalent

Appendix 2: Glossary

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
C. difficile	or C. diff is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.
E coli	is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.
HCAI	Health Care Associated Infection. An infection acquired as a result of receiving treatment in a health care setting.
MRSA	or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria,Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.
MSSA	or Methicillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.

Chair's Assurance Report
People Committee – 2 September 2021

0. Reference Information

Author:	Mary Bardsley Assistant Trust Secretary	Paper date:	23 September 2021
Executive Sponsor:	Paul Kingston, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the People Committee on 2nd September 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

- The meeting was well attended and noted as quorate
- The members of the meeting considered and noted the Guardian of Safe Working Hours Annual Report
- An update was received on the consultant capacity project plan and staff survey.
- The Committee received an update on the STW People Plan
- The Uniform Policy was considered
- Assurance Chair Reports were provided with no major concerns highlighted

2.3. Conclusion

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

3. Main Report

3.1 Introduction

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

Attendance:	
Paul Kingston	Non-Executive Director (Chair)
Harry Turner	Non-Executive Director
Chris Beacock	Non-Executive Director
Alyson Jordan	Managing Director of SSU
Stacey-Lea Keegan	Interim CEO
Sarah Sheppard	Chief of People
Hilary Pepler	Board Advisor
Ruth Longfellow	Chief Medical Officer
Shelley Ramtuhul	Trust Secretary
Sarah Thomas	Learning & Development Manager
Sue Pryce	Head of People Services
Amber Scott	Minute Secretary
Attendance:	
Craig Macbeth, Alexander Yashchick, David Low, Kerry Robinson, Sara Ellis-Anderson, Greg Moores	

3.2 Actions from the Previous Meeting

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

3.3 Key Agenda

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

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
Declarations of Interest		
None to note	N/A	
STW People Plan (highlight report)		
The STW People Plan was presented to the Committee. The guidance and development between the ICS and the ICB are currently being developed. The Trust are involved in the work being completed as part of the system. The ICS has resources centrally that are leading some projects, although, the Trust wished to highlight the progress being made in the organisation relating to the health and well-being around the occupational health, equality, diversity and inclusion and leadership development. The members of the meetings agreed that the Committee will be sighted on the Trust and System alignment. It was noted that Shropshire have a high turnover relating to retention. The Committee agreed to regular updates to provide assurance on this matter.	Partial	Further assurance to be provided on a regular basis through the People Committee. System workforce and governance to be noted as a risk at the Board of Directors meeting in September.

The performance measures were presented to the Committee. It was suggested the reporting should align and some of the measures within the internal reports to ensure the committee is cited on the data. The committee agreed to this and thanked the Trust for highlighting the issue and potential risk. Concerns were raised relating to the turnover of staff, noting that one enabler of this is the re-training of staff when moved either by request or choice, along with the delays in receiving an up-to-date DBS with the new Trust. The Trust informed the Committee that there are Training Passports in place, and these can be ported to other organisations within the system for ease of flexing across sites. Regarding the DBS, it was noted that this issue is unable to be resolved as it is a statutory requirement for every employer to receive an up-to-date DBS check on every employee. Further concerns were raised relating to the system workforce risk and governance within the ICS, and the current lack of clarity, suggesting this is raised as a risk. It was agreed that this point would be raised at the Board Meeting.		
MCSI Workforce Improvement Plan		
The Committee received the training summary noting that all disciplines are above 95% for the mandatory IPC modules and Cleaning for confidence. An action plan following an internal outbreak meeting has continued to be a focus for a Trust wide roll out of other relevant training. Further to this the courageous conversations training around challenging in an effective way can be delivered virtually by NHSE/I. An MCSI staffing paper will be submitted to the Senior Leaders Group highlighted the requirement to invest in HCAs across the unit. Along with a further paper noting the requirement to increase housekeeper provision aiming for a 12-hour 7/7 service on MCSI. A plan is to be created to conduct audits to ensure training is being implemented, this will ensure that continuous overview is offered. The Non-Executive Directors asked the information to be shared with the Audit Committee for oversight to ensure full assurance is offered on the matter.	Y	Further information to be shared with the Chair of the Audit Committee.
Consultant Capacity Project Update		
The managing directors are continuing to work closely on this and working through with the capacity, which is feeding through the recruitment plans, adding that there is recruitment ongoing now and progress is being made. The sufficient progress on the MSK Unit is not being made now due to ongoing work through the theatre capacity. The Trust is using IJP to fill session capacity at the moment, with continual checks to make sure all in job plan is booked in first. There is progress being made with job	Partial	A detailed paper to be presented at the next People Committee before presentation at the Board in October.

planning, to ensure robust plans are in place to enable recruitment. AJ added that a lot of work is going on in the background, with in depth detail that is not visible at committee level. It was noted that the job description for Knee and Sports has been submitted to the Royal College and the Upper Limb job description is being sourced ready to submit to the Royal College. The Committee required a further update to provide more assurance at the next Committee meeting in October. The Non-Executive Directors requested an update to be provided to the Board to ensure movement on the project.		
Staff Survey		
Focus groups with several staff members across all units have been set-up to understand more about two particularly decreasing trends in the staff survey around workplace well-being and communication with senior managers. There were 42 participants who joined the focus groups that were held digitally, although recognising that some groups will have trouble accessing these at a later stage. Socially distanced focus groups were held on the Hospital field to offer further staff members the chance to voice their opinions. Some findings include: • safeguarding mental health was important, with a keenness to be able to understand more and help their colleagues when they could see them suffering with mental health difficulties • poor communication with senior managers, with a desire for more visibility, accessibility, and timeliness of cascade of communication, which has been shared within the report and the qualitative feedback. An improvement plan is being created and submitted to the SLG receiving some further recommendations and deliverables. The Committee thanked the Trust for the update and the assurance offered through the report.	Y	
Performance Report		
The new reporting format was highlighted to the Committee – highlighting any exemplars, with both positives and areas of concern to note. A total of 5 areas were highlighted in month, these included: • *Mandatory training* - focus on this system to improve and retain these improvements. • *Vacancy rates* - both with regards to improvements seen and some concerns to note. There has been a noted deterioration ongoing since August 2020, previous figures came below 5%, which are now at 6.97% for the Trust. • *Radiographer vacancy* – a reduction in vacancy rates, with the target set for this at 8% and currently being on 11% showing progress in this area.	Y	

• *Health care support workers* - have increased in vacancies due to the creation of 11 nurse associate posts noting the step change to this. • *Nursing vacancy* - rate is a concern as it is still above target, improvements are being seen, but it is to currently just above that 8% target. The Trust confirmed the figures will show an improvement next month as 11 appointments have been offered included - apprenticeships and training nurse associates. The Committee noted that this is not a deficit of 11 staff but a change in status.		
Guardian of Safe Working Hours		
The Trust were informed that there are currently 18 trainees and there have been no exceptions recorded to the Trust. This demonstrates that the Trusty is compliant with the working requirements. The Trust has begun to report as a system which is designed to keep working hours safe. There has been a requirement to maintain the focus on training as the Trust restart elective work, with an increase activity. The Non-Executives noted that since the reporting started, the Trust has raised no issues no within reporting. The Board praised the Trust and the team that maintain the discipline and asked for their appreciation to be known.	Y	
Uniform Policy		
The Committee were informed at the Uniform Policy was presented to the JCG in July and further amendments have been requested. Therefore, the policy will be presented to the People Committee in October 2021.	Y	
Fixing SPA's SOP		
The SOP is a new introduction to fixing core SPAs into job plans. The document states the process and guidance to fixed SPA's There is also an additional SOP which describes time shifting of fixed SPA. This will be followed if the Trust requires a doctor to complete additional hours. The committee approved the SOP.	Y	
Funding and Study Leave for Professional Learning and Development and CPD		
The document has been reviewed to incorporate the CPD funding as well as a professional learning and development funding. This will simplify the application process going forward. The Committee approved the document.	Y	
Chair Reports		
Trust Performance and Operational Improvement Board The Committee noted the chairs' report. **Learning and Development Terms of Reference**	Y Y	

The Committee considered the terms of reference and suggested the wording is to be revised to reflect the responsibilities and reporting line.		
Racial Equality Pledges STW ICS		
The Committee noted the report.	N/A	
Any Other Business		
Employment Tribunal The Committee received a verbal update on the current employment tribunal. It was agreed a formal briefing will be scheduled to inform the Board of Directors. **Freedom to Speak Up** The Trust Board advisor highlighted the importance of the service and requested a monthly agenda item to be added to the workplan – the committee agreed.	Y Partial	Freedom to speak up to be added to the workplan as a monthly agenda item to provide assurance.

3.4 Approvals

Approval Sought	Outcome
Fixing SPA's SOP	approved
Funding and Study Leave for Professional Learning and Development and CPD	approved

3.5 Risks to be Escalated

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

3.6 Conclusion

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

Safe Working Hours: Doctors in Training

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	23 September 2021
Executive Sponsor:	Ruth Longfellow, Chef Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

2. Executive Summary

2.1. Context

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

2.2 Summary

The Trust has in place a Guardian of Safe Working and this paper presents the August 2021 report from the Guardian. It outlines the work that has been undertaken to date and highlights some of the issues being faced as the new system of monitoring and exception reporting embeds. The report provides the data currently available in relation to rota vacancies and agency and locum usage.

2.3. Conclusion

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

3. The Main Report

3.1. Introduction

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

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

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

The Guardian will:

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

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

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

Other new features of the 2016 contract include:

Work scheduling – junior doctors and employers will be required to complete work schedules for the doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement.

Exception reporting – enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose, this is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational

opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

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

3.2 Guardian of Safe Working Report

3.2.1 High level data

For the period August 2021

	Old Contract	New Contract			
ESR Organisation	MN37	MS03	MS04	MS06	Total
Junior Orthopaedic Medical staff	2	12	1	1	16
Midlands Centre for Spinal Injuries		2			2
Total	2	14	1	1	18

3.2.2 Exception reports (regarding working hours)

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

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

Currently there have been no exceptions reported to the Trust.

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

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

3.2.3 Work schedule reviews

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

3.2.4 Junior Doctor Agency and Locum usage and Rota Vacancy Report

Trauma and Orthopaedics

Number of Vacancies (28 posts)

Apr - 0

May - 0

Jun - 0

Vacant shifts

Apr - 0

May - 5

Jun - 7

Total cost - £6930

Medicine

Number of Vacancies (12 posts)

Apr -

May -

Jun -

Vacant shifts

Apr -

May -

Jun -

Total cost -

MCSI

Number of Vacancies (9 posts)

Apr – 3

May – 3

Jun - 3

Jul – 3

Vacant Shifts

Apr – 20

May – 19

Jun – 20

Jul - 17

Total cost - £8712.62

Long Term Vacant Shifts

MCSI is consistently running with vacancies (3)

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction was attended in August 2021. During the pandemic Junior Doctor Forum has been reinstated virtually. Attendance was down from previous meetings. Poor attendance has, unfortunately persisted. This is an area I would like to see increased engagement with and will liaise with the Comms department to try and achieve this.

3.3.2 Software System

Engagement with Allocate is still awaited.

Associated Risk

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

COVID will have impacted on staffing and the requirements for short notice internal locums.

Next Steps

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

3.4. Conclusion

The Trust continues to see no exception reports or fines.

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

Freedom to Speak Up

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

0. Reference Information

Author:	Elizabeth Hammond, Freedom to Speak Up Lead	Paper date:	23 September 2021
Executive Sponsor:	Sarah Sheppard, Chief People Officer	Paper Category:	Strategy / Performance
Paper Reviewed by:	People Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This is the 12 month FTSU review. The National Guardian Data provides an analysis of concerns raised via FTSU from NHS and Private hospitals.

The report was presented to the People Committee in July 2021.

2. Executive Summary

2.1. Context

This report has been prepared to provide the Trust Board with an update over the last year on the progress of FTSU within Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust. The report has been presented to the People Committee.

2.2. Summary

This report provides a summary of activity, feedback and themes of concerns raised to the Freedom to Speak Up (FTSU) Guardians. Due to the current situation, this report will focus on the concerns raised through FTSU with actions in relation to this time frame.

2.3. Conclusion

The Trust Board are asked to note the content of the report and be assured that the People Committee will continue to monitor FTSU and is now a standing item on the meeting agenda.

3. The Main Report

Summary of Activity;-

Since March 2020 to December 2020 RJAH FTSU has received 30 concerns. 50% of the concerns have been anonymous. The anonymous concerns have decreased by over 30% from the previous 6 months.

The majority of the concerns are in relation to PPE and social distancing issues during Covid Pandemic. FTSU have also received several behaviour concerns.

FTSU Concerns are acknowledged within 48 hours with action and expected outcome agreed with the colleague that has raised the concern.

Every concern has been escalated with appropriate action taken accordingly which is then fed back to those that raised a concern, in a timely manner.

All responses have been accurately documented either via the App log or manually.

FTSU has been continuously publicised in the CEO's Tuesday blog (Stacey Keegan) and via Comms.

The National Guardianship has produced a new logo to promote FTSU which was launched at RJAH during Freedom to Speak Up October.

New logo for the National Guardian's Office

National Guardian

Freedom to Speak Up

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

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

The symbol of the tree encapsulates the guardian values:

Courage: a tree stands strongly rooted in a storm

Impartiality: trees welcome all within their branches without judgment

Empathy: trees nurtures the lives which live within its branches

Learning: a 'growth' mindset.

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

The FTSU manager has attended monthly Teams meetings with the Regional Guardians. This is a chance for all Guardians to discuss concerns that have been raised, compare regional similarities and themes relating to concerns, actively share learning from concerns and

teaching resources used in different NHS hospitals to promote FTSU, patient safety and staff well-being.

Since March the main regional themes have been related to social distancing and behaviours in the majority of Trusts.

Many Trusts have found it difficult to engage with staff members due to working from home and been unable to meet face to face. However, as staff have developed their skills with Teams, face to face conversations have been taking place. Overall, Trusts are reporting a decline in staff raising concerns. This is due to several reasons:-

1) Many staff are working from home
2) Staff have been redeployed and are not aware of who the FTSUG is in a different Trust.
3) Staff have not wanted to use Teams or send e-mails about their concerns and preferred face to face consultations.

Freedom to Speak Up October

Due to the Covid Pandemic the RJAH Guardians decided against walk-abouts to promote FTSU. Instead, with the valuable support and help from the Comms team, we have produced a 'Thank you poster', highlighting some of the concerns raised, the actions taken and what, as a Trust, we learnt. It also highlighted the importance and benefit of giving contact details to the Guardians as well as highlighting the Guardians' code of confidentiality and its meaning.

In partnership with the Comms Team we are looking at using examples of FTSU 100 voices to show the different types of concerns which have been raised nationally.

Working alongside the Education People department we have produced a written overview of what FTSU is, what concerns can be raised, how staff can raise a concern, contact numbers and FTSU App details. This is part of the Induction package given to all new starters.

New e-learning resources and an induction film to support NHS staff who want to raise concerns on issues such as patient safety are being launched by Health Education England (HEE) during national Speak up Month - the national campaign run by the National Guardian's Office aimed at encouraging a speaking up culture across the NHS where people feel their voices will be heard, improving transparency and sharing best practice.

The resources include 'Speak Up' the first instalment of a three-part 'Speak Up, Listen Up, Follow Up' e-learning programme that supports staff in raising concerns on a number of issues such as inappropriate treatment, bullying harassment or poor behaviours. 'Speak Up' is aimed at all NHS colleagues including volunteers, students and those in training, regardless of their contract terms. It will help learners understand how to speak up and what to expect when they do. Release of the subsequent 'Listen Up' and 'Follow up' modules, aimed at middle managers and senior leaders respectively, will follow by March 2021.

These videos have been shared on the RJAH Facebook site by the FTSUG Liz Hammond

Managers Training

A Manger's training session/handbook is being developed. This gives managers the tools to encourage staff to Speak UP. It covers the vision of Freedom to Speak Up, objectives, how to recognise when a member of staff is speaking up, how to respond to someone who is speaking up, how to act on and manage speaking up and implementation of feeding back and learning.

RJAH Quarterly FTSU Date submitted to the NGO.

Quarterly FTSU Data April 2019-March2020				
Size of organisation	Less than 5,000 (small)	April-June	July-Sept	Oct-Dec	Jan-March
		Q1	Q2	Q3	Q4
Number of cases brought to FTSUGs / Champions per quarter		4	2	6	2
Of which there is an element of					
Number of cases raised anonymously		3	0	3	1
Number of cases with an element of patient safety/quality		1	1	1	0
Number of cases with an element of bullying or harassment		4	1	4	1
Number of cases where people indicate that they are suffering detriment as a result of speaking up		0	0	0	0
Numbers of cases brought by professional group					
Administrative/clerical staff		0	0	1	1
Allied Healthcare Professionals (other than pharmacists)		0	0	0	0
Board members		0	0	0	0
Cleaning/Catering/Maintenance/Ancillary staff		0	0	0	0
Corporate services		0	0	0	0
Dentists		0	0	0	0
Doctors		0	0	1	0
Healthcare assistants		0	0	0	0
Midwives		0	0	0	0
Nurses		1	2	1	0
Other		3	0	3	1
Pharmacists					
Response to the feedback question,					
'Given your experience, would you speak up again?					
Total number of responses					
The number of these that responded 'Yes'					
The number of these that responded 'No'					
The number of these that responded 'Maybe'					
The number of these that responded 'I don't know'					

Quarterly FTSU Data April 2020-March2021				
Size of organisation	Less than 5,000 (small)	April-June	July-Sept	Oct-Dec	Jan-March
		Q1	Q2	Q3	Q4
Number of cases brought to FTSUGs / Champions per quarter		9	5	12	0
Of which there is an element of					
Number of cases raised anonymously		6	2	4	0
Number of cases with an element of patient safety/quality		1	2	0	0
Number of cases with an element of bullying or harassment		1	0	4	0
Number of cases where people indicate that they are suffering detriment as a result of speaking up		0	0	1	0
Other		2	1	4	0
Numbers of cases brought by professional group					
Administrative/clerical staff		0	1	2	0
Allied Healthcare Professionals (other than pharmacists)		1	0	2	0
Board members		0	0	0	0
Cleaning/Catering/Maintenance/Ancillary staff		0	0	0	0
Corporate services		0	0	0	0
Dentists		0	0	0	0
Doctors		0	0	1	0
Healthcare assistants		0	0	0	0
Midwives		0	0	0	0
Nurses		2	1	2	0
Other		6	3	5	0
Pharmacists		0	0	0	0

As you can see from the latest data there has been a steady increase of the number of staff raising concerns especially in the third quarter, October 2020- Dec 2020.

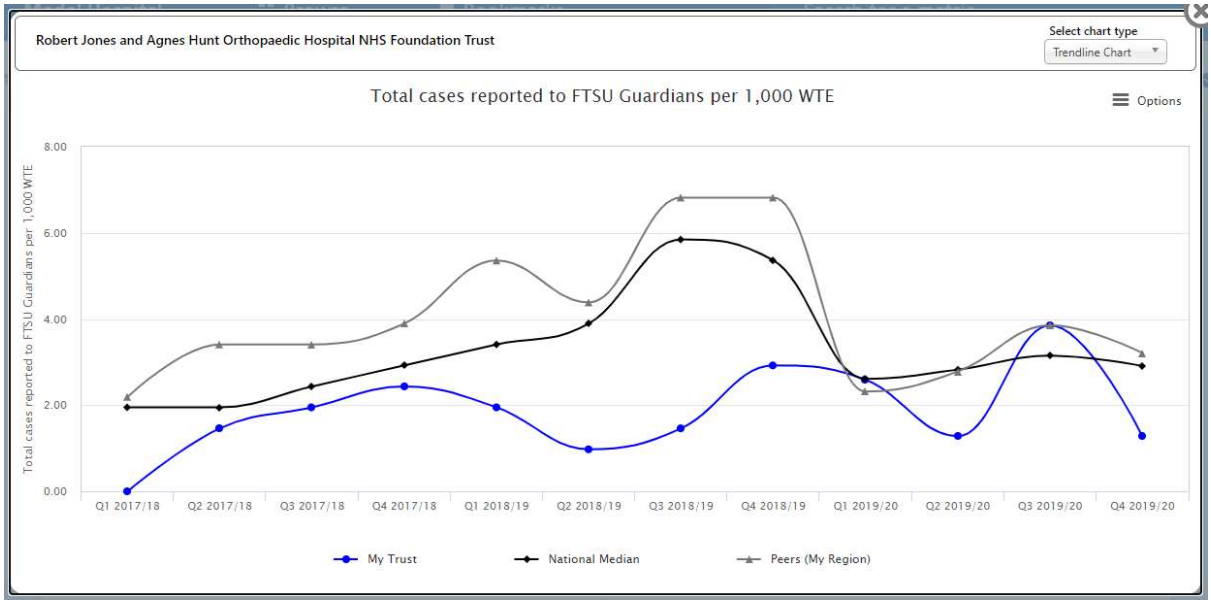
It is also noted that we have received one case which felt that they had suffered detriment from raising a concern via FTSU. This particular case is complicated as it is linked to another local Trust where the original concern was raised.

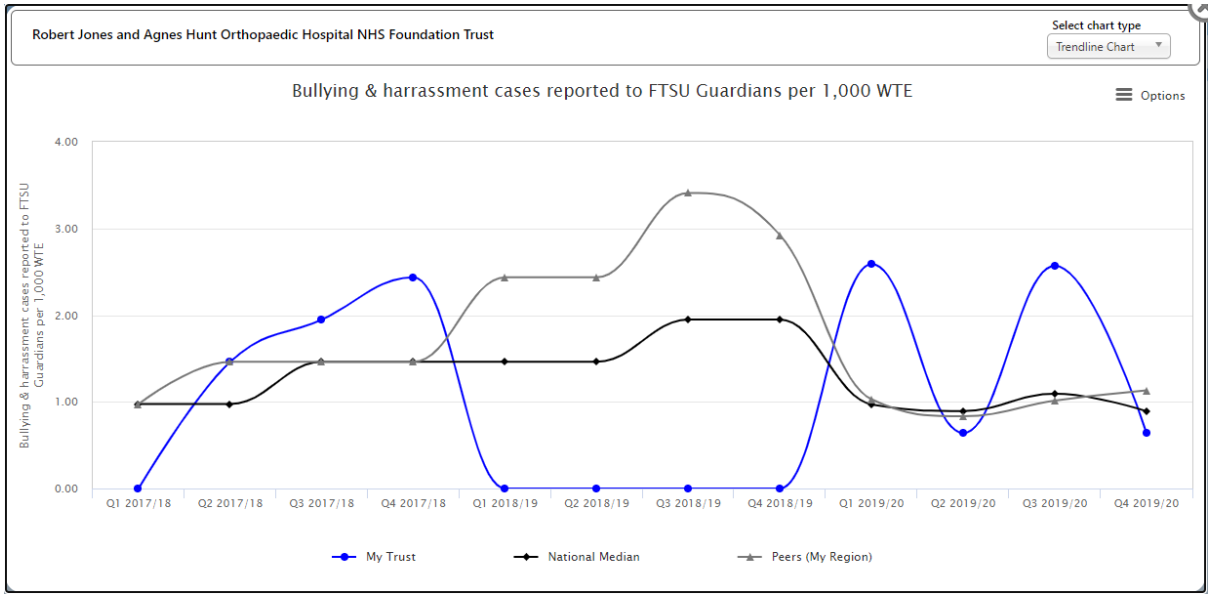
It has also been noted that over 50% of concerns have been raised confidentially and have shared their identity. This has enabled the FTSUG to give feedback and acquire additional information before escalating the concern

Below is a graph comparing the total cases reported to the FTSU Guardians, with our peers in our region and the National median over the last 3 years.

RJAH peer groups are:- Shrewsbury & Telford, Community, Worcestershire, Sandwell & West Birmingham, Lincolnshire, Nottingham, Kettering George Elliot, Manchester University, Dudley Group, Wolverhampton, Royal Orthopaedic Hospital NHS FT, University Coventry & Warwickshire and Shropshire Community.

It is notable that RJAH has 1,263 staff in comparison with the other hospitals that have between 1,994 - 12,882 staff. Keeping this in mind when analysing the graph, you would expect the other hospitals to have a higher percentage of staff raising concerns than at RJAH.





Actions

Shared learning with the Communication Team.

Share appropriate concerns about social distancing, hand washing/ gelling and PPE issues with Director of Nursing, Infection Control and H&S Lead.

Behavioural issues escalated to appropriate manages who investigated the concerns and provided feedback to the Guardians on the Actions and Learning that had taken place.

Provided teaching package on FTSU, What FTSU is? What concerns you can raise? and How to raise a concern?

Regular Comms promotion of FTSU

Learning

Monthly promotion of the FTSU service and related issues keeps the spot light on FTSU. Staff are then constantly reminded of the service.

Making sure all photos published by the Trusted are dated and an explanation as to why there appears to be no social distancing.

When staff quotes are used, check context and how it could be perceived by different staff.

Feedback is essential to all staff to demonstrate that ALL concerns raised have been acted upon and where appropriate give general feedback via Comms on any changes which have been made in the Trust as a result of concerns raised via FTSU.

Feedback and support, by Guardians, to staff, which have raised concerns has been well received and has helped build confidence in the FTSU role within the Trust.

Staff find challenging someone's, perceived, unacceptable behaviours, at the time of the incident, difficult. As a result, behaviours are not challenged at the time of the incident and are left too long until the behaviours are addressed. It would be advantageous if the Trust could develop some training and tools, for all staff, in how to challenge behaviours. This been partly addressed by the resilience and human factors training.

3.1. Conclusion

FTSU Guardians will continue to promote FTSU within the Trust. FTSUG will endeavour to monitor the concerns raised to make sure that previous lessons learnt continue to be implemented within the Trust.

With the support of the executive lead for FTSU we are planning to recruit Champions/Advocates for FTSU to support the development of FTSU within our organisation..

This would involve putting together guidance for the role and clear parameters of the expectations of this role of champions/advocates.

Having taken advice from other Trusts, Advocates would be interviewed to assess suitability for the role. We would also be looking to actively recruit champions/advocates who have protected characteristics as well as advocates for each job category.

As guardians we require the full backing of the executives to enable staff to raise concerns without detriment and to enable change in procedures to enhance patient safety and staff welfare.

Chair's Assurance Report

Extra Ordinary Audit Committee 2nd September 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	23 September 2021
Executive Sponsor:	David Gilburt, Non-Executive Director	Paper Category:	Governance
Paper Reviewed by:	Chair of the Audit Committee	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

This paper presents an overview of the Extra Ordinary Audit Committee Meeting held on 2nd September 2021 and is provided for assurance purposes.

2. Executive Summary

2.1 Context

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

2.2 Summary

Key points to highlight from the meeting

- The meeting was well attended.
- The Committee received the VFM Report for noting.
- The Committee considered the work plans for the Audit and Risk Committee and Quality and Safety Committee following the discontinued Risk Management Committee.

2.3. Conclusion

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

Chair's Assurance Report
Extra Ordinary Audit Committee 2nd September 2021

3. Main Report

3.1 Introduction

This report has been prepared to provide assurance to the Board from the Extra Ordinary Audit Committee which met on 2nd September 2021. The meeting was quorate with five Non-Executive Directors present. A full list of the attendance is outlined below:

Attendance:			
Present:	David Gilburt	Non-Executive Director (Chair)	DG
	Paul Kingston	Non-Executive Director	PK
	Harry Turner	Non-Executive Director	HT
	Alison Tumilty	Non-Executive Director	AT
	Chris Beacock	Non-Executive Director	CB
Attendance:	Craig Macbeth	Chief of Finance and Planning Officer	CM
	Shelley Ramtuhul	Trust Secretary/Director of Governance	SR
	Diana Owen	Head of Financial Accounting	DO
	Mo Ramzan	External Audit Representative	MR
	Mark Salisbury	Operational Director of Finance	MS
	Peter David	Trust Governor (Observing)	PD
Secretary:	Amber Scott	Trust Office PA	AS

3.2 Actions from the Previous Meeting

As this meeting was an Extra Ordinary Committee meeting, there were no formal minutes or actions for review/approval.

3.3 Key Agenda

The Committee received all items required which were requested, an outline of each item is provided below :

Agenda Item / Discussion	Assured (Y/N)	Assurance Sought
1. Declaration of Interest		
None to note.	N/A	
2. VFM Report		
MR informed the Committee that there is a new requirement for all organisations to undertake a separate assessment of value for money for 2020/21. Deloitte, External Audit have been assessing the Trust against the framework, this included discussions with key stakeholders and a report have been produced for the Committees consideration. The scope of the work covered included: • Financial sustainability • Governance • Improving economy, efficiency, and effectiveness Following the report, the Trust can confirm that overall, there were no significant weaknesses identified with regards to achieving value for money and therefore no further reporting is required for improvement.	Yes	

It was reported that the Trust continues to have a strong financial performance record, with a strong surplus posted in 2020/2021. It was noted that there is uncertainty going into 2021/2022 in terms of the roll forward of contracting arrangements and beyond that the impact of the ICS with its deficit was likely to pose greater challenges for the Trust. Additionally, there was uncertainty regarding the national funding settlement in a post COVID environment. DO confirmed that the report will be laid before parliament alongside the annual report before the September 16th – ahead of the annual general meeting. The Non-Executives noted that the report offers considerable assurance for the Committee.		
3. Committee Work Plans		
The work plans were presented to the Committee for consideration and approval. The committee felt the that both workplans were robust and reflective of the assurances required by the Trust. In relation to the *Audit and Risk* work plan, discussions took place regarding the timing of the meeting, and consideration is to be given to extend the meeting to ensure all agenda items are discussed. In relation to the *Quality and Safety* work plan, the Chair of the Committee was in invited and in attendance for the discussion. The Non-Executive Directors asked for a policy tracker to be added to each committee workplan with an additional note added to the Committee Chair Reports in order to offer assurance to the Board of Directors that policies are regularly reviewed, current and fit for purpose.	Yes	
4. Any Other Business		
None to note.	N/A	

3.4 Approvals

Approval Sought	Outcome
Audit and Risk Committee work plan	approved
Quality and Safety Committee work plan	approved

3.5 Risks to be discussed

During its business the Committee there were no risks to be escalated by the Committee.

3.6 Conclusion

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

Chairs Assurance Report
Finance Planning and Digital Committee 21 September 2021

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	Paper date:	23 September 2021
Director Sponsor:	Rachel Hopwood, Non-Executive Director	Paper Category:	Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Finance, Planning and Digital Committee was held on 21st September 2021. A verbal update will be provided by the Non-Executive Chair of the committee.

2. Executive Summary

2.1. Context

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

2.2. Summary

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

2.3. Conclusion

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

Month 5 Integrated Performance Report

0. Reference Information

Author:	Claire Jones, Senior Information Analyst	Paper date:	23 September 2021
Executive Sponsor:	Kerry Robinson, Chief Performance, Improvement and OD Officer	Paper Category:	Performance
Paper Reviewed by:	Executive Team	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

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

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

The committee is asked to note the overall performance as presented in the month 5 (August) Integrated Performance Report, against all areas and actions being taken to meet targets.

2. Executive Summary

2.1. Context

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

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

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

2.2. Changes to Note This Month

As references in the last few months, the Finance department have been assessing the use of SPC for financial measures. This month the following measures are represented with SPC graphs:

- Cash Balance (second month as SPC)
- Agency Core
- Agency Non Core
- BPPC % of Invoices Paid Within 30 Days

2.3. Overview

Month 5 Integrated Performance Report

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.

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

Caring for Staff;

- Sickness Absence
  - Metric showing normal variation but now exceeded target for three consecutive months, currently 1% above target.
  - Long term sickness above target for three consecutive months

Caring for Patients;

- Serious Incidents;
  - Low number of incidents have taken place
  - Further analysis provided below
- 18 Weeks RTT Open Pathways
  - Metric is showing common cause variation; although consistently failing the target as expected from covid impact which will continue for a significant time.
  - First decrease rather than improvement seen in the last six months linked to activity levels.
- Patients Waiting Over 52 Weeks
  - English showing special cause variation of a concerning nature whilst Welsh shows four months of improvement giving a combined view of a continuing reduction since March of 14%
  - BCU Transfers show an improvement with reductions since November.
- 6 and 8 Week Wait for Diagnostics
  - Both metrics indicate common cause variation with variable achievement of Welsh target and consistently failing English
  - Whilst operating over and above 19/20 capacity MRI is the predominant area of impact.

Caring for Finances;

- Total Elective Activity
  - 71.47% of baseline target (19/20); underachieving the regulatory target of 85%
  - Underachieving the regulatory target of 85% completing 121 cases below the requirement.
  - Cases per session at 1.94 against plan of 2.06 equating to a shortfall of c. 41 cases
  - 88.80% sessions used against plan;
    - whilst in normal variation the target was missed by 10% in August after three months of being over 100%
    - C. 43 sessions short of our target equating to a shortfall of c. 83 cases.
    - IJP sessions shortfall was the predominant driver.
  - Touchtime Utilisation at 79.94%
- Total Outpatient Activity
  - 82.74% of baseline target (19/20); underachieving the regulatory target of 85%
  - % Virtual below 25% target at 18.86%
  - DNA rate consistently failing target
- Bed Occupancy – All Wards – 2pm
  - Metric is consistently failing target
- Income
  - Adverse position in month

- Recurrent Financial Performance (Sustainability Plan)
    - Adverse YTD

2.4. Conclusion

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

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

Integrated Performance Report
August 2021 – Month 5

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; • **blue points** have been used to show **areas of improvement** and • **orange points** for **areas of concern.** It should be noted that SPC charts do not compare performance against targets; that is the purpose of the red and green heatmap indicators.

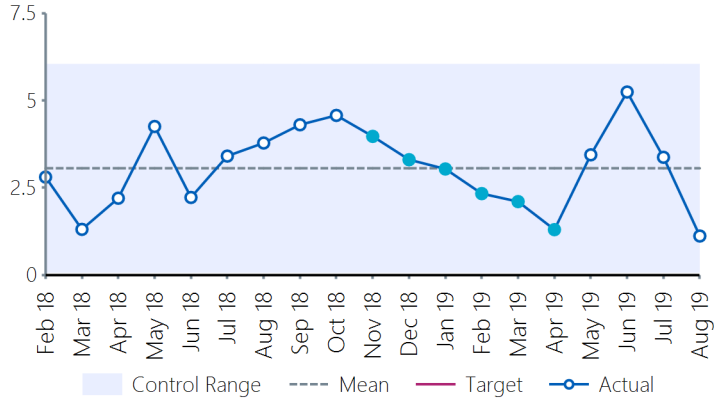
Some examples of these are shown in the images to the right:

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

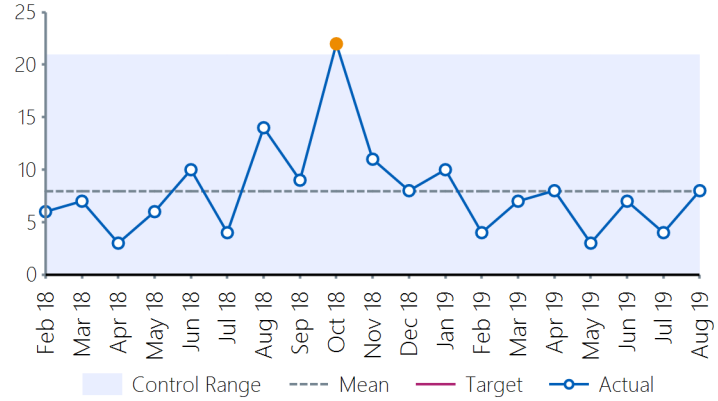
b) shows a point of concern sitting above the control range.

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

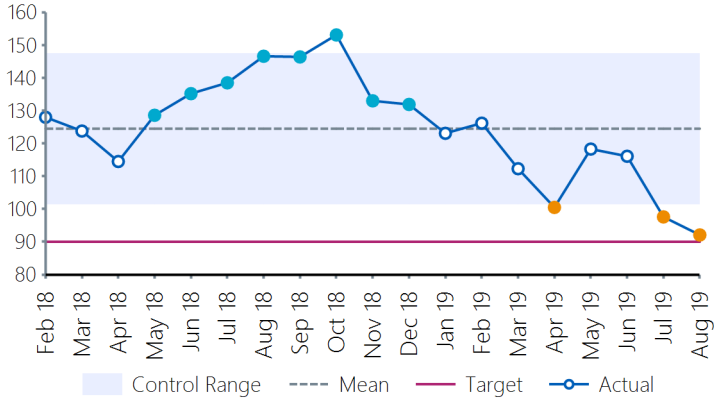
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

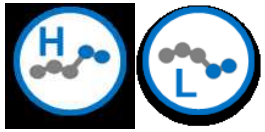
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually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

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

Variation Icons

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

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



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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Sickness Absence	3.60%	4.36%				+	27/02/20
Voluntary Staff Turnover - Headcount	8.00%	8.11%					24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	1		N/A to SPC	F	+	
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	8			?		
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Unexpected Deaths	0	0		N/A to SPC	P		16/04/18
31 Days First Treatment (Tumour)*	96%	100%		H	?		24/06/21
Cancer Plan 62 Days Standard (Tumour)*	85%	100%			?		24/06/21

Summary - Caring for Patients

KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
18 Weeks RTT Open Pathways	92.00%	57.02%			F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,475	1,304	H	F	+	24/06/21
Patients Waiting Over 52 Weeks – Welsh	0	639		L	F	+	24/06/21
6 Week Wait for Diagnostics - English Patients	99.00%	79.43%			F	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	79.39%			?	+	

Summary - Caring for Finances

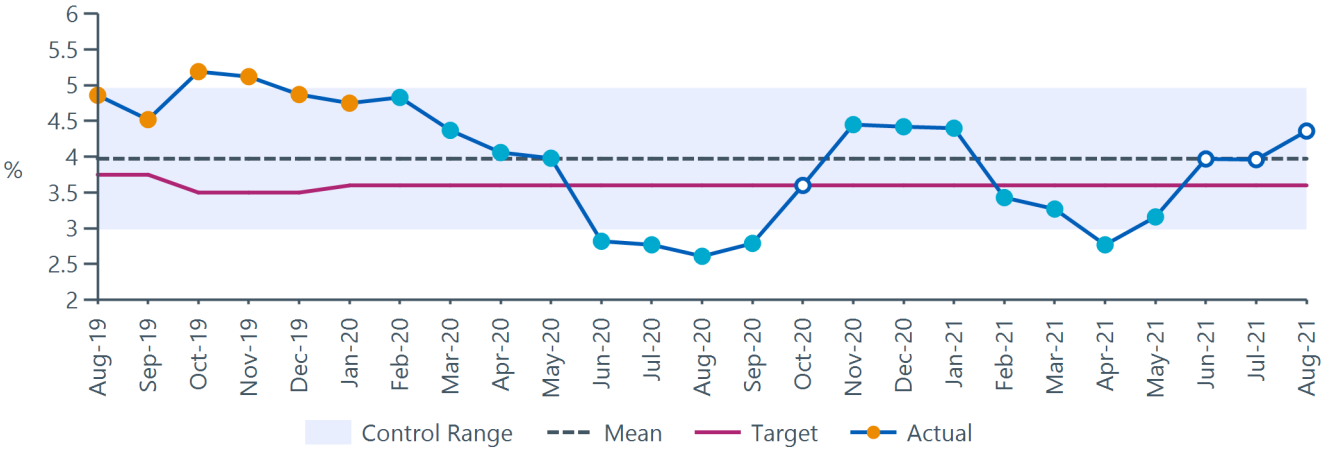
KPI (*Reported in Arrears)	Latest Target/Baseline	Latest Value	Trajectory/H1 Plan	Variation	Assurance	Exception	DQ Rating
Total Elective Activity	971	694	860	N/A to SPC	Moving Target	+	24/06/21
Bed Occupancy – All Wards – 2pm	87.00%	79.68%			F	+	05/09/19
Total Outpatient Activity	15,373	12,720	13,614	N/A to SPC	Moving Target	+	24/06/21
H1 Plan Performance	160.11	327.00	179.00	N/A to SPC	Moving Target		
Income	9,851	9,797	9,916	N/A to SPC	Moving Target	+	
Expenditure	9,735	9,517	9,737	N/A to SPC	Moving Target		
Efficiency Delivered	94.00	206.65	220.00	N/A to SPC	Moving Target		
Cash Balance	18,628.72	21,600.00		H	Moving Target		
Capital Expenditure	611	358		N/A to SPC	Moving Target		
Recurrent Financial Performance (Sustainability Plan)	-209	-256	-331	N/A to SPC	Moving Target	+	

Sickness Absence

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

Exec Lead:
Chief People Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
3.60%	4.36%		



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

Although latest data is showing normal variation, the sickness rate has been above target for three consecutive months. The August position is reported above threshold at 4.36%, driven by an increase in short term absences including an increase in Covid-19 sickness. Units above threshold for total rate of absence were MSK (5.91%) Specialist (5.24%) and CSU (4.47%). Anxiety/stress/depression and other psychiatric illnesses remained the highest reason for total sickness absence at a rate of 1.41%. Sickness absence related to confirmed cases of Covid-19 was 0.39%.

Within MSK long term sickness reduced in month but short term sickness increased from 1.67% to 2.58% with both the Surgical Wards and Theatres seeing an increase. 73.69 of the 130 FTE days increase in short term sickness were due to an increase in Covid sickness. Short term sickness also increased due to Genitourinary & gynaecological disorders; Injury, fracture, Back Problems and other musculoskeletal problems.

Within CSU total absence has increased to 4.47%. Total sickness absence in SSU has been within tolerance for the whole of the 2021/22 financial year so far. In August the total sickness absence rate was 2.03%, a decrease from 2.15% during the previous month.

Actions

Within the MSK Unit Theatres continue to review the sickness absence plan and the Surgical Wards are doing some targeted work looking reviewing active management an compliance with the sickness absence policy.

Total sickness within the CSU unit has risen since April and the unit are intending to ensure sickness absence is empathetic but robustly managed.

Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
2.61%	2.79%	3.60%	4.45%	4.42%	4.40%	3.43%	3.27%	2.77%	3.16%	3.97%	3.96%	4.36%

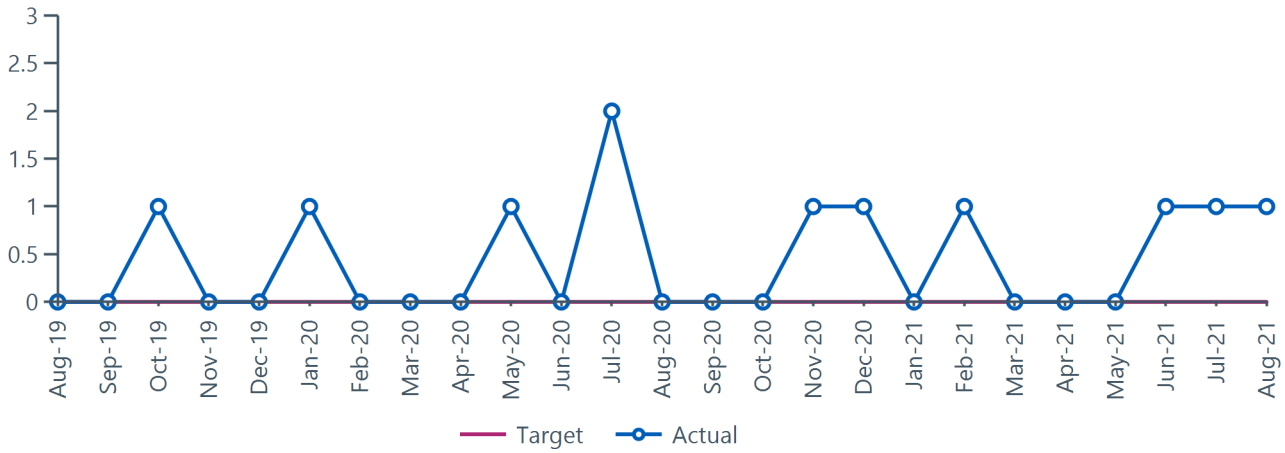
- Staff - Patients - Finances -

Serious Incidents

Number of Serious Incidents reported in month

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory/H1 Plan

What these graphs are telling us

This measure is not appropriate to display as SPC. Based on the last three months', the assurance indicates that the measure is consistently failing the target.

Narrative

There was one serious incident reported in August. A spinal injuries patient on an annual review regime was delayed in having their review that led to patient deterioration that meets the SI criteria.

Actions

An initial review has taken place with an initial action identified to ensure a harms review has been undertaken on this specific cohort of spinal injuries patient.

Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
0	0	0	1	1	0	1	0	0	0	1	1	1

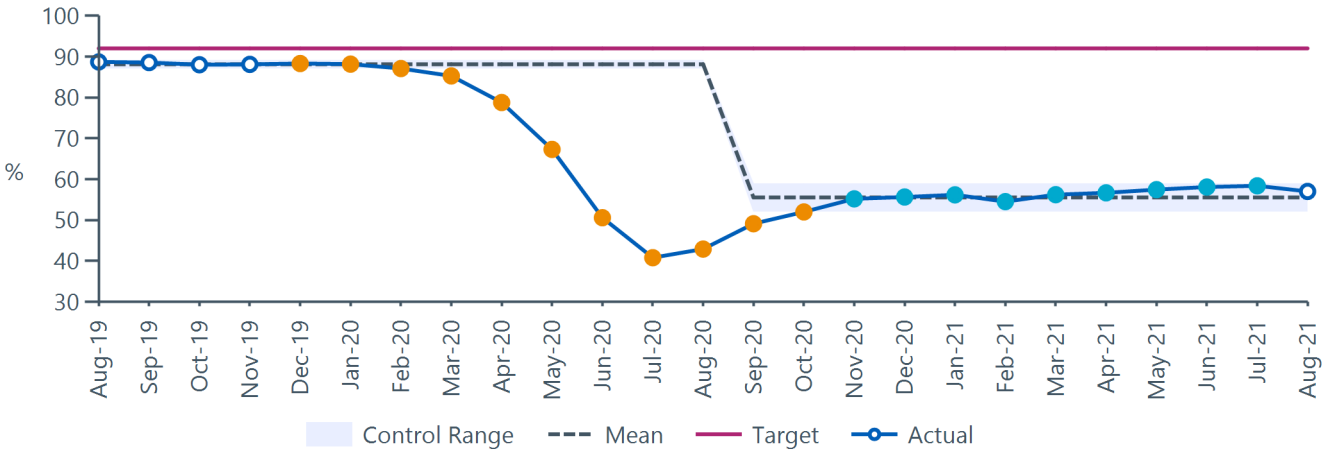
- Staff - Patients - Finances -

18 Weeks RTT Open Pathways

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

Responsible Unit:
Support Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
92.00%	57.02%		F



Trajectory/H1 Plan

What these graphs are telling us

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

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

Narrative

Our August performance was 57.02% 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 - 7503 patients waiting of which 1857 are breaches, MS2 - 1172 patients waiting of which 715 are breaches, MS3 - 4211 patients waiting of which 2967 are breaches.

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

The OJP contracts were signed on 2 August with an initial soft launch due to recognising consultants' prior commitments. We expect to see the impact of additional capacity from mid-September. All in job plan sessions are to be maximised before utilising OJP working. The OJP sessions will then be utilised for those Consultants with individual backlogs.

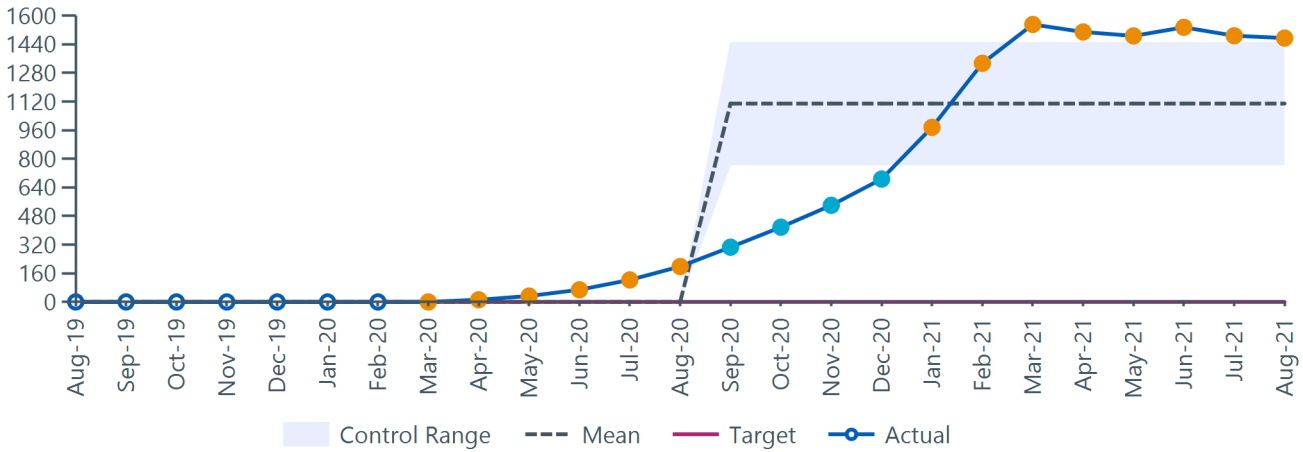
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
42.93%	49.13%	52.01%	55.21%	55.66%	56.19%	54.53%	56.23%	56.68%	57.46%	58.10%	58.40%	57.02%

Patients Waiting Over 52 Weeks – English

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	1,475	H	F



Trajectory/H1 Plan

What these graphs are telling us

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

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

Narrative

At the end of August there were 1475 English patients waiting over 52 weeks; above our trajectory figure of 1304.

The patients are under the care of the following sub-specialities; Spinal Disorders (510), Arthroplasty (337), Knee & Sports Injuries (301), Upper Limb (174), Foot & Ankle (69), Spinal Injuries (55), Tumour (13), Paediatric Orthopaedics (6), Metabolic Medicine (6), Neurology (2), Rheumatology (1) and Geriatrics (1). Spinal Disorders is our biggest backlog and actions to address the capacity requirements to meet demand have been taken. The Trust has successfully appointed one locum consultant that commenced inductions and some outpatient activity in August with further activity expected in September. The Trust is also working in collaboration with another regional provider to assess whether they are able to treat based on clinical priority.

The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 894 patients
- >78 to <=95 weeks - 476 patients
- >95 to <=104 weeks - 55 patients
- >104 weeks - 50 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

As a Trust, we have started to monitor our longest waits, as can be reflected in new measures to monitor patients waiting over 104 weeks. The OJP contracts were signed on 2 August with an initial soft launch due to recognising consultants' prior commitments. We expect to see the impact of additional capacity from mid-September. All in job plan sessions are to be maximised before utilising OJP working. The OJP sessions will then be utilised for those Consultants with individual backlogs.

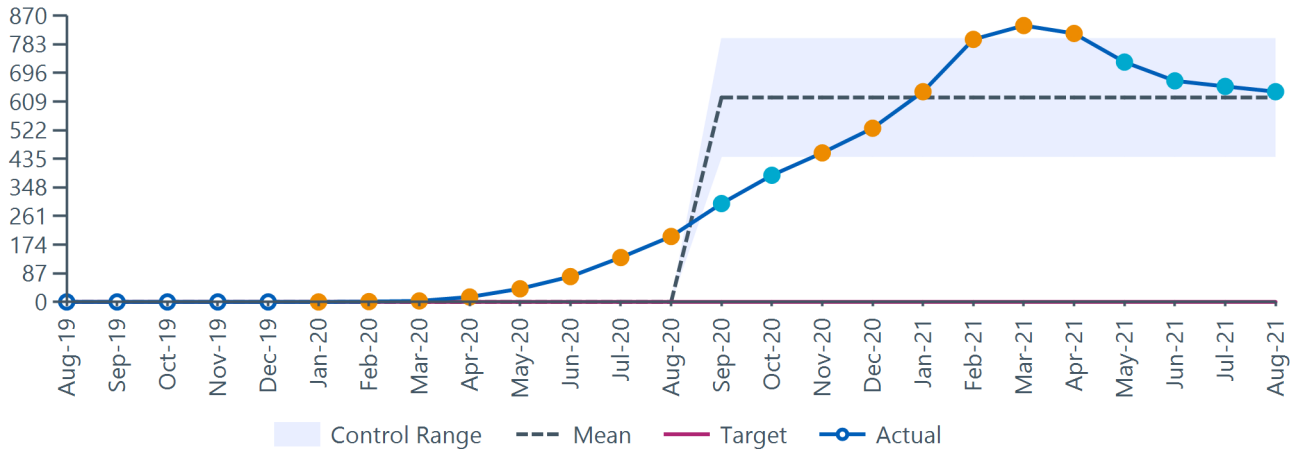
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
198	306	418	540	687	976	1334	1551	1509	1487	1535	1488	1475

Patients Waiting Over 52 Weeks – Welsh

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

Responsible Unit:
Specialist Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
0	639	L	F



Trajectory/H1 Plan

What these graphs are telling us

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

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

Narrative

At the end of August there were 639 Welsh patients waiting over 52 weeks. The patients are under the care of the following sub specialties; Spinal Disorders (330), Arthroplasty (112), Knee & Sports Injuries (85), Upper Limb (59), Foot & Ankle (23), Spinal Injuries (16), Tumour (6), Neurology (4), Paediatric Orthopaedics (3) and Metabolic Medicine (1). Spinal Disorders is our biggest backlog and actions to address the capacity requirements to meet demand have been taken. The Trust has successfully appointed one locum consultant that commenced inductions and some outpatient activity in August with further activity expected in September. The Trust is also working in collaboration with another regional provider to assess whether they are able to treat based on clinical priority.

The patients are under the care of the following commissioners; BCU (370), Powys (258), Hywel Dda (8), Aneurin Bevan (2) and Cardiff & Vale (1).
The number of patients waiting, by weeks brackets is:
- >52 to <=78 weeks - 323 patients
- >78 to <=95 weeks - 212 patients
- >95 to <=104 weeks - 59 patients
- >104 weeks - 45 patients

Actions

Our planning assumptions are now in place and we will be following good planning methodology to continually check our performance against those assumptions, ensuring our capacity is well utilised. We continue to balance our capacity between the clinical prioritisation of the most urgent patients as well as treating long waiters. We continue to review the clinical priority of patients and update harms assessments as appropriate.

As a Trust, we have started to monitor our longest waits, as can be reflected in new measures to monitor patients waiting over 104 weeks. The OJP contracts were signed on 2 August with an initial soft launch due to recognising consultants' prior commitments. We expect to see the impact of additional capacity from mid-September. All in job plan sessions are to be maximised before utilising OJP working. The OJP sessions will then be utilised for those Consultants with individual backlogs.

Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
199	299	385	453	528	639	798	840	816	729	672	655	639

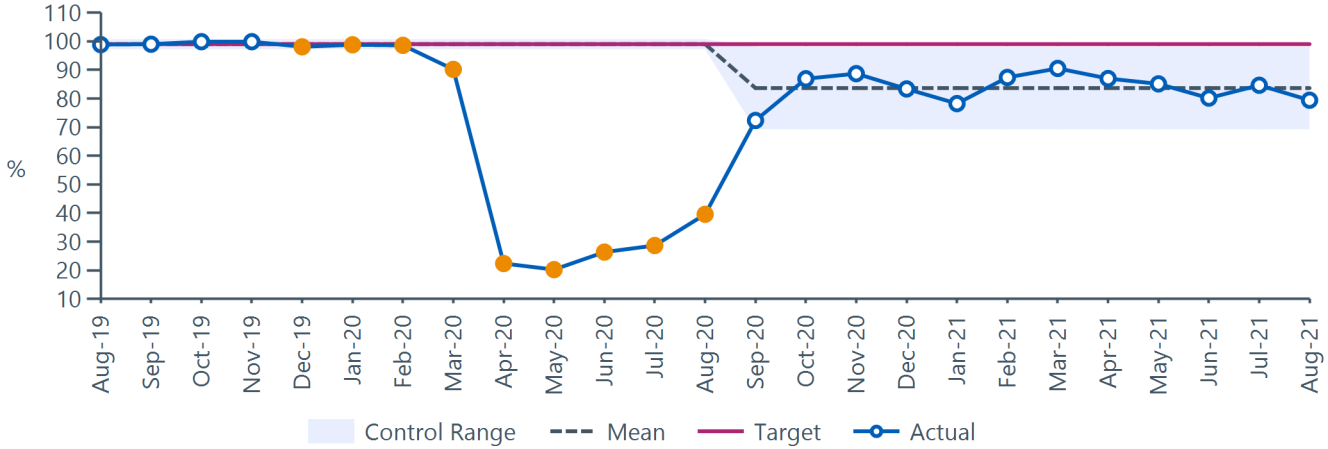
6 Week Wait for Diagnostics - English Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
99.00%	79.43%		F

Trajectory/H1 Plan



What these graphs are telling us

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

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

Narrative

The 6 week standard for diagnostics was not achieved this month and is reported at 79.43%. This equates to 230 patients who waited beyond 6 weeks. The breaches occurred in the following modalities:
- MRI (211 - with 206 dated)
- Ultrasound (19 dated)

We continue to experience high demand for MRI and this month also seen increased demand in ultrasound. Ultrasound breaches have been influenced by the volume of annual leave in August in addition to the increased referrals.

However, it must be noted that both MRI and Ultrasound activity was over 100% of the 19/20 baseline and there were no CT breaches again this month for the 4th consecutive month.

Actions

- Continuation of extended working hours and weekend working
- All internationally recruited radiographers are now in post and working within an initial training period until 1st November
- Continue to monitor the demand for MRI's
- Scoping the possibility of keeping the current MRI scanner in addition to the new one that is due. This would help with current backlog and could be used for system capacity

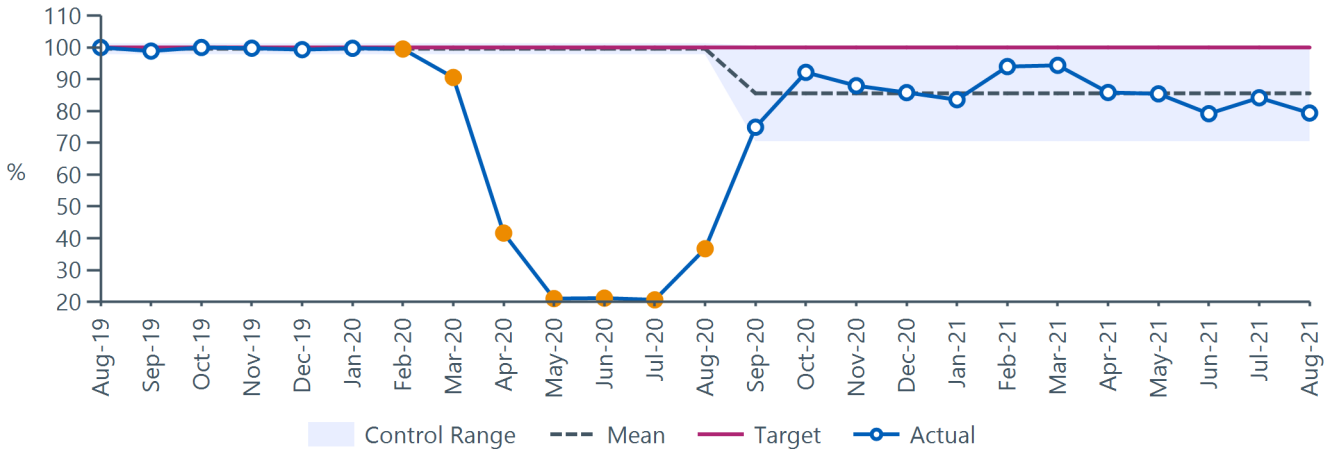
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
39.56%	72.35%	86.92%	88.70%	83.37%	78.24%	87.38%	90.53%	86.99%	85.13%	80.17%	84.66%	79.43%

8 Week Wait for Diagnostics - Welsh Patients

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

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
100.00%	79.39%		



Trajectory/H1 Plan

Actual
Trajectory

What these graphs are telling us

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

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 79.39%. This equates to 95 patients who waited beyond 8 weeks, all within the MRI modality. Of the 95 patients waiting, 92 are dated.

We continue to experience high demand for MRI and this month also seen increased demand in ultrasound.

However, it must be noted that both MRI and Ultrasound activity was over 100% of the 19/20 baseline and there were no CT breaches again this month for the 4th consecutive month and although there has recently been an increase in demand for ultrasounds there were no ultrasound breaches.

Actions

- Continuation of extended working hours and weekend working
- All internationally recruited radiographers are now in post and working within an initial training period until 1st November
- Continue to monitor the demand for MRI's
- Scoping the possibility of keeping the current MRI scanner in addition to the new one that is due. This would help with current backlog and could be used for system capacity

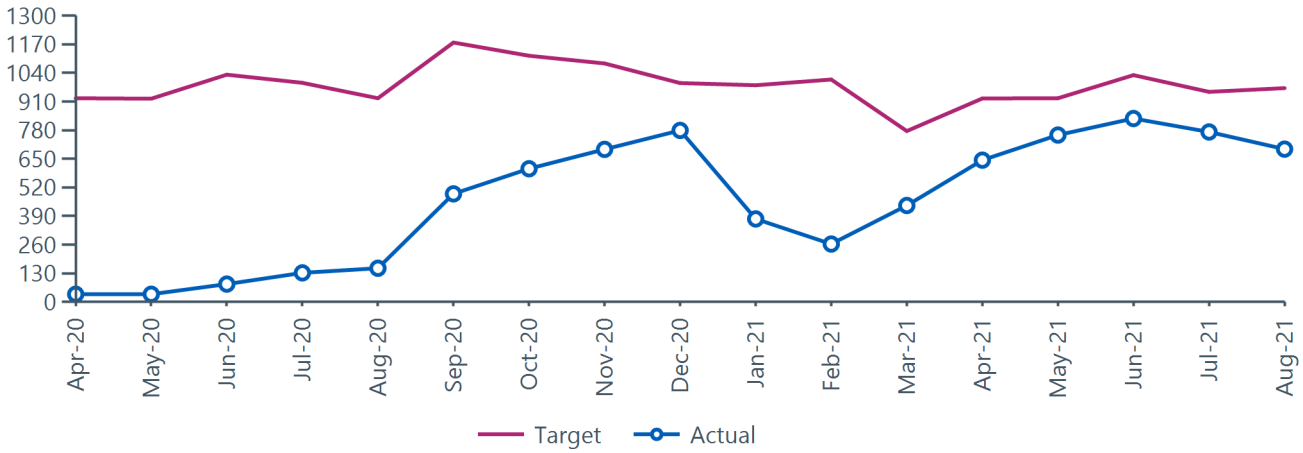
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
36%	74%	92%	87%	85%	83%	94%	94%	85%	85%	79%	84%	79%

Total Elective Activity

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

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
971	694	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

This measure has a moving target.

Following guidance from NHS EI we have updated the SPC graphs throughout the IPR to make allowance for the months impacted by covid. The data points from March-20 to August-20 have now been excluded in the control limits calculation and a step change has been introduced from September-20 after trauma was repatriated and services resumed. To recognise all elective work following the impact of COVID-19 , this new committee measure was added in 21/22. With the impacted months now excluded from the control range calculations on relevant KPIs throughout the IPR, this now leaves this measure without enough data points for robust reporting in SPC, so this measure is now displayed as a line graph.

Narrative

Total elective activity undertaken in August was 694, below the trajectory for August of 860 which is derived from the H1 plan and represented in the trajectory line above. August activity represents 71.5% of the target 19/20 baseline figure of 971; the August target, as set by NHS EI, was to meet 85% of baseline 19/20 activity.

More robust SPC analysis will be possible as data points are added.

Actions

A deep dive is being undertaken to understand the multiple factors which contributed to the decline in elective activity in August, and the resultant outcome will be reviewed in order to assess the appropriate actions required.

The MSK Operational Improvement Plan contains the actions needed to improve the activity to pre COVID-19 levels and these actions are at varying stages of completion:

* A review of Theatre sessions per day to assess efficiency of 3 session days. Benchmarking undertaken with other Trusts. Pilot approach being explored by sub-specialty/individual surgeons.
* Maximise theatre sessions through scheduling - focus on bespoke sessions for spines
* Increase Consultant capacity through recruitment. Recruitment in progress to vacancies and workforce plan (5 year) in development led by Workforce Director.
* Increase available theatre staff and maximise skills through recruitment & development.
* Reduce cancellations - on-going monitoring and taking remedial action where necessary.

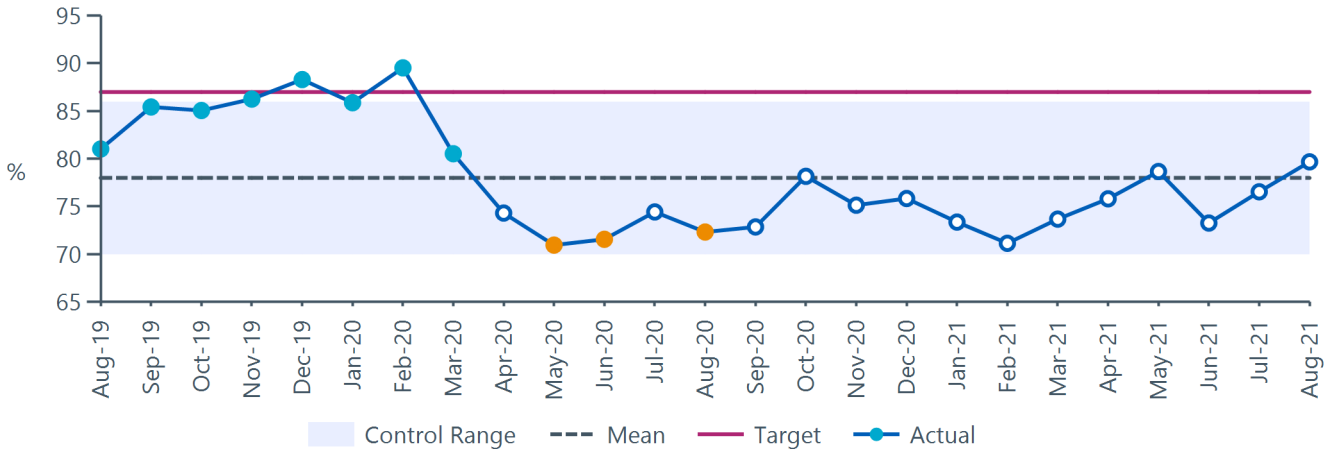
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
153	491	605	693	779	377	263	438	644	758	833	772	694

Bed Occupancy – All Wards – 2pm

% Bed occupancy at 2pm

Responsible Unit:
MSK Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
87.00%	79.68%		F



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

The occupancy rate for all wards is reported at 79.68% for August. The breakdown below gives the August occupancy per ward along with details on bed base and it's current use. Beds have been reduced in line with social distancing guidance:
MSK Unit:
- Clwyd - 81.62% - compliment of 22 beds at start of month that reduced to 16 for second half of month
- Powys - 82.28% - compliment of 22 beds at start of month that reduced to 16 for second half of month
- Kenyon - 41.67% - ward only open two days in August
- Ludlow - 81.44% - compliment of 15 beds open throughout month

Specialist Unit:
- Alice - 33.95% - compliment of 16 beds; open to 4-12 beds dependant on weekday/weekend
- Oswald - 86.47% - compliment of 10 beds open throughout month
- Gladstone - 79.79% - compliment of 29 beds majority of month, with a period of 10/12 beds closed for ten days
- Wrekin - 93.37% - compliment of 15 beds with 1-6 beds closed throughout month
- Sheldon - 85.41% - compliment of 20 beds open throughout month

Actions

We continue to monitor our occupancy across the Trust. As can be demonstrated in the SPC graph, August occupancy was the highest since March-20. With regular review, we continue to flex our bed base whenever possible to have sufficient beds open for the anticipated activity numbers based on the existing bed model. This includes assessing the variability of occupancy by weekday. Flexing has included ward and bed closures and redeployment of staff to other areas of the Trust. Bed Occupancy is expected to increase, in line with increased activity levels.

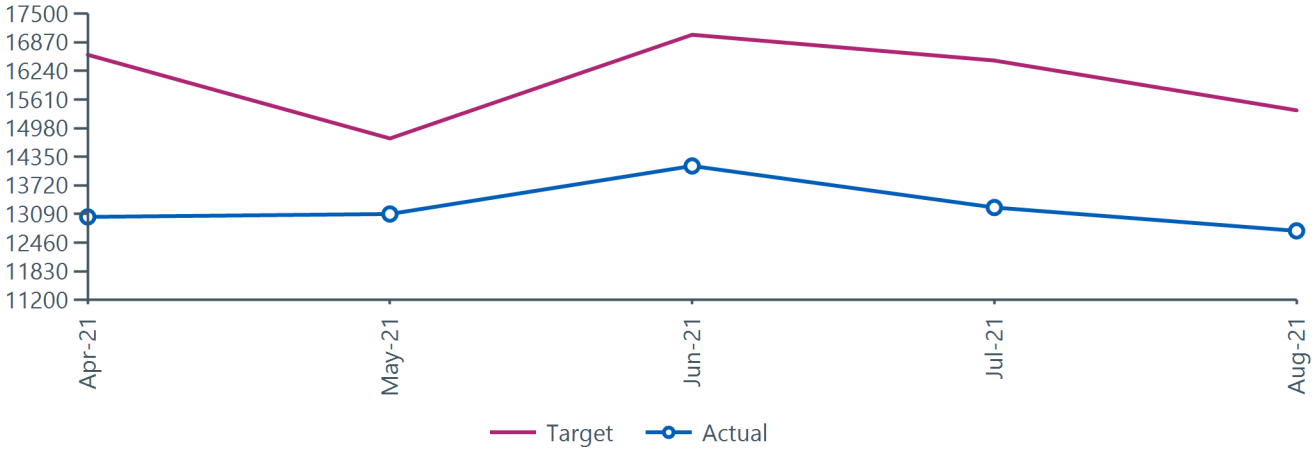
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
72.33%	72.86%	78.17%	75.14%	75.84%	73.37%	71.15%	73.68%	75.81%	78.67%	73.27%	76.54%	79.68%

Total Outpatient Activity

Total Outpatient Activity (Against Unadjusted External Plan (H1), Catchment Based)

Responsible Unit:
Clinical Services Unit

Latest Target/Baseline	Latest Value	Variation	Assurance
15,373	12,720	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

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

Narrative

This measure aligns with the NHS E/I inclusions/exclusions for restoration monitoring; consultant-led activity, non consultant-led and unmatched/unbundled activity. The target for this measure is the 2019/20 baseline activity that was delivered, with the H1 plan included as a trajectory in the trajectory graph. In August the total Outpatient activity undertaken was 12720; 93.43% of our H1 plan and 82.74% of our baseline. This is broken down as follows:
- Consultant led - 85.25% (9844 against target of 11547)
- Non consultant-led - 144.29% (1818 against target of 1260)
- Unbundled/unmatched - 131.10% (1058 against target of 807)

As at 7th September (5th working day) there were 379 missing outcomes so once administrative actions are taken with these data entries, the August position will alter. Taking into account the missing outcomes, this would mean that the Outpatient activity for August was 13099, 515 below our H1 plan of 13614. It must be acknowledged that within that missing outcomes figure, some of those appointments may be recorded later as DNAs.

Actions

A deep dive is being undertaken to understand the multiple factors which contributes to the decline in activity levels in August. The resultant outcome will be reviewed in order to assess the appropriate actions required. An initial review has been conducted to establish the unit level variances where the CSU and MSK units are those behind plan.

Within the CSU, therapy space and continuing IPC restrictions are contributing to the negative variance. The Therapy team is working with Estates to explore various options to help resolve these issues. Within MSK early indications are that IJP for August was lower than planned due to adjustments for annual leave, governance and MDTs. The deep dive will look at variance by sub-specialty.

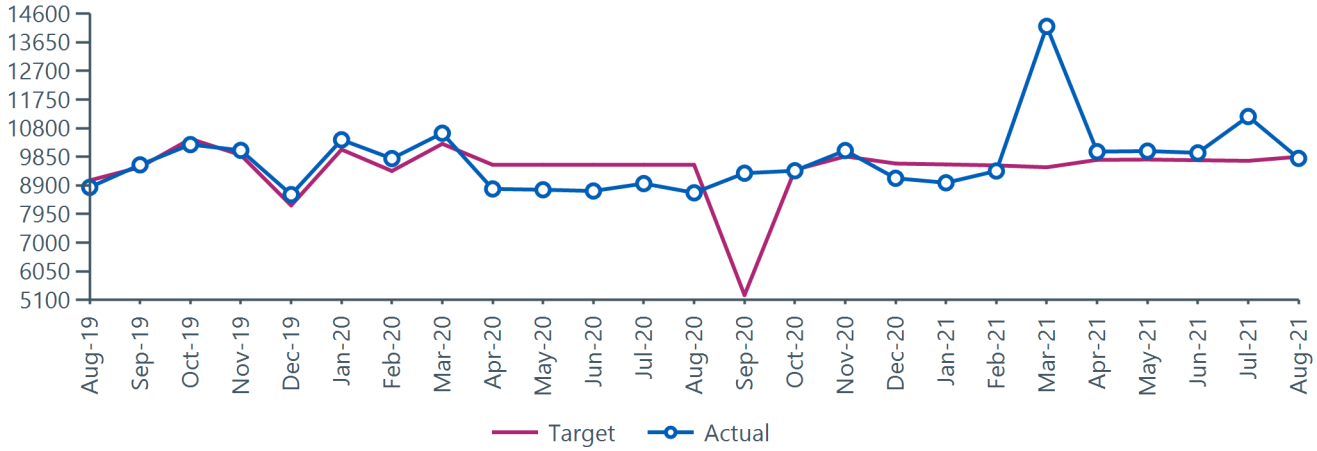
Apr-21	May-21	Jun-21	Jul-21	Aug-21
13027	13091	14148	13234	12720

Income

All Trust Income, Clinical and non clinical

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
9,851	9,797	N/A to SPC	Moving Target



Trajectory/H1 Plan

What these graphs are telling us

Narrative

Income £52k adverse:

- Planned elective recovery fund income not achieved as result of under performance against increased thresholds (offset by reduced costs)
- Pass through drugs costs adverse (offset in non pay)
- Continued pressures from shortfalls of non-NHS Income (Catering, Research & Education)

Partially offset by favourable variance:
- Private Patient income driven by activity

Actions

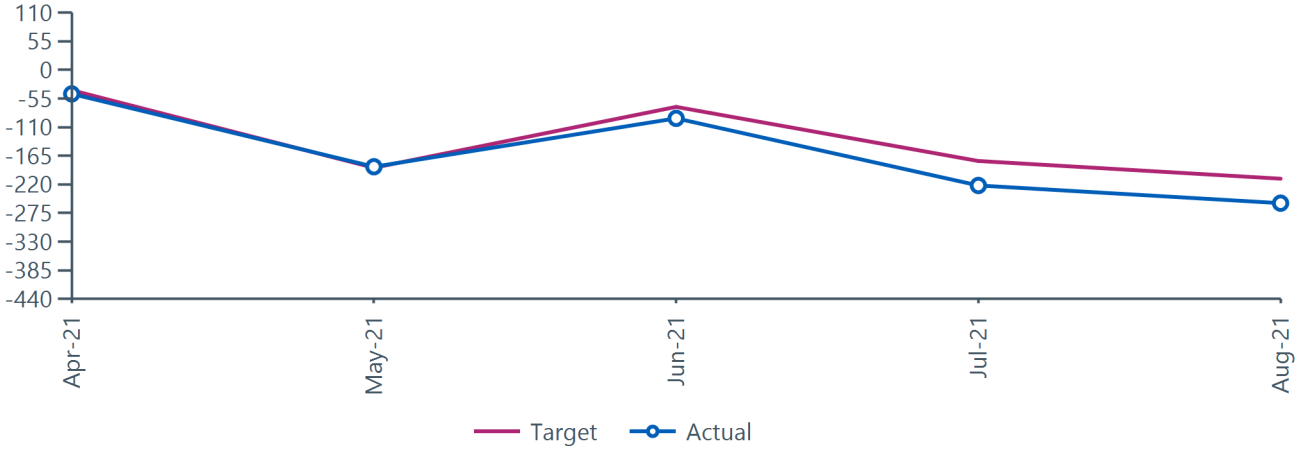
Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
8656	9306	9387	10058	9138	8988	9380	14180	10021	10039	9981	11188	9797

Recurrent Financial Performance (Sustainability Plan)

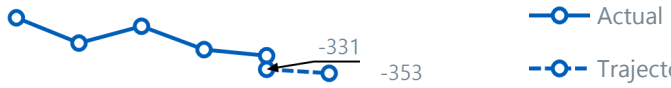
Surplus/deficit normalised to represent the recurrent financial position under the intelligent fixed payment system

Exec Lead:
Chief Finance and Planning Officer

Latest Target/Baseline	Latest Value	Variation	Assurance
-209	-256	N/A to SPC	Moving Target



Trajectory/H1 Plan



What these graphs are telling us

Narrative

Recurrent plan has been refreshed as part of a system wide exercise to reset efficiencies, contingency and investments. £121k adverse ytd, forecast on plan linked to efficiency phasing.

Actions

Apr-21	May-21	Jun-21	Jul-21	Aug-21
-46	-186	-93	-222	-256

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

Performance Against H1 Plan £'000s							
Category	H1 Plan	In Month Position			21/22 YTD Position		
		Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income	49,107	8,301	7,953	(349)	40,639	41,689	1,049
System Top Up Funding	2,597	434	434	(0)	2,171	2,171	0
Non NHS income support	878	120	120	0	758	758	0
Covid-19 Funding	1,452	242	242	0	1,210	1,210	0
Private Patient income	1,877	250	596	346	1,562	2,963	1,401
Other income	2,973	503	452	(51)	2,469	2,237	(233)
Pay	(34,334)	(5,816)	(5,709)	107	(28,485)	(28,219)	266
Non-pay	(19,681)	(3,365)	(3,254)	110	(16,006)	(16,704)	(698)
EBITDA	4,869	670	834	164	4,318	6,104	1,786
Finance Costs	(3,326)	(554)	(554)	1	(2,772)	(2,770)	2
Capital Donations	1,740	480	556	76	1,230	672	(558)
Operational Surplus	3,283	595	836	241	2,776	4,006	1,229
Remove Capital Donations	(1,740)	(480)	(556)	(76)	(1,230)	(672)	558
Add Back Donated Dep'n	269	45	47	2	224	234	10
Control Total	1,811	160	327	167	1,770	3,568	1,798
EBITDA margin	8.6%	7.1%	8.8%	1.8%	9.2%	12.4%	3.2%

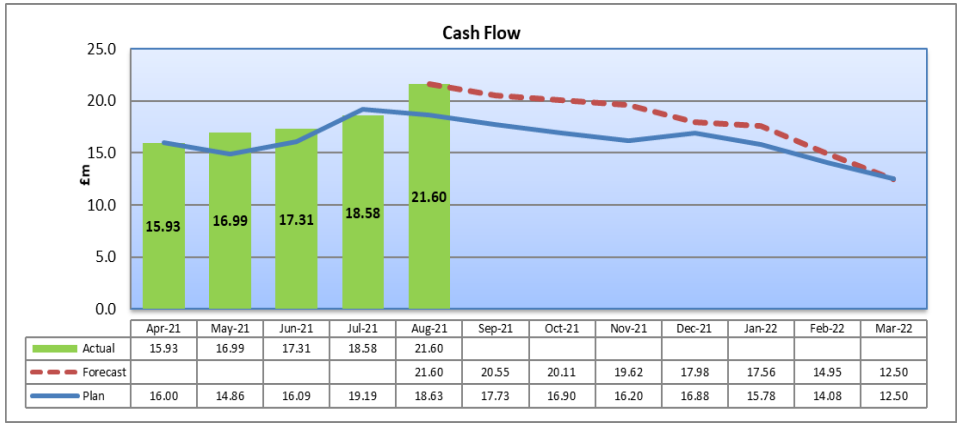
Statement of Financial Position £'000s				
Category	Jul-21	Aug-21	Movement	Drivers
Fixed Assets	79,015	78,978	(37)	
Non current receivables	1,329	1,274	(55)	
Total Non Current Assets	80,344	80,252	(92)	
Inventories (Stocks)	1,359	1,408	49	
Receivables (Debtors)	10,172	6,592	(3,580)	Payment received for prior year non nhs income shortfall from NHSE/I
Cash at Bank and in hand	18,582	21,600	3,018	
Total Current Assets	30,113	29,600	(513)	
Payables (Creditors)	(16,223)	(15,410)	813	Reduction in deferred charitable and Trust income
Borrowings	(1,459)	(1,421)	38	
Current Provisions	(690)	(687)	3	
Total Current Liabilities (< 1 year)	(18,371)	(17,518)	853	
Total Assets less Current Liabilities	92,085	92,334	249	
Non Current Borrowings	(4,500)	(3,912)	588	DH loan principal payment
Non Current Provisions	(974)	(974)	(0)	
Non Current Liabilities (> 1 year)	(5,474)	(4,886)	588	
Total Assets Employed	86,611	87,448	837	
Public Dividend Capital	(36,108)	(36,108)	0	
Retained Earnings	(22,396)	(22,396)	0	
Revenue Position	(3,169)	(4,006)	(837)	Current period surplus
Revaluation Reserve	(24,938)	(24,938)	0	
Total Taxpayers Equity	(86,611)	(87,448)	(837)	

Sustainability (Recurrent) Plan 2021/22						
Category	In Month Position (£'000)			Year To Date Position		
	Recurrent Plan	Recurrent Actual	Variance	Recurrent Plan	Recurrent Actual	Variance
Clinical Income	8,679	8,679	0	43,394	43,393	(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	378	378	0	2,235	2,240	5
Other income	553	547	(6)	2,765	2,735	(31)
Pay	(5,872)	(5,884)	(12)	(29,352)	(29,386)	(34)
Non-pay	(3,430)	(3,469)	(39)	(17,140)	(17,248)	(108)
EBITDA	308	251	(58)	1,902	1,733	(169)
Finance Costs	(562)	(554)	7.50	(2,808)	(2,770)	37
Capital Donations	480	556	76	1,447	671	(775)
Operational Surplus	227	253	26	541	(366)	(907)
Remove Capital Donations	(480)	(556)	(76)	(1,447)	(671)	775
Add Back Donated Dep'n	45	47	2	224	234	10
Control Total	(208)	(256)	(48)	(681)	(803)	(121)

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	21
Creditor Days	53

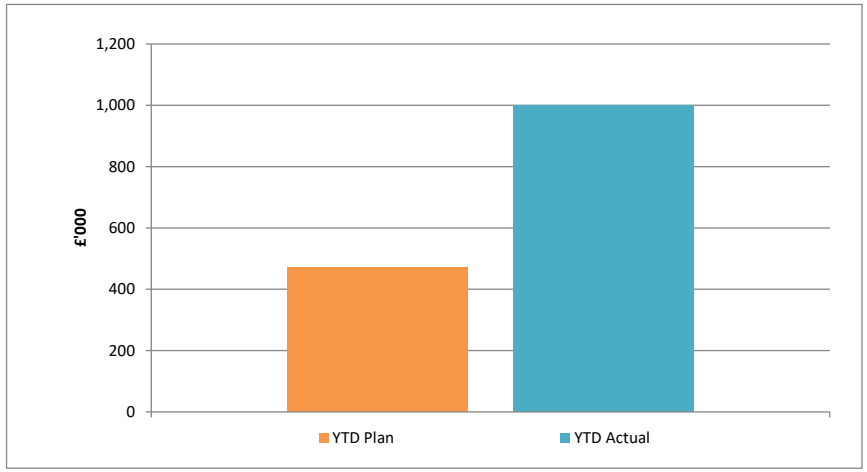


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	15.93	16.99	17.31	18.58	21.60							
Forecast					21.60	20.55	20.11	19.62	17.98	17.56	14.95	12.50
Plan	16.00	14.86	16.09	19.19	18.63	17.73	16.90	16.20	16.88	15.78	14.08	12.50

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

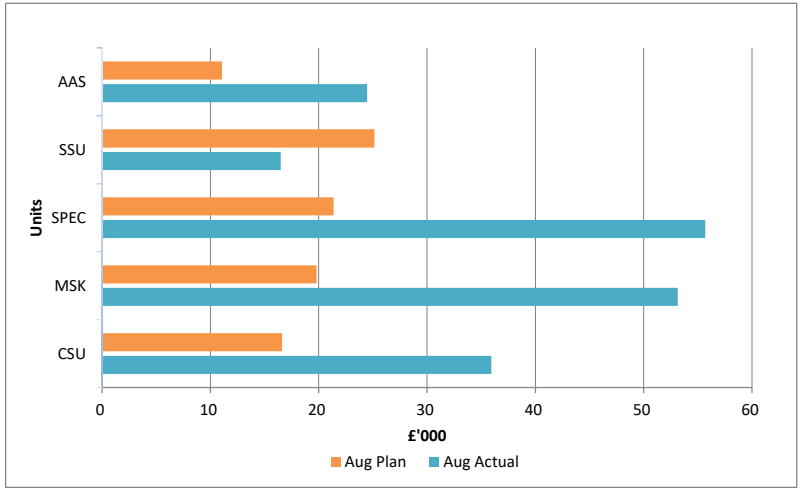
Efficiencies Total

Trust YTD Achievement Against YTD Plan £000's



In Month Efficiencies

In Month Efficiencies Achievement £000's



Capital

Position as at	2122-05	Capital Programme 2021-22						
Project	Annual Plan £000s	In Month Plan £000s	In Month Completed £000s	In Month Variance £000s	YTD Plan £000s	YTD Completed £000s	YTD Variance £000s	Forecast Outturn
Backlog maintenance	600	73	39	34	263	163	100	600
I/T investment & replacement	300	0	0	0	40	-4	44	300
Capital project management	100	8	10	-2	41	49	-8	100
Equipment replacement	500	50	0	50	150	-0	150	500
Diagnostic equipment replacement	1,701	0	0	0	600	94	506	1,701
Diagnostic equipment replacement PDC	99	0	0	0	0	0	0	99
Contingency	500	0	0	0	100	36	64	500
EPR planning & implementation	2,000	0	0	0	0	0	0	2,000
Invest to save	200	0	0	0	0	0	0	200
Donated medical equipment	200	0	0	0	125	111	14	250
Veterans' centre	4,500	480	309	171	1,105	561	544	4,500
Total Capital Funding	10,700	611	358	253	2,424	1,009	1,415	10,750
Donated medical equipment	-200	0	0	0	-125	-111	-14	-250
Veteran's facility	-4,500	-480	-309	-171	-1,105	-561	-544	-4,500
Capital Funding (NHS only)	6,000	131	49	82	1,194	337	857	6,000

Forecast

Category	Forecast			
	Plan	Actual	Variance	Notes
Clinical Income	49,106	49,767	661	Overperformance driven by pass through drugs ERF income included for Q1, further income at risk due to threshold changes
CCG Growth Funding	2,598	2,598	0	
System Top up Funding	878	878	0	
Covid-19 Funding	1,452	1,452	0	
Private Patient income	1,877	3,556	1,679	YTD overperformance, 26 cases above plan for M6.
Other Income	2,973	2,696	(277)	Continued shortfalls for Denbighs, Car Parking & Research
Pay	(34,334)	(34,027)	307	Covid underspends
Non-pay	(19,681)	(20,414)	(733)	Pass through drugs & PP implants
EBITDA	4,870	6,507	1,637	
Finance Costs	(3,326)	(3,324)	2	
Capital Donations	1,740	1,182	(558)	
Operational Surplus	3,283	4,365	1,081	
Remove Capital Donations	(1,740)	(1,182)	558	
Add Back Donated Dep'n	269	279	10	
Control Total	1,812	3,462	1,649	

NHS System Oversight Framework 2021/22

0. Reference Information

Author:	Stephanie Wilson, Performance Insight & Improvement Manager	Paper date:	23 September 2021
Executive Sponsor:	Kerry Robinson, Director of Performance, Improvement and OD	Paper Category:	Performance
Paper Reviewed by:	N/A	Paper Ref:	N/A
Forum submitted to:	Trust Board	Paper FOIA Status:	Full

1. Purpose of Paper

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

On the 24th June 2021 NHS England published the 'NHS System Oversight Framework 2021/22'. The document describes NHS England and NHS Improvement (NHS E/I) intended approach to oversight during 2021/22. It reinforces system led delivery of integrated care.

This paper is intended to provide the Trust Board with a summary of the content of the System Oversight Framework (SOF) 2021/22

Trust Board is asked to note the approaches for oversight for 2021/22.

2. Executive Summary

2.1. Context

The NHS System Oversight Framework 2021/22 provides clarity to integrated care systems (ICSs), trusts and commissioners regarding the proposed NHSE / I performance monitoring framework, and sets the expectations on working together.

2.2. Summary

NHS E/I has published its final System Oversight Framework 2021/22. This was accompanied shortly afterwards by the NHS oversight metrics for 2021/22.

The paper will summarise the principles, national themes and aligned oversight metrics as documented within the 2021/22 SOF framework.

The paper will recommend continued focus to ensure appropriate oversight against this framework.

The paper will cover:

- Background
- Oversight Principles 2021/22
- Oversight Metrics 2021/22
- Governance and Oversight
- Summary and Recommendations

NHS System Oversight Framework 2021/22

3. The Main Report

3.1. Background

Following a period of consultation over April and May, on 24 June 2021, NHS England and Improvement (NHSE/I) published its 'System Oversight Framework 2021/22'. The report reinforces system-led delivery of integrated care. This reflects the vision set out in the 'NHS Long Term Plan', 'Integrating care: Next steps to building strong and effective integrated care systems across England', the 'White Paper Integration and innovation: Working together to improve health and social care for all', and aligns with the priorities set out in the '2021/22 Operational Planning Guidance'.

To support this the oversight framework has been built around five national themes:

- Quality of care, access & outcomes
- Preventing ill-health and reducing inequalities
- Finance and use of resources
- People
- Leadership & capability

A sixth theme, local strategic priorities, recognises:

i. that ICSs each face a unique set of circumstances and challenges in addressing the priorities for the NHS in 2021/22
ii. the renewed ambition to support greater collaboration between partners across health and care, as set out in Integrated care, to accelerate progress in meeting our most critical health and care challenges and support broader social and economic development.

Accompanying the main System oversight framework is an additional document 'NHS oversight metrics for 2021/22'. These metrics will be used by NHS England and NHS Improvement and ICSs to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners. Metrics are clearly identified as for oversight at CCG, Trust or ICS levels. Metrics are aligned and categorised in to the five national themes.

Based on performance against metrics and other considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity, systems will be placed in to one of the following segments briefly described below:

- Segment 1 – Consistently high performing
- Segment 2 – On a development journey with plans that have the support of system partners
- Segment 3 – Significant support needed against one or more of the themes
- Segment 4 – Very serious and complex issues requiring intensive support

It is to be noted that alongside this framework existing statutory roles and responsibilities of NHSE/I in relation to Trusts and commissioners remain unchanged for 2021/22, as do the accountabilities of individual NHS organisations. NHS England and NHS Improvement will continue to exercise their statutory powers where necessary to address organisational issues and support system delivery in line with the principles set out in this document.

3.2. Oversight Principles and Scope 2021/22

The approach to oversight is characterised by the following key principles:

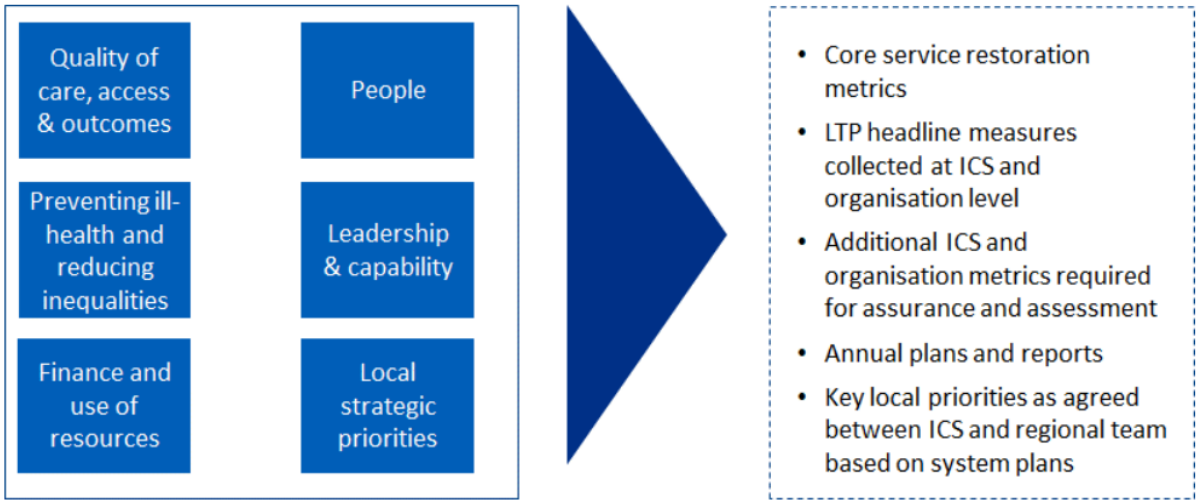
a. working **with and through ICSs**, wherever possible, to tackle problems
b. a greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals
c. matching **accountability for results** with improvement support, as appropriate
d. **greater autonomy** for ICSs and NHS organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
e. **compassionate leadership behaviours** that underpin all oversight interactions.

The scope of the framework is illustrated in the following diagram. The framework has five national themes that reflect the ambitions of the NHS Long Term Plan that are supported with a single set of

NHS System Oversight Framework 2021/22

81 performance metrics plus a sixth theme 'local strategic priorities' that complement the national NHS priorities set out in the 2021/22.

Figure 1: Scope of the NHS System Oversight Framework for 2021/22



3.3. Oversight Metrics 2021/22

There are 81 metrics documented against the five national themes. These are system wide metrics and identified for CCG, ICS or Trust performance monitoring (or multiple/all). Many are metrics that systems have been working to before e.g., 62 day and 52week waiters; some are ones that are already part of recovery and COVID expectations e.g., elective activity levels and % of COVID vaccinations and others are already being further defined and progressed within organisations. 47 of the metrics are directly identified for Trust monitoring.

Categories and metric examples within these are as below:

Quality, access and outcomes: – metrics for trusts include operational measures such as overall waiting list size, 52 week wait levels, infection rates, completion of patient safety alerts, % zero-day length of stay, discharges by 5pm, virtual attendances and outpatient transformation (patient-initiated follow-ups and Advice and Guidance), cancer metrics, elective/diagnostic activity levels and quality indicators like CQC ratings and mortality. At the ICS level additional metrics include cancer outcomes, neonatal outcomes and antimicrobial resistance.

Preventing ill health and reducing health inequalities: – Indicators in this domain are primarily measured at ICS and CCG level including vaccination coverage and screening programme uptake. Flu vaccination numbers are measured across ICS, CCG and Trusts. Trusts are also assessed on some of the measures relating to reducing health inequalities, including ethnicity and deprivation characteristics across service restoration and NHS long term plan metrics. Proportions of patient activities with an ethnicity code is also to be measured across ICS, CCG and Trusts.

Leadership and capability: – Trusts, ICSs and CCGs will all be assessed on quality of leadership, and on an aggregate score for NHS staff survey questions that measure perception of leadership culture.

People: – Trusts, ICSs and CCGs will all be assessed against the people promise index, health and wellbeing index, staff experience measures including bullying and harassment, satisfaction with flexible working patterns and % advertised as flexible, staff retention and diversity of leadership as examples.

Finance and use of resources: – assessment of performance against financial plan, underlying financial position, run rate expenditure, and overall trend in reported financial position will be made at CCG, Trust and ICS level.

The Trust has already seen in-year adaptations of Trust performance reports aligned with current NHS expectations and to monitor transformation programmes of work accordingly. This is inclusive of but not limited to elective recovery monitoring and also '% virtual attendances' now monitored through

our 'Finance, Planning and Digital Committee'. The Trust has also made significant progress to date in progressing and implementing 'Patient Initiated Follow-ups (PIFU). There has also been focus groups directly related to Staff Survey results to understand feedback from these surveys further.

The metrics published as part of the 'oversight framework' provide a further opportunity as part of evolvement of performance monitoring to assure/reassure ourselves that we have oversight across NHS E/I expectations and the published 2021/22 metrics.

It is recognised that due to system local strategic priorities, requirements for internal focus areas and the evolving national expectations that performance metrics will continue to be continuously reviewed. Likewise, it is stated that the metrics detailed within the oversight documentation are subject to being *"updated in year to reflect planning guidance for the second half of the year".*

Ensuring appropriate metrics and oversight will be key for establishing when mandated support is needed. The metrics are also key for evidencing achievements of exit criteria required to move to higher segments resulting in higher autonomy.

3.4. Governance and Oversight

NHS England and NHS Improvement will monitor and gather insights about performance across each of the themes of the framework. Depending on the type of information, the collection and review of data may be monthly, quarterly or annual or by exception. 'By exception' is where material events occur, or information is received that triggers our concern outside the regular monitoring cycle.

It is stated that *"a key outcome of the successful implementation of the framework will be the early identification of emerging issues and concerns so that they can be addressed before they have a material impact or performance deteriorates further. ICSs, trusts and commissioners are expected to engage with regional teams on actual or prospective changes in performance or quality risks that fall outside routine monitoring, where these are material to the delivery of safe and sustainable services."*

There are four 'segments' as described in Table1 below that ICSs, trusts and CCGs could be allocated to. Primary Care providers and PCNs will not be allocated to segments; however, the overall quality of Primary Care will inform ICS and CCG segmentation decisions.

Assessments are to be based on performance against the identified metrics as well as additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity (see table 1 for additional considerations). By default it is stated that all ICSs, trusts and CCGs will be allocated to segment 2 unless they meet the criteria for moving into segment 1, 3 or 4 as further documented in Table 1 (below):

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics *and* • On agreed financial plan and forecasting delivery against full year envelope *and* • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	*For ICSs and/or CCGs:* • Success in tackling variation across the system and reducing health inequalities • Whether the ICS consistently demonstrates that it has built the capability and capacity required to deliver on the four fundamental purposes of an ICS • Whether the CCG has achieved streamlined commissioning arrangements aligned to the ICS boundary, or is on track to fully achieve these against an agreed plan. *For trusts:* • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICS priorities.
2	This is the default segment that all ICSs, trusts and CCGs will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics *or* • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas *or* • An underlying deficit that is in the bottom quartile nationally and/or a negative variance against the financial plan and/or not forecasting to meet plan at year end *or*	*For all:* • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England and NHS Improvement (eg delivery against the national and local transformation agenda) • Evidence of capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances *For ICSs:* • Evidence of collaborative and inclusive system leadership across the ICS, eg where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope

NHS System Oversight Framework 2021/22

	Eligibility criteria	Additional considerations
	• A CQC rating of 'Requires Improvement' overall and for well-led (trusts) *or* • No agreed plans to achieve streamlined commissioning arrangements aligned to ICS boundaries by April 2022 (CCGs)	• Clarity and coherence of system ways of working and governance arrangements *For trusts:* • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, trusts or CCGs in SOF segment 3 *or* • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS *or* • A significant underlying deficit and/or significant actual or forecast gap to the financial plan *or* • CQC recommendation (trust)	

- Through this framework it is known that Shropshire, Telford and Wrekin STW will not be placed into the default 'segment 2' due to the criteria as laid out in Table 1. As a system we have providers with a CQC rating of 'Inadequate' as well as other system challenges.

A Trust of an ICS in mandated support will be subject to enforcement action. The Care Quality Commission (CQC) will play an active role in recommending trusts for mandated support. The CQC, through the Chief Inspector of Hospitals, will recommend to NHSE/I that a trust is mandated to receive intensive support when it is rated 'Inadequate' in the well-led key question and provide the reasons for the recommendation and the specific areas of improvement required.

Once an ICS, trust or CCG is mandated for support, NHSE/I regional teams will agree criteria with them that must be met in order for them to exit it. The support will be delivered through the nationally coordinated Recovery Support Programme (RSP), a new integrated and system-focused recovery that replaces the previously separate quality and finance 'special measures' regimes for provider trusts which has been in place since 2013.

The RSP will differ from the special measures programme in that it is system oriented, while providing focused support to organisations, will focus on the underlying drivers of the problems that need to be addressed. The following is also noted:

"On entering the RSP a diagnostic stocktake involving all relevant system, regional and national partners will:

a) identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
b) recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria)."

It is quoted multiple times within the framework documentation that *"Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s)."*

Collaboration arrangements are playing an increasingly important role in the co-ordination and delivery of joined-up care across populations. It is quoted that the oversight arrangements therefore *"reflect an expectation for evidence of effective provider collaboration and the failure of individual trusts to collaborate in a system context may be treated as a breach of governance conditions and be subject to enforcement actions."*

There is an expectation that each ICS will hold an memorandum of understanding (MOU) with NHSEI setting out agreed delivery and governance arrangements, oversight responsibilities and mechanisms and local strategic priorities.

3.5. Summary and Recommendations

Delivering the priorities for the NHS depends on collaboration across health and care, both within a place and at scale. The published 'System Oversight Framework 2021/22' reinforces system working.

NHS System Oversight Framework 2021/22

Alongside the framework was published a list of 'oversight metrics'. This provides the Trust, ICS and CCG additional assurance of current monitoring arrangements in place and supports identification of any gaps.

- An exercise within the Trust is to be conducted for further assurance of Trust oversight against the metrics.

The metrics alongside other considerations will be utilised to allocate a support segment rating to identify the type of support organisations require. This ranges from 'segment 1' with the most autonomy and those considered to be consistently high performing up to 'segment 4' where mandated intensive support is delivered through the Recovery Support Programme.

The framework released is an evolving document and metrics could be updated in year following release of planning guidance for the second half of the year. Within the published document they also state that they *"will continue to work with ICSs, trusts, commissioners and NHS partner organisations over the course of 2021/22 to further develop the approach to oversight set out in this document for future years. Subject to the parliamentary process"* and they *"will update this framework for 2022/23 to reflect the new statutory arrangements.*

- As a Trust we are already actively engaged and will continue dialogue with the system and representatives from NHSE/I to understand both the implications and future expectations concerning oversight and support.

In summary the recommendations are as follows:

- The Trust will continue to ensure appropriate oversight for performance during 2021/22.
- The Trust will assure itself against the 'oversight metrics' and evolve and include additional metrics where gaps are identified.

Well Led Review

Author:	Shelley Ramtuhul, Trust Secretary/Director of Governance	Paper date:	23 September 2021
Executive Sponsor:	Stacey Lea-Keegan, Interim Chief Executive	Paper Category:	Governance
Paper Reviewed by:	Senior Leadership Group	Paper Ref:	N/A
Forum submitted to:	Board of Directors	Paper FOIA Status:	Full

1. Purpose of Paper

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

The Board is asked to ***note*** the report produced following the Well Led Review concluded in July 2021 and further ***note*** the action plan that has been developed in response to the recommendations.

2. Executive Summary

2.1. Context

The Well Led Review was undertaken in two parts due to the impact of the pandemic and the length of time taken to receive the first draft. The review was commenced in June 2020 and concluded in October 2020. The first draft of the Well Led Report was received in February 2021 and it was clear at this point that the organisation had changed significantly during the intervening period, not least due to the organisational restructure further embedding and the impact of the pandemic. It was therefore agreed that a further update review would be undertaken by Niche whereby further documentation was requested and reviewed and further staff interviews and meeting observations were undertaken. The final draft of the report was received 27 July 2021.

2.2. Summary

This paper presents the draft report and highlights the minor points of accuracy which have been requested to be revised. These however are not material to the recommendations which the Trust accepts in full.

The Trusts action plan aimed at addressing the recommendations is attached for consideration and it is proposed that the Board will receive quarterly updates on progress. It is noteworthy that the recommendations do not repeat any of the recommendations made in the previous well led review.

2.3. Conclusion

The Board is asked to ***note*** the report and the actions that will now be taken to address the recommendations.

Well Led Review

3. Main Report

The Well Led review was undertaken by Niche Consulting over a number of months and the methodology they used is outlined in their report but included significant review documentation and meetings / interviews with relevant staff.

The Well Led Review was undertaken in two parts due to the impact of the pandemic and the length of time taken to receive the first draft. The review was commenced in June 2020 and concluded in October 2020. The first draft of the Well Led Report was received in February 2021 and it was clear at this point that the organisation had changed significantly during the intervening period, not least due to the organisational restructure further embedding and the impact of the pandemic. It was therefore agreed that a further update review would be undertaken by Niche whereby further documentation was requested and reviewed and further staff interviews and meeting observations were undertaken. The final draft of the report was received 27 July 2021.

Factual Inaccuracies

A number of minor factual inaccuracies have been highlighted to Niche and an amended report is awaited, however, these are minor in nature and therefore the report is presented in its current form in order to prevent delay in putting the report into the public domain. The inaccuracies requested for correction are as follows:

- P 13 - states performance strategy introduced before covid and does not reflect that it was amended for the current environment and communicated this year in line with the annual review process for this policy.
- P 14 – states there is no plan for ongoing training however there are dates in the diary and a contract in place for delivery.
- P 16 – recommends that a strategic planning framework is developed but there is one in place with plans now to refresh this.
- P 17 – the reference to the acceptance of trauma resulting in the backlog does not reflect the full picture that there was a national directive to stop elective work and therefore trauma was one contributing factor but not the main driver.
- P19 - the Communications and Engagement Strategy went through People Committee for update.
- P 22 - The EDI committee is Chaired by Chief of Performance, Improvement and OD
- P 27 – The Performance Framework was approved in April 21
- P 36 – The Trust's Chair is the Chair of the ICS Sustainability Committee not the ICS Board as stated and also the Chief Finance Officer is not the ICS Mental Health lead.

Action Plan

Niche Consulting have made a number of improvement recommendations which the Trust has fully accepted and the Senior Leadership Team have devised an action plan to address these.

A comparison has been made with the previous well led review to establish whether there are any areas where the same issues still exist and recommendations therefore repeated and it is reassuring to note that none of the recommendations made following the previous well led review have been repeated and appropriate improvement measures have therefore been taken.

Well Led Review

It is proposed that the action plan for the latest review is managed by the Senior Leadership Team but with quarterly updates to the Board of Directors for oversight.

Conclusion

The Board is asked to ***note*** the report and the actions that will now be taken to address the recommendations.

niche HEALTH & SOCIAL CARE CONSULTING

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

Well-led Framework

Governance Review – Final Report

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT

Private and confidential.

Updated July 2021

Authors: Kate Jury, Emma Foreman

First draft: February 2021
Updated: July 2021

Dear Sirs,

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Report has been written in line with the Engagement Letter of February 2020. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

No other party may place any reliability whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the 'Final Report' should be regarded as definitive.

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1.0 Summary

NHSI RAG RATINGS		
	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, some minor omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
	Does not meet expectations	Major omissions in quality governance. Significant volume of action plans required and concerns about management capacity to deliver

Summary

General summary

Niche Health and Social Care Consulting were commissioned by the Board of The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust in order to undertake the Trust's triennial Well-led external assessment. This work initially commissioned in early 2020, however, the emerging pandemic meant a significant delay in work commencing. Following fieldwork we also, with agreement, delayed reporting until the Chief Executive returned from his secondment and was able to do more implementation work on the restructure.

This report was updated in July 2021 in order to further review the progress of the new structure. Our key findings against the main key lines of enquiry are:

Capable and competent leadership

- This is a stable, competent Board of Directors who steward the organisation well. The new Assurance Team (made up of Executive Leads) has become more embedded and the flatter, more accountable structure is now showing planned benefits.
- The more traditional single-point Chief Operating Officer role has been replaced with a quadrant Managing Director structure; each post-holder has leadership responsibility for a Business Unit and aspects of improvement projects. The current team are observably working well together and are demonstrating impact across the Trust.
- Clinical leadership and accountability has developed considerably over the last 12 months. Particularly, the collaborative response to the pandemic between clinical leaders and managers has been galvanising. The new Medical Director role will be important in ensuring a continuation of successful clinical engagement.
- There will be significant leadership churn in the next 12 months with a new Chairman and Chief Executive. We recommend further structural redesign is minimised for at least a further 12 months.

Strategy and planning

- The Trust has a clearly articulated strategy, plan, vision and values. These appear to be well recognised by staff. The planning portfolio has been returned to the Director of Performance, Improvement and Organisational Development.
- The COVID-19 pandemic has presented a 'strategic shock' to the organisation; however, the Trust appears to have coped exceptionally well with this crisis and have acted in support of local health partners. The crisis also galvanised relationships between clinical and managerial teams in sustaining daily operational business.
- The next strategic term is imminent, and this will no doubt be influenced by the learning from the pandemic and will also incorporate new ways of working with the developing Integrated Care System.
- Strategy is a priority item for the Board and significant time is devoted to ensuring strategic viability through tri-annual strategic Board sessions, although alignment of the enabling strategies to each other and to the Trust's Strategy needs further consideration.

Culture

- Recognising the importance of staff engagement and wellbeing on service delivery, a Five-Year People Plan was introduced. This was not materially progressed until recently despite issue in 2018. While some staff feel supported and valued by the Trust, there are groups who feel their voice is not heard.
- Staff know how to raise a concern if quality is compromised; however, there is a belief that staff are not held to account equally, with some medical staff in particular perceived to behave in a way which is not always consistent with the values of the organisation. Initiatives have been introduced by the Assurance Team to address this inequity.

Summary (continued)

- The Trust has a good focus on training and development. Workforce metrics are monitored through the People Integrated Performance Report but a wider range of KPIs with alignment to the People Plan and Wellbeing Policy would allow greater assurance on the safety and wellbeing of staff.
- Equality, diversity and inclusivity are being promoted and awareness is being further increased through a variety of mechanisms. Relationships within individual teams are good but many feel that silo behaviours persist and this is limiting the ability of teams to provide practical support to each other while also potentially limiting the sharing of best practice and lessons learned.

Roles, structures and accountabilities

- A revised Governance and Delivery Framework has been introduced. This is new and evidences many elements of good practice although we have identified areas where further improvements can be made including greater alignment of terms of reference and agendas to respective strategies.
- The meeting structures for the Business Units were being developed during our fieldwork. These have now been aligned to the corporate governance structure to facilitate appropriate escalation of risks from ward to Board to ward. While there have been some references to silo working, leadership triumvirates for the new Business Units are working increasingly well together.
- A small number of staff have referenced a lack of clarity on their accountabilities with some tensions evident between the role of the Managing Directors and the Assurance Team. Levels of delegated authority must be clearly articulated for key senior leadership positions to ensure that decision making is undertaken at the right levels of the organisation and that staff can then be held to account for delivery of their objectives.

Risk

- A Performance Management Strategy and Accountability Framework has been introduced. Monthly meetings with the Assurance Team and Unit Boards allow an opportunity for key leaders to monitor performance, with areas of concern identified to ensure appropriate focus and implementation of remedial actions.
- The Trust has a programme of clinical and internal audits which are targeted to key areas of risk. The Clinical Audit Strategy is being refreshed in line with the Clinical Audit Policy and a Clinical Audit Group established. A clinical audit forward plan has been agreed in line with good practice with recognition that ownership of audits needs to increase across the services.
- The Risk Management Strategy aims to support the Board in understanding the current and future risks to the organisation but will need to be reviewed given the recent refresh of the corporate governance structure. A Risk Appetite Statement has been agreed and will need to be used when considering risks at Committee level.
- Risk registers have now been aligned to the Business Units and staff confirmed that risk processes were clear but needed to be embedded. They know how to identify a risk but have recognised that improvements can be made in relation to risk calibration and management.

Information

- The Integrated Performance Report allows Board members an overview of performance in the round with heatmaps centred around the Trust's objectives. More detailed analysis is provided through narrative, graphical and SPC charts with actions included for all underperforming metrics. Hotspot reporting is being progressed although further improvements could be made through more predictive reporting and the addition of benchmarking information.

Summary (continued)

- A range of patient experience, incidents, and claims reports are presented to the Board. These are fed by three new sub-committees including patient safety, patient experience and clinical effectiveness. Thematic reporting is improving but the extent of the triangulation of information from these sub-committees should be tested over time.
- The Board has ensured a good focus on data quality. Staff have said that this is impacted by disparate IT systems and we note that procurement of EPR is on the risk register; however, procurement is now underway. While devastating in many other areas, COVID-19 has in some ways helped to progress the Digital Strategy although some of the IT equipment at the Trust has become an increasing issue during the pandemic as it is not always adaptable or responsive to the advancements required.
- The Trust has ensured robust information governance processes which help to ensure that information is shared and personal data protected in line with national guidance.

Engagement

- The 2019-20 national staff survey responses for the Trust were some of the best in the country. Staff who we spoke with were equally positive about organisational communications (particularly during the pandemic); however, we have found that more could be done to test and improve the culture of the Trust with requirement for a more systemic approach to sharing information on changes made as a result of staff feedback.
- Inpatient survey results were also rated as "better" when compared to other Trusts and there are a range of opportunities for patients to be involved or their feedback shared with key meetings and staff groups. As with the staff, communications regarding changes made as a result of this feedback could be improved.
- Relationships with the Board and Governors continue to improve. While Governors can observe the Board and some Committee meetings, rotational presentations by NEDs at the Council of Governors meetings may further help them to discharge their function.
- External stakeholder engagement has also improved, with Board members seen to be taking a more proactive role in the work of the Integrated Care System (ICS) (previously the Sustainability and Transformation Partnership – STP). Greater emphasis on system-led engagement is now in place.
- A framework for stakeholder relationships is being considered by the Senior Leadership Group and should be expedited to ensure that engagement activities are undertaken in a co-ordinated manner.

Learning and innovation

- The Trust has been rated as good overall by the Care Quality Commission and can evidence progression of residual actions made from the 2018 inspection; however, there is a view from staff that more could be done to attain an outstanding rating.
- Increasing numbers of staff have been trained in improvement methodologies; however, a suite of tools and methods for helping to effect further improvements is not readily available to staff.
- Learning is referenced in reports, and panel meetings take place with staff who have been involved in incidents, but this could be further enhanced with improved communications to all Trust staff to ensure that actions are implemented and embedded in practice.

The following page provides a summary view on current proposed ratings against the Well-led Framework:

KLoE ratings and summary points

No.	KLoE	RAG rating	Key improvement actions required	Recs.
1	Leadership capacity and capability		The organisational restructure has introduced 'matrix management' with revised key portfolios, responsibilities and accountabilities. It has now had more time to become embedded, this continues to improve over time. The new quadrant Managing Director Team is demonstrating increased 'grip' within the Business Units and clinical engagement has improved.	1,2,3
2	Vision, strategy and plan		The Trust has a five year Strategy supported by a number of enabling strategies which need to be fully aligned and supported by detailed clinical service plans. The annual planning portfolio has now been returned to the Director of Performance, Improvement and Organisational Development.	4,5
3	Culture		The voice of all staff needs to be heard at every level of the organisation and staff held equally to account for their behaviours. This has improved over the last year, however, a wider range of cultural measures could to be introduced, and embedded.	1,3,5,6
4	Roles and accountabilities		The revised Governance and Delivery Framework has become more embedded with a greater focus on care excellence, safety and patient experience. Business Unit meetings have also been aligned to the corporate governance structure to allow appropriate escalation of risks from ward to Board to ward. Levels of delegated authority must be clearly articulated for key senior leadership positions.	7,8,9, 10
5	Risk		Risk management processes have been improved but the Trust needs to be assured that risk processes are embedded in the Business Units. There also needs to be more formalised process for assessing the quality impact of cost improvement plans, service redesign and business cases post implementation.	11,12
6	Information		The Integrated Performance Report allows an overview of performance in the round although further improvements could be made through more predictive reporting and the addition of benchmarking information. Greater thematic and same causal factor analysis is required for patient experience reports.	13,14
7	Engagement		More could be done to test and improve the culture of the Trust with enhanced communications regarding changes made as a result of staff and patient feedback. Governors observe Board and some Committee meetings and have a greater link into the NEDs. External stakeholder engagement is now going to be led at the system-level.	15,16, 17
8	Learning and innovation		A suite of tools and improvement methods should be available to staff with enhanced communications on key learning; this includes in relation to learning from deaths.	7,18,19

2.0 Scope and approach

Scope and approach

Scope

This report sets out the findings from our independent review of governance arrangements at "the Client" Robert Jones and Agnes Hunt Orthopaedic Hospital (known throughout this report as RJAH) against NHS Improvement's Well-led Framework June 2017. We have reviewed areas of good practice as well as areas for improvement in relation to each of the following key lines of enquiry (KLoE):

1. Is there the leadership capacity and capability to deliver high-quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

Fieldwork

In order to fulfil the terms of this scope, we have undertaken the following activities:

- Individual meetings and focus groups with all levels of staff and also with external stakeholders
- Extensive review of desktop materials
- Observations of the Board in Committee, Finance Planning and Digital Committee, the Quality and Safety Committee, the Audit Committee and the Senior Leaders Group
- Board member survey and staff survey

Project Omissions

This report is a limited scope review and has been drafted for the purposes as set out in the agreed terms of reference. During our review we were unable to observe the Executive Team meeting and the Strategy Implementation Group. Also, of the possible 9 responders, one Board member survey remained partially completed and we only obtained 5 full survey responses in total although this still represents a majority view.

Please note: *The fieldwork phase of this report has had an extended lifespan. This is because of the COVID-19 pandemic which significantly increased prevalence soon after signing off this engagement. The Chief Executive was, at short notice, redeployed to support the central NHS Coronavirus response which meant that the Board was in temporary form.*

The Well-led Review was paused again until there was more of a return to business as usual. This has meant that the lifespan of this project has extended over almost 2 years. However, this has provided an opportunity to track implementation over time.

How to use this report

We have included a number of recommendations within the body of this report (as an R reference) and these are included in full as a table in appendix 1. We have also risk rated and prioritised the recommendations to support implementation. We are happy to provide support in the development of the relevant action plans to meet these recommendations.

Next steps

The Board should decide whether to accept the findings and recommendations of this independent review.

A governance action-plan should be developed and a further assurance-based review of action implementation undertaken at twelve months.

3.0 Key findings

KLoE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

Summary findings:

- **This is a stable, competent Board of Directors who steward the organisation well. The new Assurance Team (made up of Executive Leads) has become more embedded and the flatter, more accountable structure is now showing planned benefits.**
- **The more traditional single-point Chief Operating Officer role has been replaced with a quadrant Managing Director structure; each post-holder has leadership responsibility for a Business Unit and aspects of improvement projects. The current team are observably working well together and are demonstrating impact across the Trust.**
- **Clinical leadership and accountability has developed considerably over the last 12 months. Particularly, the collaborative response to the pandemic between clinical leaders and managers has been galvanising. The new Medical Director role will be important in ensuring a continuation of successful clinical engagement.**
- **There will be significant leadership churn in the next 12 months with a new Chairman and Chief Executive. We recommend further structural redesign is minimised for at least a further 12 months.**

1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?

The Board of Directors comprises twelve members including:

- The Chair and five Non-Executive Directors (NEDs). These Board members (BMs) have a breadth and depth of experience with two new appointments having been made in 2019. There is also a non-voting Board Advisor (with an interest in Freedom to Speak Up (FTSU), equality and diversity) who was previously a NED but was asked to stay on.
- There has been some historic churn in relation to the Chief Nurse (CN) role, however, this has now stabilised, and staff are positive about the new nursing leadership structure.
- There is also a non-voting Director of People (DoP) who works for two days a week but with a strengthened team.

Over the last 18 months the Board and senior leadership team has been through a significant process of change and transition; this was due to COVID-19 and the Chief Executive (CEO) being seconded for seven months to the central NHS response in London, and also due to an organisational restructure towards matrix style management.

The senior leadership team has materially changed following the restructure both in form and function. The Executive Team are now the 'Assurance Team' and several staff have said that moving to this way of working was initially quite challenging, however, senior leaders are now more comfortable with the structure, and this has become well embedded.

Four Business Units have been established in the new structure, led by a triumvirate consisting of a Clinical Chair (CC) who is the accountable officer, Managing Director (MD) and Associate Chief Nurse (ACN). There has been some churn in the MD role, however, the current team are working well together and have been praised for their ability to cross-cover all operational business.

There has been some concern about the size of the units with disparity particularly around Musculoskeletal business unit which is larger than the others yet similarly resourced for the management team. Also, allocation of some of the services is being revised as they do not fit where originally placed.

Clarity about the roles, responsibilities and accountabilities of the Assurance Team has improved. The planning portfolio has now been returned to the Chief Performance, Improvement and Organisational Development Officer (CPIOD).

This, in turn, has allowed greater clarity for the Chief Finance Officer Portfolio. There is still some discomfort associated with not having a single Chief Operating Officer (COO) although senior leaders also saw the multiple benefits of the quadrant MD arrangement.

The Trust does have a Performance Management Strategy and Accountability Framework which clearly describes the responsibilities of staff; however, this was introduced just before COVID-19 and will need to be re-communicated to ensure clarity for all staff members.

There is a Board Secretary who is also the Director of Governance. She has a good skill set (including legal) but many of those interviewed feel there is an opportunity for more clinical input to the structure. This was recognised by the Assurance Team and a (clinical) Head of Governance post has been recruited to. Governance Leads have also been aligned to each Business Unit.

The impact of the restructure upon the Board will need evaluating; however, current feedback is that the Board remains effective and has assimilated the increased membership well.

An interim review of the new structure was commissioned for November 2020 and this highlighted some areas where immediate improvements were enacted. We understand these were taken forward and summary findings shared with the organisation.

R1: Clearly communicate to all staff the portfolios, responsibilities and accountabilities of the clinical triumvirates and the Assurance Team, and include the views of a broad range of Trust staff in the full post implementation review of the organisational structure.

1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?

There are monthly Board meetings which focus on the business of the Trust (held in private and public) and three times per year there are dedicated strategy sessions. This is good practice and allows BMs the opportunity to discuss current challenges but also future plans, opportunities and threats to the Trust.

There are no separate NED meetings with the Chair. Establishment of this type of meeting might help to enhance communications.

There are also no dedicated Assurance Team meetings but instead there is a weekly Senior Leaders Group (SLG) which includes MDs (and CCs on a rotational basis). We understand that there have been some Assurance Team away meetings and these have been well received.

SLG meetings have improved and are now more effective. SLG does have a large agenda and membership (c16 people) which may inhibit full and meaningful discussions, although currently feedback is positive in relation to the effectiveness of these meetings particularly with the current MD team.

Some deputy directors (now Heads of Service) who we have spoken with have said that they have no formal forum to meet, and they do not receive a written output from the SLG. This can mean that decisions are made without a full understanding of the rationale or that actions are allocated to staff who not may be aware of them.

Following COVID-19 there has been a significant focus on restoration, with a number of detailed papers considered in Board and SLG meetings. Actions required to return to business as usual (in the new constraints required) and to address the significant backlog of patients requiring treatment have been discussed at length with a recovery plan being led by the CPIOD. It is likely that recovery planning will continue for at least the next 3-5 years.

R2: Heads of Service require a substantive meeting forum to ensure connectivity.

1.3 Are leaders visible and approachable?

The February 2019 CQC report rated the Trust as good for the well-led domain, with inspectors saying that they saw strong and visible leadership. Pre COVID-19 BMs and Governors undertook visits to clinical and non-clinical areas of the Trust, an Executive Buddy system was established and 'Back to the Floor' initiatives were well received.

Visibility of the Assurance Team has been enhanced externally due to the Gold/Silver/ Bronze meetings which have been enacted by the system for the pandemic. However, some have said that the restructure, alongside the impact of COVID-19, has meant less visibility of the Assurance Team to clinical staff, and some senior staff said they felt remote from the Board and any decision making. More recently, the CCs have been invited to the Board Strategy Sessions.

Many agree that the new structure goes a long way to enhancing the clinical leadership role at the Trust. However, the CCs are only allocated two supporting professional activities (SPAs) and there is some debate about whether this is enough to fulfil the requirement of the role. The CC of Specialist Service is part-time (they also work at a local Trust) and this might present time challenges.

At the time of writing, there was a lack of clarity in relation to levels of authority and budgetary control that the CCs have, although this should evolve over time.

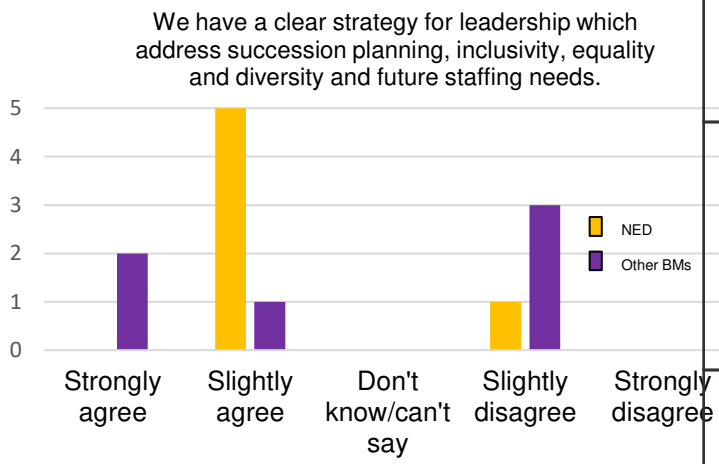
See recommendation 1.

1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?

Senior staff have said there are good leadership development opportunities (e.g. the Releasing Potential Programme) and there have been some development days for the new triumvirate leadership teams.

These were positively received although there is no plan to carry these forward on an ongoing basis. Once fully established there may be a need to revisit this type of development initiative.

The Trust has a People Plan but four BMs have said through survey that there is not a clear strategy for leadership which addresses succession planning, inclusivity, equality and diversity, and future staffing needs.



While some Heads of Service have said they are supporting their Executive Directors more and picking up Committee meetings, leading on some of the papers etc. there has been a lack of talent management processes and all staff that we spoke with said there is a need to more formally consider succession planning for senior roles, including the Assurance Team.

The restructure also had the intention of addressing succession planning and the future needs of the organisation. While there was a communications plan around the restructure with sessions held for staff to ask questions and a significant cross organisation consultation period, some BMs and staff feel that this was not well communicated nor was the rationale for it. Without a clearly articulated goal the objectives of the restructure were lost in the early stages and business appeared to become more complicated for staff. More inputs from the NEDs in the purpose and design of the restructure would have been useful.

KLoE 2: Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?

Summary findings:

- The Trust has a clearly articulated strategy, plan, vision and values. These appear to be well recognised by staff. The planning portfolio has been returned to the Director of Performance, Improvement and Organisational Development.
- The COVID-19 pandemic has presented a 'strategic shock' to the organisation; however, the Trust appears to have coped exceptionally well with this crisis and have acted in support of local health partners. The crisis also galvanised relationships between clinical and managerial teams in sustaining daily operational business.
- The next strategic term is imminent, and this will no doubt be influenced by the learning from the Pandemic and will also incorporate new ways of working with the developing Integrated Care System.
- Strategy is a priority item for the Board and significant time is devoted to ensuring strategic viability through tri-annual strategic Board sessions although alignment of the enabling strategies to each other and to the Trust's Strategy needs further consideration.

2.1 Is there a clear vision and set of values, with quality and sustainability as the top priorities?

The Trust has a clear vision to be the leading centre for high quality sustainable orthopaedic and related care achieving excellence in both experience and outcomes for patients. The vision is supported by 11 values and cultural characteristics supported by 25 Signature Behaviours which are expected of staff.

The mission, vision, strategy as well as enabling strategies, corporate objectives, values and cultural characteristics are clearly depicted on a one-page document, with reference to these being the *golden thread* of the organisation. Operationally, the priorities for the current strategic term are:

Strategic Context

These objectives are underpinned by a culture and leadership development programme (although please see comments on previous page).

2.2 Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?

The Trust has a five year strategy (2018-23) aimed at delivering a sustainable organisation (clinically, operationally and financially). This has been developed through the review of market analysis and context, capacity, finance and service line review, and is centred around four strategic priorities; operational excellence, local musculoskeletal services, specialist services, culture and leadership.

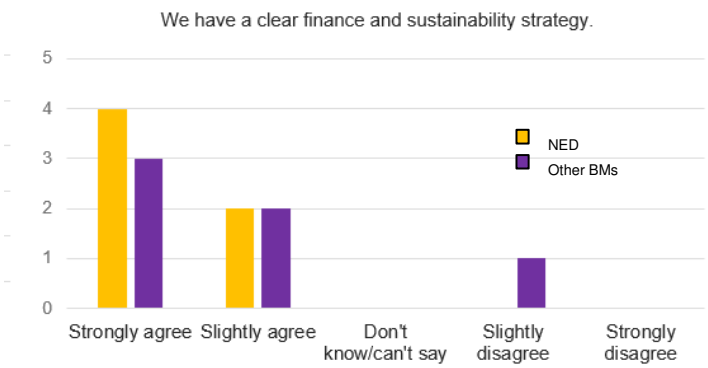
The strategy is supported by a number of enabling strategies (quality, finance, IT, patient experience, organisational development, risk management and communication) and corporate objectives which are captured in the Strategic Plan Document for 2018-23. While there is some alignment between the enabling strategies and also with the five year strategy there could be greater reference to this in the documents we have reviewed. This view is supported by BMs with some not agreeing, for example, that the Quality Strategy is fully aligned to the Trust strategy.

The organisation is approximately half-way through delivery of the five-year 'People Plan'. This provides an extensive framework for the development of staff and leaders at all levels although progress stalled soon after its introduction (see commentary in KLoE 3).

The Quality Strategy is currently nearing the end of the three-year strategic term and will require a refresh. The Strategy has historically been nursing focussed through, for example, the Leading Change, Adding Value Programme (this also requires a refresh). The CN has recognised that more clinicians will need to be involved in its refresh which was due at the end of 2020.

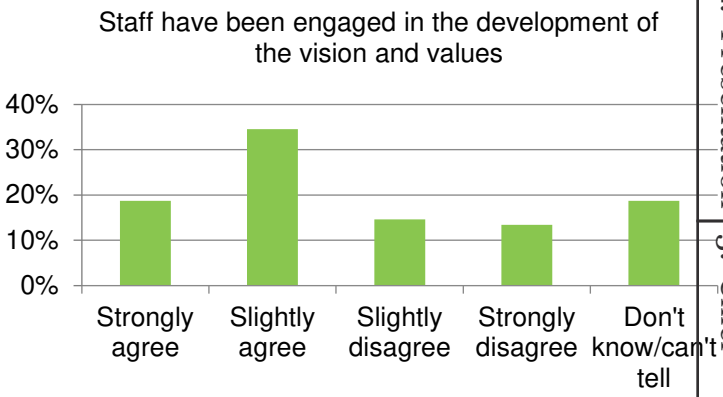
The Trust has endeavoured to improve the quality of its services following a CQC inspection in 2016 which resulted in a 'requires improvement' notice. The Trust implemented a range of actions which culminated in the delivery of an overall rating of 'good' in February 2019. This included a rating of outstanding for caring.

Operational plans are strongly focussed upon finance and sustainability, and these are closely aligned to the ICS Strategy:



2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services and external partners?

The vision, values and behaviours were developed in conjunction with staff through a series of meetings and focus groups although only 53% of our survey respondents felt that staff had been engaged in the development of these (this may be indicative of their long-standing nature).

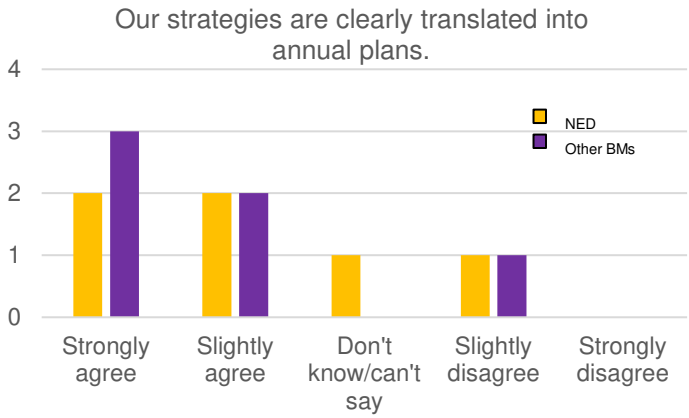


In relation to the Trust Strategy, some senior clinical staff said they went to meetings to help develop this and it was discussed in a Clinical Cabinet. External stakeholders are aware of the strategy but were not involved in its development (although the Trust does feed in external strategies).

Because of the number of enabling strategies the Trust has in place, as well as different timescales for delivery, there would likely be benefit in the development of a strategic planning framework. This will enable strategic engagement timescales to be planned and to ensure that strategic terms are sensibly aligned under the overarching 'strategy'.

R3: Introduce a strategic planning framework to support timely strategy refreshes and alignment between the enabling strategies and the Trust Strategy.

Engagement in relation to the development of annual plans is less clear; however, this is one of the issues that the restructure is attempting to address. We have been told that historically planning has been traditional and quite financially driven ('it used to be about as much activity as possible with financial benefit'). Annual planning for 2020-21 was challenging given the restructure, with the new units not having been fully established and this was then paused due to COVID-19.



While some senior staff have said they were engaged in agreeing efficiency requirements (for example, through an Executive planning discussion for the financial plan and a *Dragons Den* in January 2020 with MDs and CCs presenting their draft plans with their finance business partners), other staff have also said that the Business Units did not write or sign up to the annual plan and they were not involved in annual planning processes.

All staff were unaware of clinical service plans ('not sure if service and delivery plans exist'), and four (of 12) BMs similarly disagree that the Trust's Strategy is supported by clinical service plans.

R4: Re-launch the annual planning process and ensure that key staff from clinical services are involved in the development of service level plans which are aligned to key objectives of the Trust. Progress against these plans should be monitored with achievements communicated to staff at every level of the organisation.

2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?

Staff who we spoke with were aware of the vision and values of the Trust. This was supported in our staff survey. Many were also aware of how their personal objectives contribute to delivery of the vision.

Staff were also aware of the strategy although there was less clarity on how this is to be achieved, particularly given COVID-19. In prior years there have been some away days with key clinical and managerial staff to formulate the strategy and objectives but these have been rolled over for 2020-21 given the timing of the outbreak.

2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?

The majority of BMs do not fully agree that the Strategy is linked to the goals of the ICS.

The Trust has, however, endeavoured to assist the ICS in the safe delivery of patient care during COVID-19 and have taken trauma cases from the Shrewsbury and Telford Hospital NHS Trust (SaTH) during the pandemic. This has resulted in a significant back log of patients awaiting other orthopaedic treatment (>10,000 cases); the CPIOD is leading on the organisational restoration plan and has also been involved in system-wide restoration plans.

Some BMs, and particularly the Chair, CEO and CPIOD, have been increasingly external facing, and external stakeholders recognised the value of their contributions to system working. While some did report at the time of our fieldwork that RJAH could have a bigger voice in the system and more ambition, the CEO is now the ICS Lead so it is likely that this has now improved.

The Clinical Strategy is being formed by the ICS but some staff have said that RJAH needs to determine their own clinical strategy and be clear on how this plays into the system.

2.6 Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?

There are Strategy Board meetings three times a year where progress against the Strategy and the enabling strategies is discussed; for example, the Estates and Workforce strategies were presented at the meeting held in June 2020. This also provides a forum for BMs to review and update the strategies which is important particularly given the changing landscape post COVID-19 with a recognition that the Trust Strategy 2018-23 will need a refresh. Clinical Chairs have been involved in these strategy discussions.

Undoubtedly, the advent of COVID-19 has caused a 'strategic shock' across the NHS. However, the Trust has appeared to respond exceptionally well to this. They have worked collaboratively in support of the system and the rapid redesign of operational models to support local health partners.

COVID-19 will influence local plans and strategic priorities long into the future. The Trust is adept at managing the risks which have been presented by rapid strategic transition and have demonstrated successful clinical and managerial collaborative working.

Summary findings:

- Recognising the importance of staff engagement and wellbeing on service delivery, a Five-Year People Plan was introduced. This was not materially progressed until recently despite issue in 2018. While some staff feel supported and valued by the Trust, there are groups who feel their voice is not heard.
- Staff know how to raise a concern if quality is compromised; however, there is a belief that staff are not held to account equally, with some medical staff in particular appearing to behave in a way which is not always consistent with the values of the organisation. Initiatives have been introduced by the Assurance Team to address this inequity.
- The Trust has a good focus on training and development. Workforce metrics are monitored through the People IPR Report but a wider range of KPIs with alignment to the People Plan and Wellbeing Policy would allow greater assurance on the safety and wellbeing of staff.
- Equality, diversity and inclusivity are being promoted and awareness is being further increased through a variety of mechanisms. Relationships within individual teams are good but many feel that silo behaviours persist and this is limiting the ability of teams to provide practical support to each other while also potentially limiting the sharing of best practice and lessons learned.

3.1 Do staff feel supported, respected and valued?

The 2016 Communications and Engagement Strategy acknowledged the importance of the workforce being engaged in understanding the vision, values and culture. It described the objectives required to achieve this but it is unclear how progress against the phased actions was tracked. The Strategy was due for review in 2018 and we cannot see any evidence of this being refreshed or replaced.

Recognising the impact of staff engagement and wellbeing on service delivery, a Five Year People Plan was, however, introduced in 2018.
This was aimed at continuously improving the organisation's culture and performance through consistently bettering the employee experience. This plan was not materially progressed initially and was further stalled through the pandemic but is now being actively implemented.

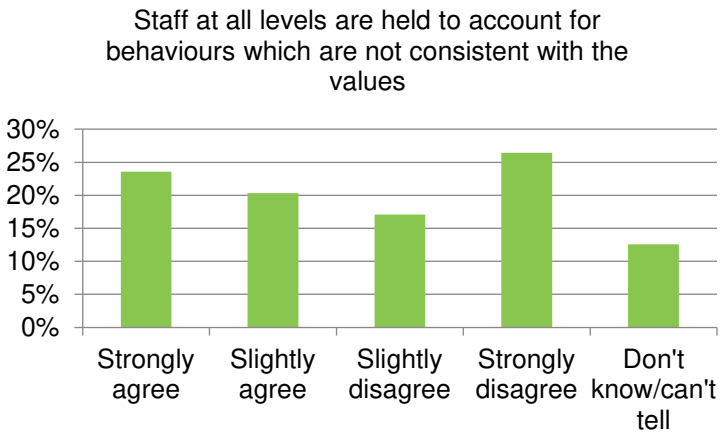
Staff who we spoke with referenced a sense of pride in working at the organisation and most fee supported by their line managers and other team members. In relation to staff feeing valued, the Trust has historically worked under a medical model and many said that the voice of nursing has been reduced, with staff referencing a sense that 'we better tell the nurses' rather than involving them because their views matter. This sense of being undervalued was further compounded by aspects of the restructure; for example, a Deputy CN was appointed to each unit but there were previously four matrons in the Trust and these were reduced to two without any apparent challenge. One of the posts removed was also in theatres despite a number of issues such as bullying and recruitment difficulties. Understanding this deficiency, the Matron posts have now been re-established by the respective triumvirate leadership teams.

Some allied health professionals also feel their voice and representation has been lost at a senior level and this was raised during the consultation exercise that concluded in March 2020. The current substantive CN, in conjunction with the previous interim CN, has helped to raise the profile and voice of nursing staff and agrees that a similar strategy is required for other supporting professions.

3.2 Is action taken to address behaviour and performance that is consistent with the vision and values, regardless of seniority?

As referenced in KLoE 2, there are 25 signature behaviours expected of staff working at the Trust.

That said, staff being equally held to account for behaviours which are not consistent with the vision and values at all levels of the organisation was the most negative response from our staff survey with only 44% agreeing this was the case:



When asked about this in our interviews and focus groups, some staff said '*we hear the same names mentioned*' with many believing that some medical staff in particular are allowed to behave in ways that would not be tolerated by others possibly because '*some clinicians are bringing in a lot of money*' and there was some disparity over job planning.

Over the last year this has been reported as an improving position and the MDs have helped to facilitate improved job planning and engagement. In addition to this, the COVID response has helped to galvanise relationships between the clinical teams and managers. That said, a continued focus on maintaining a positive medical staff culture is important going forward.

Where standards of conduct are not met, the Trust has a Disciplinary Policy and Procedure which should be read in conjunction with the Disciplinary Procedure and Management of Performance Procedure for Medical Staff; this latter document was significantly out of date (due for review 2017) at the time of our fieldwork but has now been updated.

Staff recognise efforts made by the CEO, MD and CPIOD to address issues around equity of conduct and accountability.

Other improvement initiatives include:

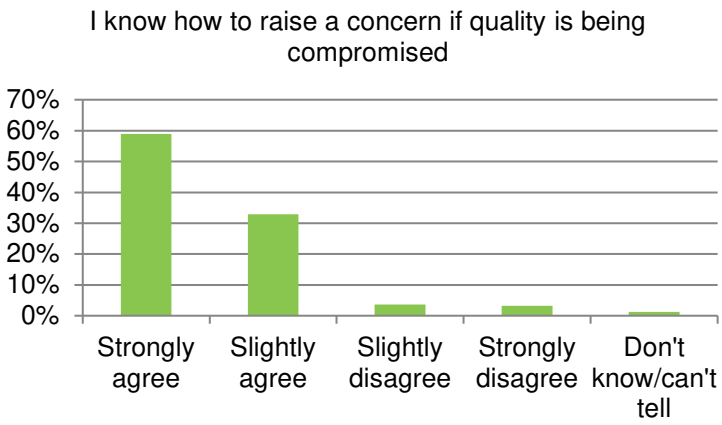
- delivery of Human Factors training to some multi-disciplinary staff with more non-clinical staff due to start their training;
- establishment of a theatres working group to look at behaviours within this service;
- establishment of a Responsible Officers Advisory Group to support the MD in making decisions about the behaviours of clinicians. This allows issues to be openly discussed with a proposal for an annual report be shared with the People Committee; and
- introduction of a Job Planning Consistency Panel and use of Allocate to ensure transparency or working hours (job plan updates are being reviewed each month at the People Committee).

Staff said they feel supported by the Human Resources team and have been encouraged to report poor behaviours with proposals to add a drop down category for this type of incident to Datix. This is good practice although we note that in relation to incident reporting, some staff have said that there are occasions when Datix is not used in the right way; for example, as a threat rather than as a tool for learning.

R5: Further progress initiatives aimed at ensuring that all staff are equally held to account for behaviours which are not in line with the Trust values and behaviours framework.

3.3 Does the culture encourage, openness and honesty at all levels, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns, and is appropriate learning and action taken as a result of concerns raised?

Staff interviewed and through our survey said that they know how to raise a concern if quality is compromised and would feel able to speak with their line managers or report through Datix if required (see graph overleaf).



There are a range of other mechanisms for raising concerns with a facility to anonymously report through an email address. The Trust has a FTSU Policy with three FTSU Guardians (including a permanent postholder, the Lead Governor and a staff side representative); the Board Advisor also has an interest and expertise in this area. The FTSU service has been promoted though videos and posters, and the team meets bi-monthly. There have previously been annual reports to the Board but update reports are now also being presented to the People Committee. The majority of BMs agreed through our survey that they were aware of the concerns that had been raised to this group of staff.

The Duty of Candour Policy requires the Governance Leads to prepare a quarterly report for presentation at Q&SC (through Unit reports) and an annual audit for the Board. Some examples of good practice were noted in the June 2020 report although it was noted that the Policy was not consistently applied across the Trust. Remedial actions are now being enacted.

3.4 Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?

Staff who we spoke with referenced a good focus on training and development and spoke about opportunities for coaching and team development. New starters have said they had a planned induction although more recently some were paused due to COVID-19.

Local induction was benchmarked by the internal auditors against other Trusts in Quarter 2 of 2019-20 and the resultant report noted that the contents were sufficient and timings for completion consistent with other Trusts. They also found that the Trust had made significant efforts to align themselves to the Core Skills Training Framework through training delivered in the induction process.

The previous Interim CN established a monthly Ward Managers forum but recognised the need for a targeted development programme aimed at further enhancing the impact of these key senior roles. This is good practice that we have seen work well in other organisations.

3.5 Is there a strong emphasis on safety and well-being of staff?

The Board has endeavoured to promote staff health and wellbeing, and this is reflected in one of the Trust's mission statements 'caring for staff' and also the Wellbeing Policy. Staff have access to a range of initiatives aimed at improving their wellbeing including 24/7 access to counselling and support, a self-referral physiotherapy service, and access to the onsite hydrotherapy pool. There is also an annual Health and Wellbeing Day which is positively received by staff.

Workforce metrics are monitored through a key domain of the People IPR. Measures include: absence, vacancies, turnover, appraisals and mandatory training although metrics provided to the Board are more limited.

More recently there have been COVID-19 Workforce Information Reports detailing the impact of the pandemic on staff in relation to absences, working from home and testing rates. Changes to service delivery models (e.g. phone consultations and trauma provision for Shropshire) are included and also feedback from staff and learning. A wider range of KPIs in the People IPR with alignment to the People Plan and Wellbeing Policy would further enhance reporting and allow greater assurance on the safety and wellbeing of staff,

In relation to specific groups of staff, a gap analysis is being conducted against the GMC wellbeing recommendations and a Wellbeing Guardian has been appointed for medical staff; this is a new position and the role is being scoped to ensure clarity of remit.

R6: Introduce a wider range of cultural measures into the People IPR (e.g. use of temporary staff, job transition success rates, grievances, staff concerns and inclusion of staff 'pulse' survey data) ensuring alignment to the People Plan and Wellbeing Policy.

3.6 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

The national staff survey results for 2019-20 showed that the Trust scored an above NHS average score for ED&I. Similarly, the majority of staff responded through our survey that ED&I is promoted through the organisation although they recognised that further improvements could be made. A recent concern was raised about the use of the FTSUGs for some cohorts of staff with protected characteristics and the Trust is now seeking an appropriate representative to join this group of champions.

The Board has, however, recognised that there has been insufficient focus on equality, diversity and inclusivity (ED&I) and that staff at all levels need to have a greater understanding of the depth and breadth of this subject.

This is despite ED&I being one of the workstreams of the 2018 People Plan and this lack of focus is also reflected by:

- the Equality and Diversity Annual Updates which are included on the intranet but not since 2017; and
- the Workforce Race Equality Standard (WRES) action plan which is included for 2018-19 but not for 2019-20.

An ED&I Group chaired by the HRD and reporting to the People Committee has now been established.

This is supported by a number of networks and aims to increase mandatory training; introduce ED&I KPIs; and increase training opportunities for staff/service users who have physical, mental health or learning disabilities.

3.7 Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict?

Staff told us that relationships within individual teams are good but many feel that silo behaviours have increased as a result of the restructure (and also COVID-19) and that this is limiting the ability of teams to provide practical support to each other while also potentially limiting the sharing of best practice and lessons learned. Some staff also feel that the interconnectivity of some of the services could have been better reviewed in the restructure; for example, pathology and diagnostics being in different units. This finding was supported through our staff survey, with only 56.5% of respondents agreeing that teams work collaboratively together:

We have been told that this extends to all levels of the organisation although the triumvirates of the newly formed Units have said connections with each other have become enhanced due to regular meetings. The ACNs are also working closely together and have divided their corporate responsibilities to ensure appropriate focus on each area of work (e.g. workforce, patient safety, patient experience).

See recommendation R1 regarding the restructure

KLoE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Summary findings:

- A revised Governance and Delivery Framework has been introduced. This is new and evidences many elements of good practice although we have identified areas where further improvements can be made including greater alignment of terms of reference and agendas to respective strategies.
- The meeting structures for the Business Units were being developed during our fieldwork. These have now been aligned to the corporate governance structure to facilitate appropriate escalation of risks from ward to Board to ward. While there have been some references to silo working, leadership triumvirates for the new Business Units are working increasingly well together.
- A small number of staff have referenced a lack of clarity on their accountabilities with some tensions evident between the role of the Managing Directors and the Assurance Team. Levels of delegated authority must be clearly articulated for key senior leadership positions to ensure that decision making is undertaken at the right levels of the organisation and that staff can then be held to account for delivery of their objectives.

4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?

Committees of the Board have evidenced many elements of good practice including:

- NEDs sitting across the Committees to ensure triangulation, oversight and assurance;
- Risks for escalation to the Board are a specific agenda item;
- Chairs assurance reports presented to the meetings they report into; and
- Meetings which have annual reviews of terms of reference and effectiveness scheduled into their workplans.

The Committee structure has recently been revised and a new Governance and Delivery Framework is currently being implemented which is broadly in line with other Trusts that we have worked with.

Committees of the Board include:

Audit Committee

This meeting is chaired by a NED with extensive financial expertise. Meeting agendas allow appropriate oversight of the Trust's financial and governance obligations with review of the other Committees self-assessments to ensure the Board are sighted on risks from all areas of the business. Risks are escalated to the Board via Chairs reports.

Quality and Safety Committee:

This meeting is chaired by a clinical NED with extensive NHS experience. This covers a wide agenda but the sub-Committee structure has been reviewed to ensure appropriate scrutiny of the quality agenda. In addition to Chairs reports, Unit reports are also received which allow greater insight into the quality performance of supporting specialties.

We note, however, a lack of alignment of the agenda to the Quality Strategy which states that a proposed dashboard will report on the four aims of the Strategy. We are aware that the Quality Strategy is currently being refreshed and the Committee will need to ensure that it actively tracks progression of this.

Finance Planning and Digital Committee

The meeting is chaired by a NED with extensive financial expertise. The meetings have full agendas and we note that in the July 2020 self-assessment over 50% of members reported that they do not always have sufficient opportunities to contribute to discussions on all areas of the meeting with some concerns that issues arising are not identified early on. Agendas are now being rotated and KPIs reviewed to allow deteriorating performance to be identified in a more timely manner. There are proposals for the impact of these changes to be reviewed in early 2021.

Risk Management Committee:

The Risk Management Committee is chaired by a NED with extensive risk management experience and is responsible for establishing a strategic approach to risk management ensuring overall coordination of risk management activity. Deep dives are undertaken into individual units; these include risks for escalation with remedial actions agreed.

Having a Risk Management Committee of the Board is unusual and can impact on the ownership of risks which would normally be assigned to the other Committees (including, for example, receiving and reviewing the Board Assurance Framework (BAF) bi-monthly). This is now being amalgamated into the Audit Committee and will need to be reviewed within a defined timeframe to ensure revised processes are effective.

People Committee:

This was established in May 2019 and is chaired by a NED. Until recently this was held each quarter; however, recognising the importance of the workforce and the impact of the NHS People Plan, this has now been increased to monthly.

The agenda of this meeting is centred around 'Caring for staff' and has now been aligned to the People Plan to ensure that all areas of this are appropriately implemented and monitored.

R7: Further revise the Committees to ensure that terms of reference, reporting groups, workplans and agendas are aligned to their respective strategies.

Business Unit meetings

The governance structures of the units are evolving as they mature and we have been told by some of the triumvirate staff that '*how we do this is up to us*'. That said, all Units have Management Meetings for which there are some generic terms of reference although some had not yet met at the time of our field work, and other meetings were being reviewed at SLG.

From the papers reviewed, we note some variances in agendas with the CSU Group more overtly aligned to the Trust's mission (Caring for patients, people and finance) than the others. Unit Governance Meetings have now been established and the Trust will need to ensure that these are facilitating appropriate escalation of risks from ward to Board to ward.

We also note that in one of the meeting papers reviewed (Specialist Delivery Unit Group Meeting) that the Trust IPR was supported by ward scorecards but we could not see that this was the case for all services.

R8: Review the Unit governance structures within six months of full implementation to ensure all areas of the business are covered with risks appropriately identified and escalated through the Trust framework.

4.2 Do all levels of governance and management function effectively and interact with each other appropriately?

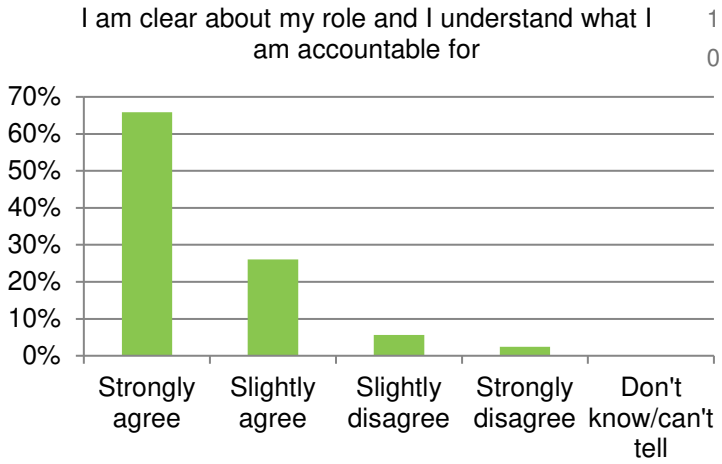
Despite a number of staff referencing silo working as a result of the restructure, the clinical leadership triumvirates for the Units have said they are working closely with each other on a day to day basis but also through weekly meetings which have been described previously. The previous interim CN also introduced twice weekly huddles with the ACNs as there was previously no robust mechanism for delivering the quality agenda.

The units have business partners (BPs) for HR, finance, and governance (non-clinical) with central oversight from the respective function and Executive Director. This model appears to be working well although some staff have said that it is more challenging for MSK who have a significantly higher headcount than the other units.

This BP model has not yet been tested fully regarding cross-cover and we note that no formal arrangements have been made for absences other than annual leave.

4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?

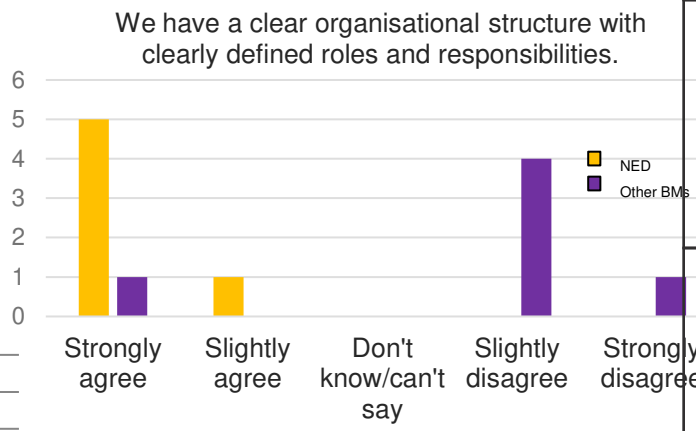
The majority of staff that we have spoken with said their roles and responsibilities are clear and this was reflected in our survey:



However, a small number, including some of the clinical leadership triumvirates, have referenced a lack of clarity on their accountabilities; with some tensions evident between the role of the MDs and the Assurance Team. As part of the restructure, the triumvirate leadership teams were told that they would have full responsibility for their areas of the business but in reality they have said they have limited autonomy or control (e.g. over spend) and they do not feel trusted by the Assurance Team. Notably, the roles and responsibilities of the Assurance Team and the SLG have not been formally documented and this is reflected in our BM survey responses (see opposite).

Staff are also unclear about how the Board holds the CEO to account when he is the Responsible Director for the Units with line management of the Clinical Chairs. The CEO leads on the objective setting for this cohort of staff but some confusion remains about the role of the MD in relation to their professional requirements and revalidation.

See commentary in KLoE 2 regarding the role of the CPIOD and DoP.



There is a small PMO which has been responsible for delivery of Trust-wide projects such as e-job planning but its remit has not been formalised and some staff that we spoke with said this is not clear.

R9: Levels of delegated authority must be clearly articulated for key senior leadership staff and Unit leadership teams to ensure that decision making is undertaken at the right levels of the organisation and that staff can then be held to account for delivery of their objectives.

4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated person-centred care?

The Trust has a number of partnership arrangements with internal staff and external providers; however, we have not seen a register of contracts or evidence of governance processes being regularly reviewed in any of the Committee other than through occasional updates to ensure compliance with contract terms. This includes in relation to the LLP. We have been provided with papers for monthly LLP meetings; however, agendas are set, minutes are not included within these (small) packs and it is unclear what scrutiny is placed on this work.

R10: Introduce a register of formalised partnership arrangements/ joint ventures and ensure associated governance processes are reviewed and contract terms complied with at least annually, with oversight by a Committee of the Board.

Summary findings:

- A Performance Management Strategy and Accountability Framework has been introduced. Monthly meetings with the Assurance Team and Unit Boards allow an opportunity for key leaders to monitor performance, with areas of concern identified to ensure appropriate focus and implementation of remedial actions.
- The Trust has a programme of clinical and internal audits which are targeted to key areas of risk. The Clinical Audit Strategy is being refreshed in line with the Clinical Audit Policy and a Clinical Audit Group established. A clinical audit forward plan has been agreed in line with good practice with recognition that ownership of audits needs to increase across the services.
- The Risk Management Strategy aims to support the Board in understanding the current and future risks to the organisation but will need to be reviewed given the recent refresh of the corporate governance structure. A Risk Appetite Statement has been agreed and will need to be used when considering risks at Committee level.
- Risk registers have now been aligned to the Business Units and staff confirmed that risk processes were clear but needed to be embedded. They know how to identify a risk but have recognised that improvements can be made in relation to risk calibration and management.

5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?

As mentioned previously, the Committee structure has recently been revised and a new Governance and Delivery Framework implemented. This clearly depicts the Committee meeting structure. Reporting lines and interface with the weekly SLG have also been strengthened with chairs reports from the Committees now received at the meeting.

Chairs assurance reports are received from the Committees and presented at Board. These are RAG rated for each agenda item and allow BMs to understand areas of risk.

Also see commentary on Committees and the IPR in KLoE 4 and KLoE 6.

5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?

The Trust has a Performance Management Strategy and Accountability Framework which was approved in February 2020. This aims to ensure that delivery of the Trust's strategy and corporate objectives are managed in a systematic way from 'Ward to Board' and 'Board to Ward'. According to this document, each Unit is assessed and given weighted ratings using the caring for patient, staff and finances categories although we have not seen the ratings assigned as a result of meetings held.

Monthly Performance and Operational Improvement Board meetings have been established and terms of reference agreed in June/July 2020. These were in their infancy and their effectiveness will be reviewed annually in line with other key Committees.

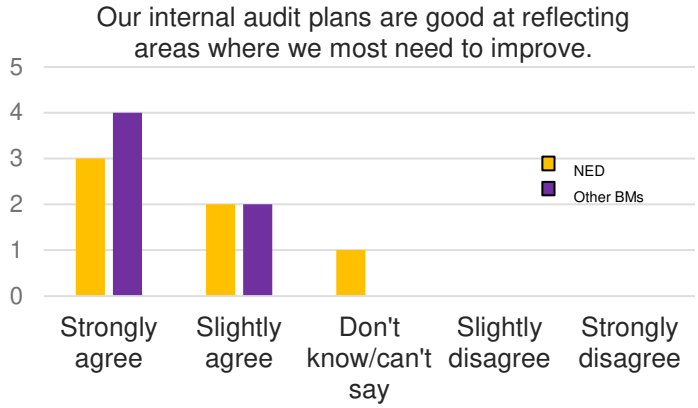
Monthly Performance Review meetings, chaired by the CPIOD, are also held and provide an opportunity for Unit Boards to meet with Executive Directors to monitor and oversee performance. Action logs are maintained to ensure completion and implementation of actions discussed. Agendas are currently being revised to ensure sufficient time is spent on each of the supporting specialties. Some areas of focus are requested of the services by the CPIOD prior to the meeting and this is good practice that we have seen work well in other Trusts. A template is provided for reporting; however, Units present their own information rather than this being provided by the corporate functions. We have been told that this requires significant volumes of manual data collection by staff who already have competing demands on their time. This approach also means that the business units can more easily 'hide' information that they might not want to share.

At the time of our fieldwork some, but not all, of the Units had commenced performance meetings for their specialties (e.g. in MSK) and the Trust will need to ensure that these commence across all Units.

5.3 Is there a systemic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken?

The Trust has a programme of clinical and internal audits which are reviewed at QSC and the Audit Committee respectively.

The Internal Audit Plan is aligned to the risk framework of the Trust and BMs largely agreed that audits are appropriately targeted at areas of concern while allowing some flexibility for issues as they arise.



Internal Audits were paused for Q1 due to COVID-19; prior to this were mostly completed as per schedule with actions appropriately progressed although we note that the report from the meeting held in July 2020 said '*it was difficult getting responses from HR about their audits*'.

The 2019-20 Internal Audit Annual Report provided Moderate Assurance that there is sound system of internal control designed to meet the Trust's objectives and that controls are being applied consistently. The Internal Audit forward plan ensures that audits are aligned to key areas of strategic risk.

In relation to clinical audits, there is no longer a dedicated audit facilitator role though a Clinical Audit Lead has been appointed.

Each Governance Lead and their Assistant is now responsible for the audits that are proposed and undertaken in their Division. The Governance Lead responsible for Clinical Audit is updating the Clinical Audit Strategy (which is out of date) in line with the Clinical Audit Policy which was refreshed in May 2020.

There is a quarterly Clinical Audit Group which reports to QSC via the Clinical Effectiveness Committee. This is now attended by the CPIOD and the Board Secretary to ensure appropriate focus and links to risk and safety.

Staff have said that the Clinical Audits and Registries Management Service (CARMS) is used to good effect although QSC in July 2020 identified some issues across some services. In response to this, the Board Secretary confirmed that the new Governance and Delivery Framework includes a forward plan with recognition that ownership needs to increase across the services. This has also been recognised by the clinical leadership triumvirates that we have spoken to who will need to ensure that clinical audits are progressed according to plan with monitoring and discussion at key Unit meetings.

A National Clinical Guidance and Standards Group has been established following recognition by the Board that previously there had been insufficient oversight of GIRFT, NICE and Royal College Guidance. This meeting will report to the Clinical Effectiveness Committee and will, again, need to be reviewed to ensure appropriate response to guidance which affects the Trust.

5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

The 2019-22 Risk Management Strategy aims to support the Board in understanding the current and future risks to the organisation. It includes an overview of the Trust's risk management process as well as the roles and responsibilities of staff in relation to the identification of risks as they arise. This is a comprehensive document but will need to be reviewed given the recent refresh of the Governance and Delivery Framework.

A Risk Appetite Statement is included in the strategy document which supports the amount and type of risk that the Trust is willing to take in order to meet its strategic objectives. However, we have seen no reference to this being used when discussing risks in the meetings observed.

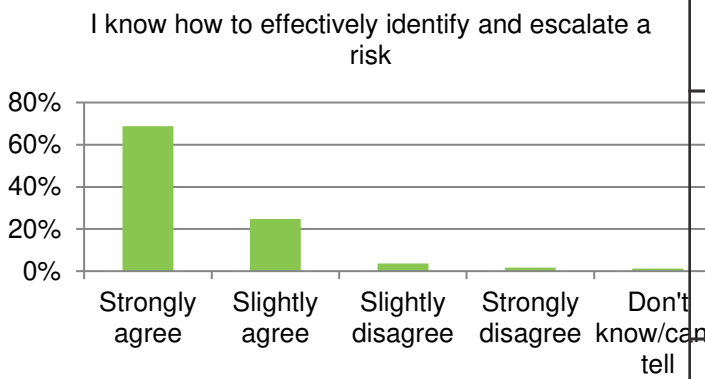
The Board gains assurance that risks are being appropriately managed through BAF. This has been refreshed with approval by the Committees and a new IPC BAF COVID-19 was introduced shortly after the start of the pandemic.

The Corporate Risk Register is reviewed at the Risk Management Committee with deep dives undertaken into Unit risks. A Risk Management Report is also presented to the Committee. This includes the Trust's risk profile and information on incidents but does not overtly seek to ensure that this latter information converts to risks on the risk registers.

A Risk Maturity Toolkit internal audit in 2019-20 found a number of areas of good practice but also areas where improvements could be made. The report concluded that the current position for the Trust was Defined, which is the third position on their five point scale. Some resultant actions have been implemented, including in relation to staff training, although a medium recommendation requiring reconfiguration of Datix required further progression as at May 2020.

The majority of staff who we spoke with confirmed that the Trust is on a journey with "*issues previously reported rather than risks*". They have said that risk awareness and processes are clear but not yet embedded in the Units with some staff saying that Datix and the risk registers have previously been used inappropriately (e.g. as a threat or a way to get funding). There is also some concern that clinical risks can go onto a risk register without being reviewed by a clinical person given that the governance and patient safety staff are non-clinical; however, we have been told that the ACNs (who are clinical) oversee the risk registers via their Unit Governance Meetings.

Staff have confirmed that they know how to identify a risk (see graph below) but that there now needs to be a focus on how the risks are being calibrated and managed. Risks have been discussed in meetings following the restructure but it has become clear to the triumvirate leadership teams that there is not a standardised approach to scoring, with further education being needed in some areas. At the time of our fieldwork, risk registers were not yet fully aligned to the Units but these have now been established.



R11: Deep dives of unit risks need to include a review of the articulation and calibration of risks to ensure an appropriate and consistent approach to risks by all business units.

5.5 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored?

The Trust ensures that Cost Improvement Plans (CIPs) are assessed and scrutinised prior to assignment of a savings target with service changes requiring a Project Initiation Document and Quality Impact Assessment before approval for the schemes can be given. The Internal Auditors have confirmed that there are robust procedures in place for this. While larger projects have post implementation reviews there are many other service CIPs which are not clinically owned or reviewed post implementation (other than financially). This also extends to business cases.

R12: All CIPs and business cases should be assigned quality KPIs which can be monitored during and post implementation of the schemes to ensure that there have been no adverse impacts on patient care or staff health and wellbeing.

KLoE 6: Is appropriate and accurate information being effectively processed challenged and acted on?

Summary findings:

- The Integrated Performance Report allows Board members an overview of performance in the round with heatmaps centred around the Trust's objectives. More detailed analysis is provided through narrative, graphical and SPC charts with actions included for all underperforming metrics. Hotspot reporting is being progressed although further improvements could be made through more predictive reporting and the addition of benchmarking information.
- A range of patient experience, incidents, and claims reports are presented to the Board. These are fed by three new sub-committees including patient safety, patient experience and clinical effectiveness. Thematic reporting is improving but the extent of the triangulation of information from these sub-committees should be tested over time.
- The Board has ensured a good focus on data quality; however, staff have said that this is impacted by disparate IT systems and we note that procurement of EPR is on the risk register given that funding and procurement has yet to be agreed. While devastating in many other areas, COVID-19 has in some ways helped to progress the Digital Strategy although some of the IT equipment at the Trust has become an increasing issue during the pandemic as it is not always adaptable or responsive to the advancements required.
- The Trust has ensured robust information governance processes which help to ensure that information is shared and personal data protected in line with national guidance.

6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure improvement, not just assurance?

Performance data is presented in many of the Trust's meetings in standardised and ad hoc reports.

A Performance Framework has been agreed and the format of reports are evolving.

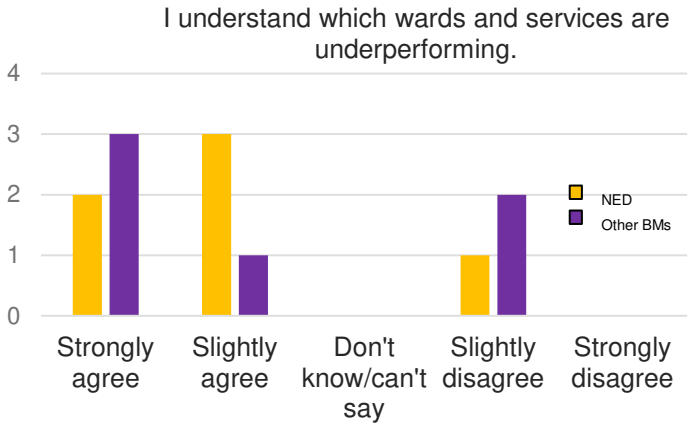
The IPR which is reviewed at the Board (in whole) and Committees (in its respective parts) has been refined to include many elements of good practice. Heatmaps are centred around caring for staff, patients and finances with more detailed analysis through narrative, graphical and SPC charts to ensure an overview of historical trends. Actions are also included for all underperforming metrics. This report could be further improved through:

- more predictive reporting. RAG ratings are forecast on the heatmaps but trajectories should also be included on the SPC charts to allow a more timely understanding of deteriorating performance;
- inclusion of benchmarking information with other local or specialist Trusts. This will allow a better understanding of where the Trust is performing well in relation to other organisations and where further improvements can be made. Internal benchmarking can also be very motivational for individual services and teams; and
- use of thresholds rather than targets for quality metrics such as complaints, pressure ulcers, infection prevention and control, sickness (given that rates have, on occasion, been less than the 'target').

Unit level information with hotspot reporting has been proposed as part of the Performance Framework; however, implementation has been delayed due to COVID-19. This needs to be introduced so that BMs can understand which services are performing well and less well, and is important given that some BMs reported that they were not always aware of this information (see graph overleaf).

R13: Further refine the IPR through inclusion of:

- **trajectories to ensure a more prospective view of performance; and**
- **internal and external benchmarking.**



Patient experience, incidents, and claims reports are presented to QSC with annual reports to the Board. Within each of these there is some reference to thematic analysis; however, this has been limited and patient feedback has been reported on in isolation of other sources of feedback (including in the Patient Experience Report which deals with complaints, PALS, Friends and Family Test separately but without inclusion of incidents and claims). Further analysis of same causal factors is required to ensure that actions are appropriately targeted to prevent recurrence. Learning, rather than actions taken, also needs to be more clearly articulated and shared with teams and Trust-wide departments as staff have said that themes and trends were not well communicated to them.

We also note that medical staff receive a list of incident reports for their appraisal meetings. These are discussed but recognising the importance of understanding individual events, learning would be improved by analysis of these incidents to determine whether there were any themes which needed to be addressed by the clinician.

In relation to information at a ward and department level, staff who we spoke with said this was similarly limited. safety boards display some information but staff cannot access dashboards to give them an overview of KPIs so that they know where they are performing well and less well.

We understand that service level scorecards were being developed prior to the pandemic, with progression delayed due to the demands for additional reporting placed on the performance team.

R14: Include same causal factor analysis of all patient experience sources (including complaints, incidents, claims and FFT) in quarterly reports to QSC with dissemination of key learning to all staff groups.

6.2 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

The Trust has a good focus on data quality. The Data Quality Policy was refreshed in 2019 and confirms the importance of high quality information. There is also a Data Quality Assurance Group that reports to the Information Governance Committee (IGC) (although a number of senior staff who we spoke with were unaware of this Group), with data quality an agenda item at FP&IC.

The Data Quality Maturity Index score has been over 99% for the last 12 months, the Trust is compliant with the DQ Toolkit, and reported KPIs (including those on the IPR) are reviewed over a two year period with findings reflected in the data quality RAG ratings assigned to some, but not all, metrics. However, the Data Quality Programme has, like many other areas of the Trust, been impacted by the pandemic. The Performance Team is now on seven day working due to reporting requirements and have had to respond to urgent national data requests. This has resulted in less focus on internal data although there is an expectation that this will be resumed once infections are reduced.

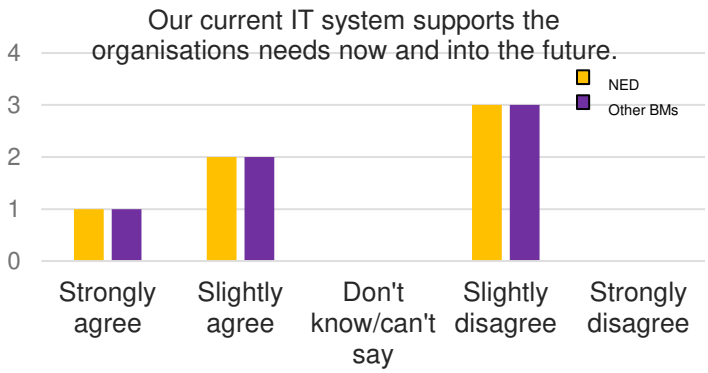
Staff have said that data quality is also impacted by disparate IT systems and we note that procurement of EPR is on the risk register (scored 12-15) given that funding and procurement still has to be agreed.

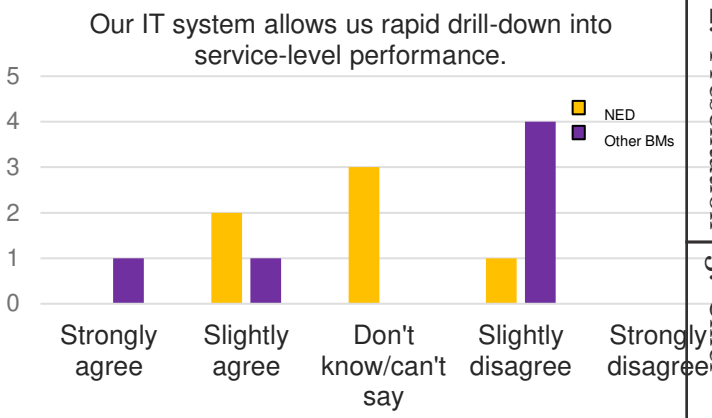
6.3 Are information technology systems used effectively to monitor and improve the quality of care?

Recognising the importance of information technology in the delivery of healthcare services, the restructure resulted in the establishment of a Digital Director who is taking the strategic lead on this area of the business with support of a Digital and Transformation Lead who oversees the operational elements of this function. The Digital Director is a member of SLG, FP&IC and the Data Quality Assurance Group, with attendance at the Board by invitation. They are also chair of IGC (no reportable issues in the last 12 months) and are the Senior Information Risk Owner.

There is a IM&T Digital Strategy 2018-23 aligned to the Corporate Strategy. A paper is presented to FP&DC each month and includes a workplan and strategy update. Digital updates are also taken to SLG but have historically been low on the agenda with occasions when time constraints have not allowed full discussion of this subject.

Although devastating in many other areas, COVID-19 has in some ways helped progress the Digital Strategy with justifications for additional technology made simpler e.g. Microsoft Teams was rolled out in 10 days and video consultations have been introduced for some patients. That said, and as mentioned above, we have also been told that there disparate IT systems remain at the Trust, with many that are antiquated. This has become an increasing issue during the pandemic as they are not adaptable or responsive to the advancements that are required. BMs recognise this and their views are reflected in our survey results:





6.4 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

The Trust has an Information Governance Strategy and supporting Policy which have been developed in line with requirements of the Information Governance Toolkit (now the Data Security and Protection Toolkit). This is supported by an IG Training and Communications Strategy, implementation of which is monitored by the Information Governance Committee which reports to the Audit Committee.

The Trust is responsive to requests for information from external bodies and submissions are made in line with national requirements.

6.5 Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons earned when there are data breaches?

The Trust has a Data Protection Policy which is available on their website. This aims to ensure that personal data is used in accordance with the Data Protection Act 2018. A staff training needs analysis has been performed to identify the training required for all aspects of data security and confidentiality as advised by the National Data Guardian and the Information Commissioner, and Trust employment contracts include appropriate information security, confidentiality and data protection clauses.

Data security and protection were subject to a mandatory internal audit in 2019-20. This found appropriate data security and protection policies in place and an established Information Governance Management Framework to ensure that information governance is embedded across the Trust. The audit gave an 87% compliance score and concluded substantial assurance over the Trust's Data Security and Protection Toolkit self-assessment as at December 2019. Three improvement actions were recorded but timelines for implementation were delayed due to COVID-19.

Information governance breaches are discussed at IGC with escalation to the Audit Committee via a Chair's Report. In July 2020 the Committee was told that between December 2019 to February 2020 there were some breaches in confidentiality (number not specified) mainly due to incorrect letters being sent to the wrong patients. The number was lower in the following period March 2020 to May 2020 (in our view this may have been due to the pandemic and fewer patients being seen at the Trust). Remedial actions included additional training for the Access Team with a reminder to staff about how to handle information.

We note that homeworking will be added to the risk register in relation to information governance; this is advisable given the circumstances of the pandemic.

KLoE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services'

Summary findings:

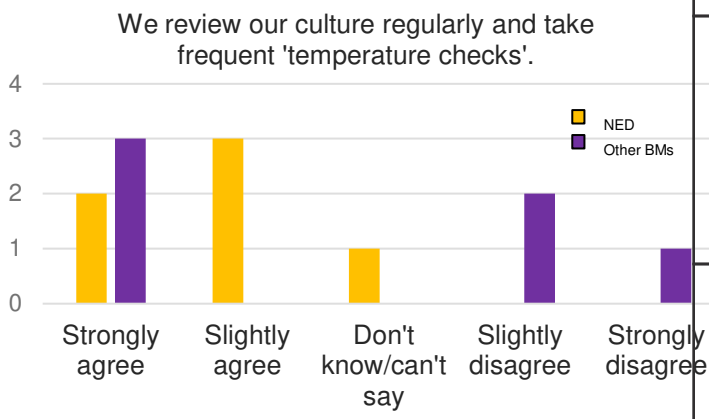
- The 2019-20 national staff survey responses for the Trust were some of the best in the country. Staff who we spoke with were equally positive about organisational communications (particularly during the pandemic); however, we have found that more could be done to test and improve the culture of the Trust with requirement for a more systemic approach to sharing information on changes made as a result of staff feedback.
- Inpatient survey results were also rated as "better" when compared to other Trusts and there are a range of opportunities for patients to be involved or their feedback shared with key meetings and staff groups. As with the staff, communications regarding changes made as a result of this feedback need to improve.
- Relationships with the Board and Governors continue to improve. While Governors can observe the Board and some Committee meetings, rotational presentations by NEDs at the Council of Governors meetings may further help them to discharge their function.
- External stakeholder engagement has also improved, with Board members seen to be taking a more proactive role in the Sustainability and Transformation Partnership. Greater emphasis on system-led engagement is now in place.
- A framework for stakeholder relationships is being considered by the Senior Leadership Group and should be expedited to ensure that engagement activities are undertaken in a co-ordinated manner.

7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

The 2019 national staff survey results were some of the best in the country. 94.8% of staff were happy with the standard of care provided by the organisation if a friend or relative needed treatment here and 77% of staff recommended RJAH as a place to work.

The majority of staff who responded to our survey agreed that the Trust regularly seeks feedback from staff. We have seen evidence of this through the People Committee and also staff (and/or patient) stories at the start of each Board meeting.

We also note that the 2016 Communications and Engagement Strategy references monthly cultural staff surveys, a Barometer Group, and quarterly national staff pulse surveys; we have seen no reference to these in the meeting packs that we have reviewed and BMs do not all agree that the culture of the organisation is regularly tested.



Staff were less positive about seeing actions taken as a result of feedback gained. YSWD has been initiated by the CPIOD; however, this approach is not routinely adopted by services across the Trust.

Staff commented positively on the Trust communications throughout COVID-19 including the Tuesday Talks and the updates from the acting Chief Executive on Facebook. Understandably, many are missing the informal contact that they would have with colleagues in corridors or on walkabouts but the introduction of Microsoft Teams has helped with staff engagement and attendance at key meetings. Clinicians in particular said their attendance at meetings has improved during the pandemic as a result of everyone using this technology, and staff who are having to shield or self-isolate have said that this has helped them to continue with their work.

R15: Introduce a range of communications centred on changes made as a result of staff and patient feedback, including through more systematic adoption of 'You Said, We Did' methodology.

7.2 Are people who use services and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

The Trust's national inpatient survey results for 2019-20 were rated as "better" when compared to other Trusts. They demonstrate that patients feel well looked after and are actively engaged in their care. RJAH also scored highly in their FFT with 99.17% of inpatients saying they would recommend the Trust to family and friends, ranking fourth out of 146 Trusts in England.

The Trust actively seeks the views of the service users through a range of mechanisms, including patient (and/or staff) stories at Board meetings. Patient stories are shared at other meetings and an evaluation of the four patient stories that were presented to Board in 2019 is referenced in the Annual Patient Experience Report; actions implemented as a result of these are not stated.

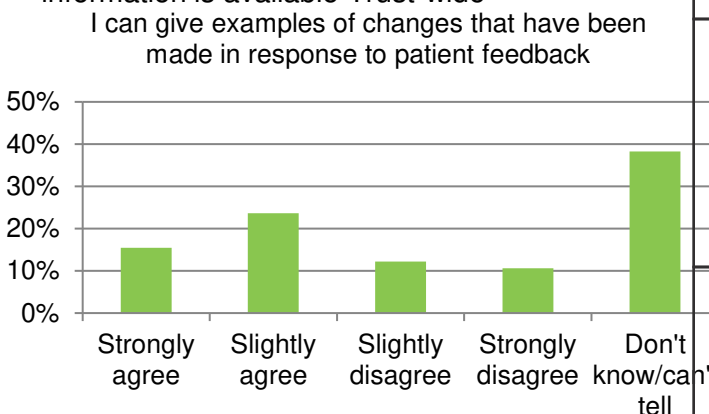
The 2017-20 Patient Experience Strategy is currently being refreshed by the ACNs.

A Patient Experience Report is presented to the Quality and Safety Committee each quarter and this includes feedback from a range of sources (although please see commentary in KLoE 6 in relation to same causal factor analysis and lessons learned).

A Patient Participation Group has also been established and members of this group take part in a monthly rota of Observe & Act (previously Sit and See) observations. During April 2019 – March 2020 there were 77 observations of care carried out across wards and departments by patient representatives. The numbers of positive observations are captured in the Annual Patient Experience Report but thematic analysis of this feedback is not captured.

Complaints received by the Trust are relatively low but increasing (c112 in 2019-20). While all complaints are acknowledged within three working days, only 60% of complaints were closed within an internal target of 25 working days. This has been acknowledged as a concern by the QSC and a number of remedial actions are being introduced.

While the Communication Strategy indicates that there are patient experience notice boards in all wards that include actions taken from patient feedback, our survey results indicate that staff are not always aware of changes which have been made in response to this feedback. Our focus groups also confirmed that while some staff receive local feedback about national staff or patient surveys and actions being taken, that less information is available Trust-wide



See recommendation R15 opposite.

7.3 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

Governors

We have been told that relationships with the Board and Governors are improving, with good communications between the Chair and Lead Governor. Council of Governors meetings are held quarterly with attendance by NEDs if available. Recognising a lack of clarity around their roles, NHS Providers were also invited to facilitate a workshop session with NEDs in attendance. However, there are areas where the role and function of Governors could be further enhanced and which we have seen work well in other organisations. For example:

- NEDs currently attend the CoG meetings but in order for Governors to more fully understand the NED roles, there could be rotational presentations on their portfolios with an opportunity for questions on their areas of expertise;
- Governors do not have their own meeting structure and are not attendees at any of the Committees. The Chair of the Risk Committee has invited them to observe some of their meetings but not all NEDs agreed that this was appropriate for their committees. Continued rotational Committee attendance (as an observer) would help the CoG to better discharge their statutory duty to hold the NEDs to account for the performance of the Board; and
- Pre COVID-19 Governors participated in some of the Executive walkabouts and Sit and See observations, however, they received limited feedback about action taken in response to these. This should be included in meeting packs.

R16: Enhance Governor engagement and their ability to discharge their statutory duties through rotational NED presentations and observations of the Committees of the Board. Information on changes made as a result of their feedback from ward and service visits should be included in meeting papers.

External stakeholders

External stakeholders have told us that relationships between RJAH and members of the ICS are positive and there is an increasing Board profile across the system. The Gold/Silver/Bronze meetings that were established for COVID-19 have assisted with this and external stakeholders confirmed that some of the RJAH BMs have been instrumental in ensuring a joined up response to the pandemic.

BMs also represent the organisation at other key system meetings; for example, the Chair is also Chair of the Integrated Care System (ICS) Shadow Board, the CFO is the ICS lead for mental health, and the Audit Chair has established an ICS-wide Audit Chairs meeting where CRRs and BAFs will be shared to allow a greater understanding of system risks. Recognising the very many meetings that need to be attended, there has been a recent discussion in SLG around a framework for stakeholder relationships in order to confirm who will attend which meeting and what their delegated responsibility will be. This is good practice that we have seen work well elsewhere and should be expedited, particularly given the relatively small staff base of the Trust and comments during focus groups where staff members mentioned “they don’t always know what the Trust wants them to say” when they attend external meetings.

External stakeholders who we spoke with said the Trust was a place they could always go to for help or support. They gave many examples of RJAH “stepping up” to help the system or individual organisation when needed; again, this was very evident during the pandemic when the Trust took all trauma cases from Shrewsbury and Telford Hospital (SaTH).

External stakeholders also agree that the Trust are good at sharing information and have been open about issues; for example, with their theatre recovery plan which resulted in the ICS brokering support from the Clinical Commissioning Group (CCG). External stakeholders are aware of changes happening within the Trust but have commented that the restructure, for example, could have been explained more proactively (including the role of the CCs and MDs). Some stakeholders commented that the COO role is a gap at the Trust but were very positive about the CPIOD and her profile within the system.

External stakeholders believe that historically the Trust has been inward facing but is increasingly focussed on system thinking with potential for this to continue and to be seen as an opportunity for the organisation rather than a threat.

R17: Introduce an external stakeholder engagement framework which supports an integrated approach to communications and ensures that engagement activities are undertaken in a co-ordinated manner.

KLoE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

Key findings:

- The Trust has been rated as good overall by the Care Quality Commission and can evidence progression of residual actions made from the 2018 inspection; however, there is a view from staff that more could be done to attain an outstanding rating.
- Increasing numbers of staff have been trained in improvement methodologies; however, a suite of tools and methods for helping to effect further improvements is not readily available to staff.
- Learning is referenced in reports, and panel meetings take place with staff who have been involved in incidents, but this could be further enhanced with improved communications to all Trust staff to ensure that actions are implemented and embedded in practice.

8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation?

The Trust was last inspected by the CQC at the end of 2018. The report that was published in February 2019 rated the organisation as good overall and outstanding in the caring domain. While staff have said there is a good focus on continuous learning and improvement, some have said that the Trust is not ambitious enough; the CQC action plan from the inspection undertaken in 2018 has been progressed but they should be aiming more robustly at being outstanding overall. Some have said that staff groups are not equally empowered to innovate and that the relatively static workforce has, in some cases, become stifled.

The Trust has an increasing academic base and there is a Research Department on site which is supported by the University. Professors have been appointed to lead in this field but there is also a key vacancy which has not been filled for more than two years.

The department has commissioned an independent audit of their efficiency and benchmarking of the financial environment, results for which were pending at the time of this review.

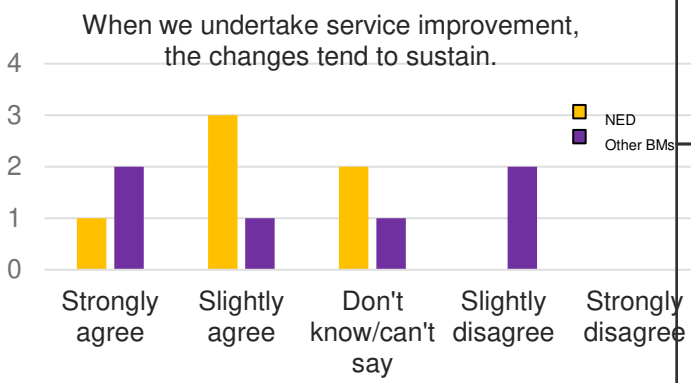
There is an established Research Committee that reports to QSC but we note little alignment of the Research Strategy for 2019-2024 to the agenda and it is not clear how delivery of the objectives or plan are being monitored. Research governance was queried by a NED in a recent Audit Committee meeting and this has now been added to the forward Internal Audit plan.

See recommendation R7

8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them?

One of the workstreams outlined in the People Plan is Service Improvement Champions. While increasing numbers of staff have been trained in this role, there is no forum where feedback or updates on projects which have been initiated can be discussed. Also, the methodologies which these champions have been taught are not readily available to other staff across the Trust.

BMs did not fully agree when asked in our survey that changes made as a result of service improvements are always sustained.



This also applies to actions taken in response to staff and patient feedback, including complaints, incidents, claims and PALS. Only one BM believes that there are clear processes to ensure that lessons are learned and shared across the organisation (see graph overleaf).

R18: A range of quality improvement tools should be made available to all staff and processes for ensuring that staff are aware of lessons learned need to be revised in order to ensure that key communications are shared with all levels of the Trust.

8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

A Learning from Death's Policy was introduced in 2017. This was due for review in November 2019 but was appropriately deferred to November 2020 to allow time to incorporate the Medical Examiner Role which was being introduced over the forthcoming year.

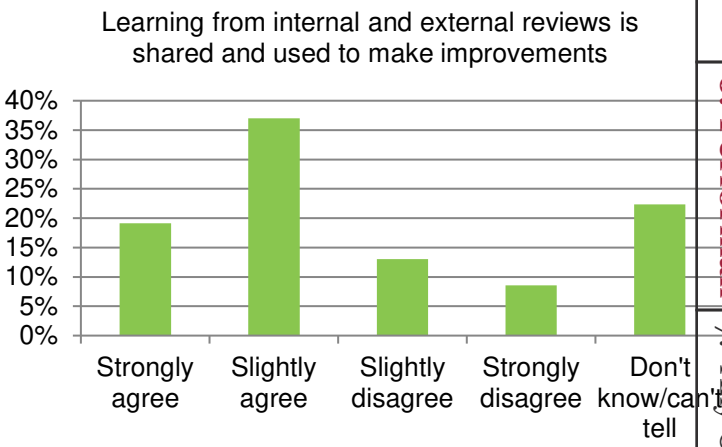
The Trust has a Clinical Lead for mortality reviews although this is not a formal position. This postholder helps to ensure that all deaths are reviewed by the responsible team using the SJR methodology in line with good practice. Findings are presented to the Consultants, the Mortality Steering Group and to QSC. We note, however, that mortality reviews were discussed in the July 2020 QSC following presentation of the Learning from Deaths Report which showed no lessons learned. The attending NED queried this and we agree that the report is unduly brief, does not include whether the deaths were expected, narrative on positive practice (from which learning could be shared) or any other information which may better assure the Committee that no risks were identified.

R19: Enhance the Learning From Deaths Report to include further detail on whether deaths were expected, narrative on positive practice and greater detail on the 'themes' identified.

The Trust took the decision in 2017 to further encourage its staff to report near misses and this was put into practice by creating two new incident types in Datix, near miss clinical and near miss non-clinical, to facilitate reporting. An annual report to the Risk Committee has confirmed an increasing trend in reporting, and some themes are identified; however, lessons learned are not.

Learning from serious incidents was found by the previous Interim CN to be sub-optimal with a small number having to be reviewed following a poor sign-off process which has now been revised. Twice weekly meetings have been established by this postholder to ensure that all incidents are more robustly discussed and signed off.

Other internal and external reviews are reported through the Committee structure; however, many staff who replied to our survey do not fully believe that learning is always shared with them:



We understand that monthly governance half days have now been agreed for medical staff and learning is discussed at these with lessons learned additionally highlighted at Consultant meetings. It is not clear how this information will then be shared with other staff groups.

See recommendation R18 opposite.

4.0. Appendices

Risk Key		Priority Key	
1	High Risk – Requires urgent action	**H**	High Priority - Urgent
2	Medium Risk- requires planned action.	**M**	Medium Priority - Planned
3	Low risk – should be linked to an improvement plan.	**L**	Low Priority – longer term

Appendix 1. Summary of recommendations *(added into final report)*

No.	Page	Recommendation	Risk level	Priority
1	13	Clearly communicate to all staff the portfolios, responsibilities and accountabilities of the clinical triumvirates and the Assurance Team, and include the views of a broad range of Trust staff in the full post implementation review of the organisational structure.	Medium	High
2	13	Heads of Service require a substantive meeting forum to ensure connectivity.	Low	Low
3	16	Introduce a strategic planning framework to support timely strategy refreshes and alignment between the enabling strategies and the Trust Strategy.	Medium	Medium
4	17	Re-launch the annual planning process and ensure that key staff from clinical services are involved in the development of service level plans which are aligned to key objectives of the Trust. Progress against these plans should be monitored with achievements communicated to staff at every level of the organisation.	High	High
5	20	Further progress initiatives aimed at ensuring that all staff are equally held to account for behaviours which are not in line with the Trust values and behaviours framework.	Medium	High
6	22	Introduce a wider range of cultural measures into the People IPR (e.g. use of temporary staff, job transition success rates, grievances, staff concerns and inclusion of staff 'pulse' survey data) ensuring alignment to the People Plan and Wellbeing Policy.	High	High
7	25	Further revise the Committees to ensure that terms of reference, reporting groups, workplans and agendas are aligned to their respective strategies.	Medium	Medium
8	25	Review the Unit governance structures within six months of full implementation to ensure all areas of the business are covered with risks appropriately identified and escalated through the Trust framework.	High	High
9	26	Levels of delegated authority must be clearly articulated for key senior leadership staff and Unit leadership teams to ensure that decision making is undertaken at the right levels of the organisation and that staff can then be held to account for delivery of their objectives.	Medium	High
10	26	Introduce a register of formalised partnership arrangements/joint ventures and ensure associated governance processes are reviewed and contract terms complied with at least annually, with oversight by a Committee of the Board.	Medium	Medium

[Continued]

No.	Page	Recommendation	Risk level	Priority
11	**29**	Deep dives of unit risks need to include a review of the articulation and calibration of risks to ensure an appropriate and consistent approach to risks by all business units.	Medium	Medium
12	**29**	All CIPs and business cases should be assigned quality KPIs which can be monitored during and post implementation of the schemes to ensure that there have been no adverse impacts on patient care or staff health and wellbeing.	High	High
13	**30**	Further refine the IPR through inclusion of: • trajectories to ensure a more prospective view of performance; and • internal and external benchmarking.	Medium	Medium
14	**31**	Include same causal factor analysis of all patient experience sources (including complaints, incidents, claims and FFT) in quarterly reports to QSC with dissemination of key learning to all staff groups.	Medium	Medium
15	**35**	Introduce a range of communications centred on changes made as a result of staff and patient feedback, including through more systematic adoption of 'You Said, We Did' methodology.	Medium	Medium
16	**36**	Enhance Governor engagement and their ability to discharge their statutory duties through rotational NED presentations and observations of the Committees of the Board. Information on changes made as a result of their feedback from ward and service visits should be included in meeting papers.	Low	Medium
17	**37**	Introduce an external stakeholder engagement framework which supports an integrated approach to communications and ensures that engagement activities are undertaken in a co-ordinated manner.	Medium	Medium
18	**39**	A range of quality improvement tools should be made available to all staff and processes for ensuring that staff are aware of lessons learned need to be revised in order to ensure that key communications are shared with all levels of the Trust.	Medium	Medium
19	**39**	Enhance the Learning From Deaths Report to include further detail on whether deaths were expected, narrative on positive practice and greater detail on the 'themes' identified.	Low	Low

Appendix 2: Long-form staff survey responses

	Question	Strongly Agree	Slightly Agree	Slightly Disagree	Strongly Disagree	Don't know/can 't tell	RAG Rating
1	I am aware of Board members visiting clinical areas of the organisation	51	84	21	31	59	A
2	I am aware of Board members visiting non-clinical areas of the organisation	36	66	31	36	77	A
3	Senior leaders are visible and approachable	61	89	45	32	19	G
4	I am aware of the vision of the organisation	102	101	23	10	10	G
5	The values of the organisation are clear	146	73	15	9	3	G
6	Staff have been engaged in the development of the vision and values	46	85	36	33	46	A
7	I understand how my personal objectives contribute to the delivery of the organisation's vision	90	77	27	35	17	G
8	Staff at all levels are held to account for behaviours which are not consistent with the values	58	50	42	65	31	A
9	I know how to raise a concern if quality is being compromised	145	81	9	8	3	G
10	I have access to training which helps me to deliver my role effectively	129	90	16	10	1	G
11	There are a variety of activities available to staff to promote their safety and well-being	108	92	21	11	14	G
12	Equality and diversity are actively promoted	99	84	21	21	21	G
13	Teams work collaboratively across the organisation	45	94	59	33	15	A
14	I am clear about my role and I understand what I am accountable for	162	64	14	6	0	G
15	I know how to effectively identify and escalate a risk	169	61	9	4	3	G
16	I am aware of key risks in my part of the organisation	139	80	10	5	12	G
17	Staff are asked for their views on the impact on quality of cost improvement schemes	26	60	52	69	39	A

[Continued]

	Question	Strongly Agree	Slightly Agree	Slightly Disagree	Strongly Disagree	Don't know/can't tell	RAG Rating
18	We have regular team meetings	101	54	37	50	4	G
19	I am provided with meaningful information which helps improve performance in my part of the organisation	58	101	45	36	6	G
20	I understand how my specialty is performing in relation to other areas of the organisation	56	83	47	33	27	A
21	Information Technology is used effectively to improve and monitor the quality of care	57	100	18	22	49	G
22	The organisation regularly seeks feedback from staff	60	111	40	25	10	G
23	Actions are taken as a result of staff feedback	37	83	41	32	53	A
24	I can give examples of changes that have been made in response to patient feedback	38	58	30	26	94	A
25	I am supported to improve service delivery	72	106	34	21	13	G
26	Good practice is celebrated and shared across the organisation	96	97	25	15	13	G
27	This is an organisation that encourages learning and development	89	93	33	22	9	G
28	Learning from internal and external reviews is shared and used to make improvements	47	91	32	21	55	A

Grey: Highest response

Criteria for RAG rating:

Red: Less than 30% agree with positive statement
Amber: Less than 60% but more than 30% agree with positive statement
Green: More than 60% agree with positive statement

Appendix 3: Glossary of terms

ACN	Associate Chief Nurse	**KPI**	Key performance indicator
BAF	Board Assurance Framework	**LLP**	Limited Liability Partnership
BM	Board member	**MD**	Managing Director
BP	Business Partner	**MDT**	Multi-disciplinary team
CC	Clinical Chair	**NED**	Non-Executive Director
CCG	Clinical Commissioning Group	**PALS**	Patient Advice and Liaison Service
CEO	Chief Executive Officer	**QSC**	Quality and Safety Committee
CIP	Cost Improvement Programme	**RMC**	Risk Management Committee
CN	Chief Nurse	**SLG**	Senior Leaders Group
COO	Chief Operating Officer	**SPA**	Supporting professional activities
CQC	Care Quality Commission	**STP**	Sustainability and Transformation Partnership
DoP	Director of People		
CPIOD	Chief Performance, Improvement and Organisational Development		
ED&I	Equality, diversity and inclusivity		
FTSU	Freedom to Speak Up		
HR	Human Resources		
ICS	Integrated Care System		
IGC	Information Governance Committee		
IM&T	Information management and technology		
IPR	Integrated Performance Report		
KLoE	Key line of enquiry		

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NHSI Criteria and Prompts (including CQC KLOE)		Recommendation	Action	Owner	Assurance Goal	Target Deadline	Progress / RAG	Progress / Evidence
1	**Is there the leadership capacity and capability to deliver high quality, sustainable care?**							
1.1	Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?	Clearly communicate to all staff the portfolios, responsibilities and accountabilities of the clinical triumvirates and the Assurance Team, and include the views of a broad range of Trust staff in the full post implementation review of the organisational structure	Re-publish the structure with a summary of the responsibilities and accountabilities of the Assurance Team	Chief of People	Improved understanding of the Trust's organisational structure and individual accountabilities	Sep-21	Completed	Structures now published on intranet. New portal (due December 2021 will be more interactive and have links etc)
			Undertake a post implementation review with forums to be established to capture the views of a spectrum of staff groups	Interim Chief Executive		Dec-21	Not started	
1.2	Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?	Heads of Service require a substantive meeting forum to ensure connectivity	Enhance the Managers Briefing Forum through monitoring of attendance to ensure connection across the organisation and target areas of non-attendance	Assistant Director of Communications	Improved connection from Ward to Board	Dec-21	On track	Focus groups taken place with action plans (staff surveys) - monitoring to take place over 3 months
1.3	Are leaders visible and approachable?	See recommendation 1.1						
1.4	Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	No recommendation						
2	**Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?**							
2.1	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?	No recommendation						
2.2	Is there a robust realistic strategy for achieving the priorities and delivery good quality sustainable care?	No recommendation						
2.3	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?	Introduce a strategic planning framework to support timely strategy refreshes and alignment between enabling strategies and the Trust Strategy	Strategic framework already in place, due to changing personnel and governance will be refreshed and approved through FPD in line with previous version	Chief of Performance, Improvement and OD	An up to date strategic framework	Nov-21	On track	Document reviewed, updates being made.
		Re-launch the annual planning process and ensure that key staff from clinical services are involved in the development of service level plans which are aligned to key objectives of the Trust. Progress against these plans should be monitored with achievements communicated to staff at every level of the organisation	Planning framework to be established, due to changing NHSEI requirements this will be for the 22/23 planning round.	Chief of Performance, Improvement and OD	Improved engagement in the service level plans leading to improved delivery	Dec-21	On track	After action reviews following the planning rounds this year (which have been multiple) have occurred this will be utilised within the planning framework.
2.4	Do staff know and understand what the vision, values and strategy are, and their role in achieving them?	No recommendation						
2.5	Is the strategy aligned to local plans in the wider health and social care economy and how have services been planned to meet the needs of the relevant population?	No recommendation						
2.6	Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?	No recommendation						
3	**Is there a culture of high quality, sustainable care?**							
3.1	Do staff feel supported , respected and valued?	No recommendation						
3.2	Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?	Further progress initiatives aimed at ensuring that all staff are equally held to account for behaviours which are not in line with the Trust values and behaviours framework	Review of Performance Policy	Chief of People	Consistent and robust performance management	Oct-21	Completed	Performance Managemnet policy reviewed and updated.
			EDI pre-formal action to be introduced	Chief of People		Oct-21	Completed	The EDI pre-formal action has been introduced
			Management development programme to be developed with a focus on performance management	Chief of People		Mar-22	On track	The programme is in development
3.3	Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	No recommendation						
3.4	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?	No recommendation						
3.5	Is there a strong emphasis on safety and well-being of staff?	No recommendation						
3.6	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?	No recommendation						
3.7	Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?	See recommendation 1.1						
4	**Are there clear responsibilities, roles and systems of accountability to support good governance and management?**							
4.1	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?	Further revise the Committees to ensure the terms of reference, reporting groups, work plans and agendas are aligned to their respective strategies.	Review of Quality Committee agenda / TOR and work plan against the Quality Strategy	Trust Secretary / Chief of People / Chief Nurse	Improved alignment of committee agendas to the relevant strategies	Oct-21	On track	Meeting in the diary in October to carry out the review
			Review of People Committee agenda . TOR and workplan against the People Plan and further review the reporting groups			Oct-21	On track	Meeting in the diary in October to carry out the review
		Review the Unit governance structure within six months of full implementation to ensure that all areas of the business are covered with risks appropriately identified and escalated through the Trust framework	Trust Secretary to attend and observe the Unit Governance Meetings and feedback recommendations ahead of a full assurance review in Jan 2022	Trust Secretary / Chief Nurse	Improved Unit governance with better distinction between corporate risks and unit risks	Jan-22	On track	The Trust Secretary has commenced the observations and is feeding back either during / immediately after the meeting regarding potential improvements
4.2	Do all levels of management and governance function effectively and interact with each other appropriately?	No recommendation						
4.3	Are staff at all levels clear about their roles and are they clear about what they are accountable for and to whom?	Levels of delegated authority must be clearly articulated for key senior leadership staff and unit leadership to ensure that decision making is undertaken at the right levels of the organisation and that staff can then be held to account for delivery of their objectives.	Review of scheme of delegation with all senior members to be provided with any update copy and to confirm it has been read.	Chief Executive / Chief of Finance	Improved decision making and increased accountability	Jan-22	On track	On the work plan for Audit Committee in January 2022
			Review of delegation to the Units to ensure there is clarity amongst the senior team of the portfolios	Senior Leadership Team		Jan-22	On track	On the work plan for Audit Committee in January 2022
4.4	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?	Introduce a register of formalised partnership arrangements or joint ventures and ensure associated governance processes are reviewed and contract terms complied with at least annually with oversight by a Committee of the Board	Six monthly reporting to FPD to be introduced	Chief of Finance	Robust contract management to ensure quality and value for money achieved	Oct-22	On track	Contract register in place. Contract management being conducted under SLA with SaTH.
5	**Are there clear and effective processes for managing risks, issues and performance?**							
5.1	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?	No recommendation						
5.2	Are there processes to manage current and future performance? Are these regularly reviewed and improved?	No recommendation						
5.3	Is there a systemic programme of clinical and internal audit to monitor quality, operational and financial processes and systems to identify where action should be taken?	No recommendation						
5.4	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between recorded risks and what staff say is on their worry list?	Deep dives into risks need to include a review of the articulation an calibration of risks to ensure appropriate and consistent approach to risks by all business units	Deep dives to be undertaken through Unit Governance Meetings with Governance Leads and Trust Secretary supporting the calibration and articulation	Trust Secretary / ACNs	Consistent approach to risk management across the Units	Dec-21	On track	Trust Secretary is currently attending all Unit governance meetings to assess the risk management processes - risk escalation to be included as standing agenda item going forwards
5.5	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?	All CIPs and business cases should be assigned quality KPIs which can be monitored during and post implementation of the schemes to ensure that there have been no adverse impacts on patient care or staff health and wellbeing	Business case and efficiency process to be amended to incorporate this requirement with template to be updated and link through to IPR	Chief of Improvement Performance and OD / Chief of finance	Greater assurance around the maintenance of quality standards	Nov-22	Not started	CIP evaluation meetings in Q4 to review the quality impact similar to the sign off process with the CNO/CMO and agree
6	**Is appropriate and accurate information being effectively processed, challenged and acted on?**							
6.1	Is there a holistic understanding of performance which sufficiently covers and integrates peoples views with information on quality, operations and finances? Is information used to measure improvement, not just assurance?	Further refine the IPR through inclusion of trajectories to ensure a more prospective view of performance and internal and external benchmarking	Trajectories in place on limited number of KPI's being developed across a wider range. Benchmarking to be included at a later date in IPR, but regular update reporting is monitored and provided.	Chief of Performance, Improvement and OD	Clear trajectories in IPR and benchmarking identified	Dec-21	On track	Trajectories in development, not currently on all kpi's
		Include same causal factor analysis of all patient experience sources (including complaints, claims, incidents and FFT) in quarterly reports to QSC with dissemination of key learning to all staff groups	Establish Unit specific reporting into Patient Experience Committee to then feed to Quality and Safety Committee via the Quality Reports	Chief Nurse / Trust Secretary	Robust overview of factors impacting on patient experience	Nov-21	Not started	Deep dive analysis of FFT completed for Q1
6.2	Are there effective arrangements in place to ensure that the information used to monitor, managed and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues arise?	No recommendation						
6.3	Are information technology systems used effectively to monitor and improve the quality of care?	No recommendation						
6.4	Are there effective arrangements to ensure that data or notificaitons are submitted to external bodies as required?	No recommendation						
6.5	Are there robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data management systems in line with data security standards? Are lessons learned when there are data breaches?	No recommendation						
7	**Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?**							
7.1	Are people's views gathered and acted on to shape and improve services and the culture? Does this include a range of people in equality groups?	Introduce a range of communications centred on changes made as a result of staff and patient feedback, including through more systematic adoption of 'You Said, We Did'	Wider roll out of staff focus groups and introduction of thematic reviews at Staff Experience Group	Chief of People	Improved feedback as a result of staff and patients seeing the positive impact of sharing their experiences	Mar-22	On track	Focus groups used to identify and agree actions. Staff experience Group identifying key areas for focus
			Review of Patient Panel membership and greater patient involvement in meeting groups	Chief Nurse		Dec-21	On track	Learning Disability Group now has a patient representative and looking to roll this out further
7.2	Are people who use services and their representatives actively engaged in decision making to shape services and culture? Does this include people in a range of equality groups?	No recommendation						
7.3	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?	Enhance Governor engagement and their ability to discharge their statutory duties through rotational NED presentations and observations of committees of the Board. Information on changes as a result of their feedback from ward and service visits should be included in meeting papers.	NED presentations to be added to the Council of Governor Work Plan.	Trust Secretary	Evidence of NED presentations in Council of Governor minutes	Oct-21	Not started	
			Committee observations to be organised via the relevant Chair	Trust Secretary	Ongoing observations from Governors	Sep-21	Completed	These have been organised on an adhoc basis and discussion around formal arrangement to take place
			Ward and service visit feedback to be included in Council of Governor Work Plan with action taken to be reported	Trust Secretary	Workplan	Oct-21	Not started	
		Introduce an external stakeholder engagement framework which supports an integrated approach to communication and ensures that engagement activities are undertaken in a co-ordinated manner.	External stakeholder register to be developed with relationship leads identified	Trust Secretary	Register in place	Nov-21	Not started	
			Trust engagement and communication framework to be aligned to the ICS framework	Interim Chief Executive	Alignment with the ICS	Mar-22	Not started	
8	**Are there robust systems and processes for learning, continuous improvement and innovation?**							
8.1	In what ways do leaders and staff strive for continues learning, improvement and innovation? Does this include participating in appropriate research projects and recognised	See recommendation 4.1						
8.2	Are there standardised improvement tools and methods and do staff have the skills to used them?	A range of quality improvement tools should be made available to all staff and processes for ensuring that staff are aware of lessons learned to ensure that key communications are shared with the Trust at all levels	Intranet to be updated with standardised tools	Chief of Performance, Improvement and OD	Consistent approach to improvement	Jun-22	On track	Improvement training framework approved through people & quality & safety committee. Training in place aligned to this which includes the standardised tools. Intranet being updated for such and next stage of wider roll out this year
			Improvement training framework to be implemented	Chief of Performance, Improvement and OD		Jun-22	On track	Improvement training framework approved through people & quality & safety committee. Training in place aligned to this which includes the standardised tools.
			Improvement Champion to be added to the membership of each Quality Priority Task and Finish Group	Chief Nurse		Oct-22	On track	Request sent to Chairs of the Task and Finish Groups for the membership to include a Quality Improvement Champion
8.3	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?	Enhance the learning from deaths report to include further detail on whether deaths were expected, narrative on positive practice and greater detail on the themes identified	Template for learning from deaths report to be reviewed	Chief Medical Officer	Improved opportunities for learning	Dec-22	Not started	