The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Director (Public) 06.09.2023

MEETING
6 September 2023 09:30

PUBLISHED
5 September 2023

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	6/09/23		09:30
1. Welcome			09:30
1.1. Apologies		All	
1.2. Declarations of Interest		All	
1.3. Minutes of the previous meeting 05 July 2023		Chair	
1.4. Action Log / Matters Arising		Chair	
2. Patient Story		Chief Nurse and Patient Safety Officer	09:40
3. Chair and CEO Update		Chair and CEO	09:55
3.1. Lucy Letby Letter and Freedom to Speak Up Briefing			
3.2. Corporate Objectives			
3.3. ROH Colloboration			

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	6/09/23		09:30
4. Quality and Safety			
4.1. Chief Nurse and Patient Safety Officer Update (verbal)		Chief Nurse and Patient Safety Officer	10:10
4.1.1. IPC Feedback Letter			
4.2. Chief Medical Officer Update (verbal)		Chief Medical Officer	
4.3. IPR Exception Report		Chief Nurse Patient Safety Officer	
4.4. PSIRF Implementation and Policy		Chief Nurse and Patient Safety Officer	
4.5. Duty of Candour Annual Report		Chief Nurse and Patient Safety Officer	
4.6. Safeguarding Annual Report		Chief Nurse and Patients Safety Officer	
4.7. Learning From Deaths (Q1) Report		Chief Medical Officer	
4.8. Chair Report from Quality and Safety Committee		Non Executive Director	
4.8.1. Q&S Terms of Reference			
BREAK			10:55

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	6/09/23		09:30
5. People and Workforce			11:10
5.1. IPR Exception Report		Chief People Officer	
5.2. Freedom to Speak Up (Q1) Report		Chief Nurse and Patient Safety Officer	
5.3. Guardian of Safe Working Hours (Q1) Report		Chief Medical Officer	
5.4. EDI Strategy		Chief People and Culture Officer	
5.5. Openness Policy		Chief People and Culture Officer	
5.6. Chair Report from People and Culture Committee		Non Executive Director	
5.6.1. P&C Terms of Reference			

Continued on the next page...

Agenda

Location	*Date*	*Owner*	*Time*
Meeting Room 1, Main Entrance	6/09/23		09:30
6. Performance and Finance			11:35
6.1. Chief Operating Officer Update (verbal)		Managing Director for MSK Unit	
6.1.1. Industrial Action			
6.2. IPR Exception Report		Managing Director for MSK Unit	
6.3. Long Waiters (Presentation)		Managing Director for MSK Unit	
6.4. Activity Mitigation Plan		Managing Director for MSK Unit	
6.5. Agency Reduction Plan (verbal)		Chief Nurse and Patient Safety Officer	
6.6. Finance Performance Report		Chief Finance and Planning Officer	
6.7. Chair Report from Finance, Performance and Digital Committee		Chief Finance and Planning Officer	
6.7.1. FPD Terms of Reference			
7. Questions from the Governors and Public		Chair	12:10
8. Any Other Business		All	12:20
8.1. Next Meeting: 04 October 2023			

Board Members and Senior Leaders Declarations of Interests

First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From & To dd-mm-yy		Comments, including action taken to mitigate any potential conflict of interest.
					From	To	
Harry	Turner	Chairman	Non-Financial Personal Interests Non-Financial Professional Interests	Presiding Justice West Mercia judiciary Chair of Dudley Integrated Care NHS Trust, Dudley	October 2006 July 2019	Ongoing Ongoing	
Sarfraz	Nawaz	Non Executive Director	Financial Interests	Director of Finance and Procurement at Ofwat, No conflict between role at Ofwat and RJAH	March 2018	Ongoing	
Paul	Kingston	Non Executive Director	No interest to declare	N/A	N/A	N/A	
Penny	Venables	Non Executive Director	Financial Interests Non-Financial Professional Interests Non-Financial Personal Interests Non-Financial Personal Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business. Non-Executive Director –British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA and the Finance and Audit Committee. Vice-Chair /Acting Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS. Currently acting chair during the ill-health of the substantive chair of the Board of Trustees . Vice – Chair Birmingham Ethnic Education Advisory Service, 1st Floor Lozells Methodist Community Centre, 163 Gerrard Street, Lozells, Birmingham B19 2AH. Vice – Chair of the Board of Trustees.	January 2021 June 2020 December 2014 June 2015	Ongoing Ongoing Ongoing July 2023	
Martin	Newsholme	Non Executive Director	Financial Interests	I am a Non executive director of Shropshire Doctors Co-operative Limited ("Shropdoc") which provides out of hours services to STW and Powys Health Commissioners. Shropdoc has no direct dealings with RJAH but is part of the same ICS.	01/08/2019	Ongoing	
John	Pepper	Associate Non Executive Director	Financial Interests	NHS England GP Appraiser	01/07/2022	Ongoing	
Martin	Evans	Associate Non Executive Director	Financial Interests Financial Interests	Non-Executive Director at Dudley Integrated Health and Care NHS Trust Director at MJE Associates Ltd	01/04/2020 01/04/2020	Ongoing Ongoing	
Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests Financial Interests Financial Interests	Member of CIPFA Employed by Black Country ICB Director of Maubach Consulting Ltd	01/07/2022	Ongoing 10/04/2023 Ongoing	
Lindsey	Webb	Associate Non Executive Director	Financial Interests Indirect Interests	Vice Chair of Birmingham Hospice My husband, Paul Taylor, is NED at BSOLICB.	January 2016	July 2023 Ongoing	
Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
Ruth	Longfellow	Chief Medical Officer	Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	November 2019	Ongoing	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Craig	Macbeth	Chief Finance and Planning Officer	No interest to declare	N/A	N/A	N/A	
Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust May 2022 - May 2023	May 2022	Ongoing	
Denise	Harnin	Chief People and Culture Officer	No interest to declare	N/A	N/A	N/A	
Paul	Kavanagh-Fields	Chief Nurse and Patient Safety Officer	No interest to declare	N/A	N/A	N/A	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
05 JULY 2023 AT 9:30PM, MEETING ROOM 1 AT RJAH
MINUTES OF MEETING

Voting Members in Attendance

Name	Role	Attending
Harry Turner	Chairman	✓
Paul Kingston	Non-Executive Director	x
Martin Newsholme	Non-Executive Director	✓
Penny Venables	Non-Executive Director	✓
Lindsey Webb	Non-Executive Director	✓
Sarfraz Nawaz	Non-Executive Director	✓
Stacey Keegan	Chief Executive Officer	✓
Craig Macbeth	Chief Finance and Planning Officer	✓
Paul Kavanagh Fields	Chief Nurse and Patient Safety Officer	✓
Ruth Longfellow	Chief Medical Officer	x
Mike Carr	Chief Operating Officer	✓

Others in Attendance

Name	Role	Attending
Martin Evans	Associate Non-Executive Director	✓
Paul Maubach	Associate Non-Executive Director	✓
John Pepper	Associate Non-Executive Director	x
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Richard Potter	Deputy Chief Medical Officer	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minutes)	✓
Chris Hudson	Head of Communications	✓
Colin Chapman	Governor	✓
Victoria Sugden	Governor	✓
Kate Betts	Governor	✓
Nikki Kuiper	Governor	✓
Sheila Hughes	Governor	✓

Ref.	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting and in particular, the Governors, Amiee Woosnam, who joined the meeting to present her staff story and Richard Potter, Deputy Chief Medical Officer who is representing Ruth Longfellow. HT welcomed Atif Ishaq, Associate Non-Executive Director and Lindsey Webb, Non-Executive Director who have both joined the Trust at the beginning of July.
1.1	**Apologies**
	Apologies were received from Paul Kingston, John Pepper and Ruth Longfellow. It was noted that the Board was quorate.
1.2	**Declarations of Interest**
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making. Both LW and AI confirmed they have completed a declaration of interest documentation as part of the recruitment process.

Ref.	Discussion and Action Points
1.3	**Minutes of Previous Meetings**
	The minutes of the Board meeting held on 01 March 2023 were approved as an accurate record of the meeting. The Minutes of the Board meeting held on 03 May 2023 were approved as an accurate record of the meeting.
1.4	**Action Log and Matters Arising**
	All actions were noted as completed. There were no matters arising.
2.0	**Patient Story**
	PKF introduced Amiee who joined the meeting to deliver an update on her patient journey. The update covered the following areas: • Amiee spoke about her battle with anorexia and explained she has been under the care of the metabolic care at the Trust for some time. • Discharges from the service in 2019 and continues to improve herself. • Went back to education and completed a degree in sports coaching. Aimee is a keen runner. • A GP noticed the shape of her spine at an appointment. Aimee has a curvature in the spine and was referred for further assessment. • Covid 19 influenced waiting list and appointments therefore Aimee's operation was placed on the hold. Last year, Aimee was offered a referral to London for treatment however due to the complex case, her treatment was declined. • The spinal consultants arranged for Aimee to have a period of halo gravity protection due to lack of flexibility in the spine before surgery. • In January, Aimee was called and offered the traction fitting in 2 weeks' time. Although she was apprehensive, she wanted to give it a go for a better life. • The first 2 weeks were difficult but was beginning to feel better. There was noted movements at 8.5 weeks following the traction being completed and Aimee started to feel physically better. • Surgery was scheduled for 13th March. It was an all-day theatre case which was a success. • Amiee thanked the Trust for the amazing experience, for supporting her though her recovery and for persevering with her treatment. Following the presentation from Amiee, the members queried the following points: • Thanked Amiee for taking the time to share her story with the Board which brought the Boards exceptional reporting item, waiting lists to life. • The Board were blown away by the story and her determination. • It was pleasing to hear that staff continue to support patients, especially through challenging times. • The Board queried how regular Aimee was communicated between referral and surgery. Aimee explained there was little communication throughout Covid which was expected however it was difficult not knowing. • Noted the complex referral for Aimee's treatment to be completed in London wasn't suitable. • There was a communication gap between confirmation of surgery and the operation date surgery which was approx. 2 months however Aimee was informed about the spinal waiting list and overall capacity pressure. On behalf of the Board, HT thanked Aimee for sharing her Inspirational story and wished her a speedy recovery!
3.0	**Chair and CEO Update**
3.1	HT provided the following verbal update: • The Trust have enjoyed celebrating 75 years of the NHS. The NHS continue to face challenges however, the Trust continue to take advantage of the changes to embed a sustainable future. • Following the appointment of 2 new Non-Executive Directors, HT confirmed a review of the committee membership will be considered. The revised membership will be implemented after the summer. • The ICS continues to be challenged upon governance processes and therefore a review is being completed by the GGI.

Ref.	Discussion and Action Points
	• Togetherness week at the Trust has been scheduled for the first week of September. A full week of activities will be arranged. HT encouraged attendance from the Non-Executive Directors.
3.2	SK highlighted the following key points from the CEO Update paper: • Westminster Abbey– staff members attending the event which celebrated 75 years of the NHS. • Park Run – the Trust participated in the Oswestry park run to celebrate the 75 years of the NHS. • Theatre expansion – work has commenced on the theatre development. • Recruitment – improvement have been implemented and the success of those initiatives have started to be reported as part of the recruitment and retention work. • EDI listening event completed and bespoke session for Theatre staff. • Armed Forces Week – the Trusts reservist were awa at camp however a team's meeting was scheduled where they presented an insight of the work, they completed within their reservist roles. The call was shared on social media and noted by the BBC. • Volunteers' week – the volunteer complete 26,000 hours dedicated to the organisation in a range of roles. A celebration evening was scheduled, and Jayne Thomas won volunteer if the year and Horatio Garden won team of the year. • The Trust has submitted entries into the NOA, and the Trust have been announced as finalist for an entry relating to the recruitment agenda. • Publication of the long-term workforce place has been received. • ICS – a joint forward plan for STW approved last week which is aligned to other programmes. • RJAH Star – Sammy Davies, for leading on the myrecovery app being rolled out. Sammy has been praised for the support she gives to her colleagues and overall brilliant work she completes. Well done, Sammy! • RJAH Star – Dan Hodgetts, for supporting patients with dietary requirement. Dan has been prised for being extremely helpful. Well done, Dan! The Board noted the update and there were no questions raised.
Quality and Safety	
4.1	**Chief Nurse and Patient Safety Officer Update**
	PFK provided the following verbal update: • RCN fell beneath the threshold for strikes and therefore no further strikes have been scheduled. • Dame Ruth May has agreed to attend the Trusts first Nurses and AHP Day Celebration. • The team are currenting reviewing the quality strategy. • There have been some concerns raised following the reporting of the Trust key performance indicators. These relate to medicines management, falls and pressure ulcers, all three areas have been included within the Trust priorities for the year. • The Quality Account has been approved and published on the Trust website. • Sam Young has been appointed Deputy Chief Nurse and Chief Clinical Information Officer. The Board thanked PKF for the verbal and there were no questions raised.
4.2	**Quality and Safety Performance Report**
	PKF highlighted the following key points from the performance report: • 13 complaints – majority are relating to cancellation of treatment. • 1 SSI post infection – this was an unavoidable case. The patients had been transferred from Stoke. The Trust continue to focus on medicine management, falls and pressure ulcers which have been reported as concerns via the performance report. With relation to medicine management, medication targeted intervention has been introduced and supporting staff with training has been commenced. PFK confirmed there have been no harms to patients. The Trust is to commence a tissue viability lead training to support pressure ulcers and targets interventions will be introduced to support falls. The three areas have been included in the Trusts quality priorities.

Ref.	Discussion and Action Points
	The Board note the Performance Report relating to Quality and Safety.
4.3	**Chairs Assurance Report – Quality and Safety Committee**
	CB shared the following key points from the Quality and Safety Committee: • Recommended approval of the Quality Accounts – thanks to Sara Ellis Anderson who led the report within minor amendments requested relating to waiting lists. • Performance - reassuring the medication errors, further assurance at a later meeting, • Identified an issue with delayed discharges. • The Committee has asked for regular information on trends and themes with complaints. • Noted that the pressure ulcer was not RJAH acquired. • Helpful update on PSIRF – a session is to be arranged to align with the implementation on the framework. • Security annual report – the Committee asked for bench marking data to support comparison reporting. • PROMs data information isn't being received which has been escalated. • ICB offered support with quality support checks. • Received the IPC report and assured with detail presented. • IPC quality report – Sheldon ward was commended for recent work with managing the recent outbreak. In relation to the medication error, ME queried whether the People and Culture Committee were able to assist in cross cover of information. CB confirmed that the Quality and Safety Committee is satisfied, and confident issues are monitored. The Board noted the updated from the Quality and Safety Committee.
4.4	**Patient Experience Annual Report**
	PFK presented the patient experience annual report, highlighted the following points: • Overall, a positive report which outlines the Trust performance. • Overall assures as the Trust is delivering a good service and inpatient surgery – number 1 on the country for the third year running! • The annual report was presented to the Quality and Safety Committee for consideration in July. Following presentation of the report and Board provided the following comments: • Positive to note the compliments have increased 70% Consideration to be given as to whether the data can be broken down through to explore opportunities to understand the EDI agenda further. Confirmed the report reflects the Trust only. The Board noted the positive patient experience report.
People and Culture	
5.1	**People and Culture Performance Report**
	DH provided an update relating to the performance report: • All 4 KPI targets are below target which is good news and commendable to the managers and staff across the organisation. • There are still challenges within the people agenda but the collective work being completed is being to be reported. • 2 more recruitment days have been for 5th July and 8th October. The success of the previous 2 days was commended. • Nursing colleagues and Assistant Chief Nurse have commenced the carer café which is a drop-in session to explore opportunities of other lines of work within their profession. • Agency spend and controls continue to be a challenge – the Trust is required to revert to agency to support staffing levels. The Trust utilised off framework agency in May however there is an increased scrutiny within the reporting and approval process. The Board congratulated the team on the positive changes with the KPI.
5.2	**Chairs Assurance Report - People and Culture Committee**
	ME provided the highlights from the People and Culture Committee Chair report: • Sickness remains within target which is positive news to report. • Vacancy rates are reducing.

Ref.	Discussion and Action Points
	• Time to recruit and staff retention KPIs to be approved. • OPOD – oversight projections to be included to support proactive focus. • Agency – is a focus within the committee. Contributing factors include the 3 bank holidays and industrial action. The Trust confirmed PKF is the Executive lead for agency and a task and finish group has been established. • Asked for report following a review of the statutory and mandatory training. The committee requested further assurance that staff are completing the correct training for their profession. • Approved the Fit Note SOP which is a new policy following changing regulations – good work completed by the Trust. • Extreme weather policy is to be aligned into one overarching document. • Endorsed the performance and capacity policy which is to be shared with the JCG. • EDI plan – great to see the progress which included the next steps. • Powys Ward – no areas of concern to raise. It was agreed that the detailed action plan was not appropriate for the Committee to review and therefore ME and PV are to meet with MC, DH and PKF for assurance outside of the meeting. Following presentation of the Chair Report, the Board provided the following comments: • Career café – encouraged the Trust to consider establishing for non-clinical roles. • Encouraged triangulation on agency spend between people, finance and quality. • Noted that retire and return, generally relate to covid staff. However, there is an increase in retirements. The Board noted the update.
5.3	**Freedom to Speak Up Annual Report**
	PFK encouraged questions from the Board regarding the freedom to speak up annual report. It was confirmed that the annual report has been considered by the People and Culture Committee in July and is shared with the Board for noting. Following presentation of the annual report, the Board provided the following comments: • Queried whether issues are being raised through the freedom to speak up process or elsewhere. The Trust confirmed that each issue is reviewed in detail and re-directed to the relevant staff lead. There are alternative routes to raise patient safety issues. • It was positive to note that there have been no negatives for reporting patient safety incidents. • Increased the hours of the freedom to speak up guardian to support further. • The Trust have reinvented freedom to speak up, introducing the freedom to speak up guardians. • Commended the 0 anonymous reporting which suggests a positive culture step change. ME assured the Board that quarterly reports are received at the People and Culture Committee, along with a clear action plan. The increase of the guardians working hours and implementation of the champion have been positive changes. PKF reminded the Board that the freedom to speak up isn't the only avenue to raise concerns. The Trust also complete buddy visits, patient safety walkabouts and staff have the availability to raise concerns in safe and non-blame culture. The Trust confirmed they have not received a National guidance letter from the national office. The Trust have asked for a review to be completed of the policy but awaiting a response.
Performance and Finance	
7.1	**Chief Operating Officer Update**
	MC provider the following verbal update: • MSK strategy day completed in June. The session was facilitated by the value circle with an aim to present the findings to the ICB meeting in August/September. • GIRFT visit from regional team were pleased with the progress being made at RJAH. MC thanked Becs Warren for the enhanced recovery presentation and highlighted that the theatre utilisation was highlighted for being in the higher quartile on the report. It was noted that thee needs to be a greater system integration. • The Trust remains focused on theatre productivity, especially in relation to cancellations. An education process has been implemented.

Ref.	Discussion and Action Points
	• Workforce development within theatre has commenced. The teams are considering the skill mix and recruitment. The next challenge is noted as inducting the new staff. • Peer review in therapies services is scheduled for September. • NJR accreditation has the Trust has a good data organisation – well done to all involved! The Board noted the Chief Operating Officer Update.
7.2	**Industrial Action**
	MC provider the following verbal update: • The industrial action affected 40 theatre cases in June. • The Trust continue to protect long waiting patients. • Staff used their time to complete their training. • The next round of strikes has been scheduled for 13th-18th July (Junior Doctors) following by 2 of BMA Consultant action. • The Trust plan to complete more day case surgery operations throughout the Junior doctor strikes. • The Trust continue to identify which Consultants will be available through the strike action. The team have welcomed support from clinicians with the planning. Following PV query, MC confirmed there has been no information received on the radiology strikes as the ballot did not meet the threshold for the Trust to participate. The Board acknowledged the challenges faced relating to industrial action and commended staff for continuing to support one another.
7.3	**Performance report**
	MC highlighted the following key points relating to performance report: • Cancer performance – 2 patients have breached the target. The Trust are completing a thematic review of the cancer breaches. It was noted that the breaches were due to complex cases and therefore a complex patient pathway. • Diagnostics remain above standard. • Activity - areas of concern relates to consultant capacity within outpatients is being reviewed. • Elective surgery was recorded at 95% due to lack of workforce. It was noted that the gap was mainly within theatre. The Board noted the performance report, and no further questions were raised.
7.4	**Long Waiters Presentation**
	MC delivered the Long Waiters presentation, highlighted the following key points to the Board: • Positive performance has been noted by the region (English patients) • Patients are being tracked on an individual basis to ensure tracking and oversight of patients is scrutinised. • The Trust performs favourable in comparison to other providers. • Welsh spina disorders patients are unable to benefit from the mutual aid which is place. The Trust confirmed they have withdrawn from private care and currently utilising the Walton centre and ROH, however, this is only available to English patients/ • There is an informal agreement to seek support for Welsh patient however, further discussion is required. The Board noted the presentation and commended the Trust for the great achievement.
7.5	**Finance Performance Report**
	CM highlighted the following key points from the Finance Performance presentation: • The full finance report which is reported through the Finance, Performance and Digital Committee will be circulated with the pack going forwards. • The Trust are currently behind plan by £89k. The main driver continues to be income due to activity shortfalls. • The Trust have been receiving funding by a fix block for the national work that the Trust completes. It was flagged that the Trust does not get paid per patient and therefore the Trust is currently over performing. This has costed £118k year to date and is forecasted to be in excess of £0.5m. The Trust has raised the issues with NHSE for consideration, support and guidance. • Efficiency plans are behind plan. This remains a focus area for the FPD Committee and deep dives have been scheduled for future meetings.

Ref.	Discussion and Action Points
	• There is a noted risk to the financial plan following the effects of industrial action, agency pressures and income performance of BPR. The Board noted the updated and acknowledged the unmitigated risks. The Board asked for an empathises on the risks which are to be scrutinised by the FPD in the coming month.
7.4	**Chairs Assurance Report – Finance, Performance and Digital Committee**
	SN provided the highlights from the Finance, Performance and Digital Chair report: • OPOD – developed the dashboard to provide a forward look. The detail will be shared with the Board going forwards. • Scenario planning is being completed and presented to the Executive team meeting to support further assurance on the financial detail. • Theatres – there is a delay expected. The Committee asked the Quality and Safety Committee to gain assurance on the safety of the current Barns compliance. • Overall performance is concerning and noted there is an expectation that there will be an increase. • Private board discussion tabled relating to the discrepancy on English and Welsh patients waiting list. The Board discussed the following areas: • 78-week waiters – helpful to hear that the Trust us liaising with the Welsh assembly. The Trust assured the Board that patients are being selected by clinical priority. • OPOD was well received. • Reasons for not hitting the activity plan within July relate to cases per session completed, industrial action, more complex patients being treated, and the Trust are yet to achieve the 5 joint lists. The Board discussed the confidence of the plan begin achievable. There is an underperformance with theatre activity and the current challenges being faced are not likely to be resolved. The Trust have reviewed the current mitigations, and have highlighted other areas of improvement, these include weekend lists, bank rates for the Trust have been standardised across the organisation which is favourable to increase update of staffing from bank. An in-sourcing company has been used for the first time. With these new mitigations implemented, there remains a shortfall and therefore further improvements are to be made. The Board made the following suggestions: • Expedite training requirements – the Trust is recruiting more staff, whilst a portion of established staff are more productive. • Full reassessment of the financial plans to be completed including outlying current and newly identified mitigations. • Scenario planning and forecasting – this is to be completed for Q1. This will be presented to the FPD Committee in August for onward presentation to the Board. The Board noted the report and welcomed an update in the next meeting.
7.5	**Chair Assurance Report from Audit and Risk Committee**
	MN provided the following highlights from the Audit and Risk Committee: • Noted that the meeting was a one agenda item to consider the annual report and accounts following delegation from the Board of Directors. • External Audit, Deloitte attended and presented a thorough report, there were no concerns raised. There were 3 minor control improvements suggested which have been implemented. • The Trust received a modified opinion last year, areas have been satisfactory address and therefore a standard non modified report has been received. • Full assurance was received. The Annual Report and Annual Accounts have been signed off and completed. The Board noted the update and thanked all involved for
8.0	**Question from the Public and Governors.**
	The following comments/questions were received from the Governors: • Freedom to Speak Up - noted the positive reference that there has been no anonymous freedom to speak up reports submitted. It is positive to read that staff feel supported and safe to raised concerns.

Ref.	Discussion and Action Points
	• Career Café – the Trust confirmed that there are discussion taking place to implement the café into others profession and confirmed that registered nurses and AHPs are the beginning of the initiative to support the recruitment agenda. The Trust confirmed that drop-in session can be scheduled which may support more up take. • Visitor Feedback – KB informed the Board of some recent feedback she had received from a member of the public. The individual described the Trust as friendly and a warm environment. • Theatre development plan – the Governors asked for an update on the new theatre build. RP explained there is a two-story block being constructed which will offer four additional theatres for the Trust. It was noted that phrasing of the building is being completed. The Trust agreed to share an update at a future Council of Governors meeting. • Patient Safety – from listening to the Public Meeting it was apparent that patient safety is a priority for the Trust. • Patient Safety Walkabout – welcomed the patient safety walkabouts and was pleased with the walks, report and the process of feedbacking back to all involved. • Recruitment and Retention – assurance noted on the recruitment and retention agenda. It has been a known challenge for the Trust, but improvements are being reported. HT thanked the Governors for attending the meeting. There were no questions from the public.
9.0	**Any Other Business**
	Chair Appraisal HT informed the attendees that his appraisal was completed recently which followed the NHSE guidance. A multi-source assessment (360) was circulated to captured feedback. HT explained that a report will be shared relating to the feedback on Board development. The appraisal was completed by the Senior Independent Director and formally sign off from the Lead Governor. **Close** HT thanked all attendees for their contributions and closed the meeting.
Next Meeting: 06 September 2023	

Board of Directors

Updated: 03 September 2023

Action Log No.	Original Meeting Date	Public or. Private	Minute reference	Action	By Whom	By When	Comments/Updates Outside of the Meetings	Status
3	05-Jul-2023	Public	Chair Report from PC Committee	Agreed for Agency to be a separate 'exceptional' item on the Board of Directors agenda.	Dylan Murphy	02-Aug-2023	Complete - updated the Board agendas	COMPLETED
4	05-Jul-2023	Public	Performance Report	The next Board meeting (August) add review of plan as an agenda item following the completion of Q1.	Mike Carr	02-Aug-2023	Complete - added to the agenda for discussion	COMPLETED
5	05-Jul-2023	Public	Questions from the Governors/Public	Presentation on the Theatre Building to be delivered to a future Counsel of Governors meeting	Dylan Murphy	02-Aug-2023	Complete - added to the Council of Governors workplan	COMPLETED
6	05-Jul-2023	Public	Any Other Business	Board appraisal has been completed and there have been some recommendation suggested. A report to be shared with the Board at the next meeting (August)	Harry Turner	06-Sep-2023	On going	ONGOING

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Directors (Public Meeting), 06 September 2023

Author:		Contributors:
Name:	Stacey Keegan	Chris Hudson,
Role/Title:	Chief Executive Officer	Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

This paper provides an update to Board members on key local activities across several business areas not covered within the main agenda.

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

Recommendations:

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

Acronyms

NHS	National Health Service
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
AHP	Allied Health Professional
EDI	Equality, Diversity and Inclusion
ICS	Integrated Care System
SAND	Safe Ageing No Discrimination
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, questioning, intersex, or sexual community
Lt	Lieutenant
Capt.	Captain
CEO	Chief Executive Officer

Chief Executive Officer Update

1. Togetherness Week

As Board members will be aware, we are currently in the middle of our second Togetherness Week. It started on Monday and will run until Friday. I often hear it said that RJAH is like a big family, and I do believe there really is something special here. Togetherness Week is about celebrating that and saying a big thank you to each and every one of our people. Across the week there are all sorts of events and activities taking place – some for entertainment, some for education or development purposes, and some to try and bottle that special community spirit.

2. Nurses and AHP Celebration Day

We held our inaugural Nursing and Allied Health Professionals Celebration event on Friday 21 July, which was a wonderful day put together to celebrate the great work going on across this Trust by nursing and AHP colleagues. The day included an opening by Dame Ruth May, the Chief Nursing Officer for England, as well as the presentation of our Dame Agnes Hunt Medals. It was the seventh year in a row that we have presented a Nursing Medal, with this year's award going to Ambily Sunil. For the first time ever, we also presented separate Dame Agnes Hunt Medals for Healthcare Support Workers and AHPs as well. Congratulations to William Walter, who won the Healthcare Support Worker medal; and Geraint Davies, who received the AHP award.

3. NHS Providers Governance Conference

In July 2023, Harry Turner, Chair, and I attended the annual NHS Providers Governance Conference, an opportunity to explore Boards role in governance during times of challenge and change. As part of the conference theme, they considered how boards prioritise, retain oversight and seek improvement while addressing the dilemmas of competing demands for resources in times of challenge. The conference also stressed the need to build common cultures between organisations as well as dealing with some of the nuts and bolts of the board role in collaboration.

4. Data Quality Provider

We were delighted earlier this month to officially be named as a National Joint Registry (NJR) Quality Data Provider, after successfully completing a national programme of local data audits. This is the fifth year running that we have been named as a Quality Data Provider by the NJR, who introduced the scheme to offer hospitals a blueprint for reaching high-quality standards relating to patient safety. The NJR monitor the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers.

5. Recruitment Work

Our recruitment efforts have continued at pace over the summer period. July saw the third open day of the year, and once again we were inundated with interested parties for a number of clinical roles across the Trust. We also continue with our international recruitment efforts, which have already seen some fabulous new members of Team RJAH joining us over recent months from across Africa, Asia and the Caribbean. As part of our work to make them feel welcome, we have recently revamped and renovated three cottages on the hospital grounds. The cottages provide a comfortable and convenient home for our new recruits as they settle into life in Shropshire and gives them time and space to work out where they want to live in the longer term. We are grateful, as ever, to our League of Friends for helping to finance this work.

6. Cost of Living – free sanitary products

As part of our ongoing wellbeing and cost of living support, I was delighted that we have been able to introduce free period products for staff. Boxes with period products have been delivered to wards and departments across the hospital site. We understand that we are one of the first NHS Trust's in England giving staff free sanitary products, and I am grateful to the League of Friends for supporting us. It is a

small but significant step to addressing women's health in the workplace. Periods are a normal part of life and providing free period products for emergency situations can make a big difference to our staff's comfort and wellbeing.

7. Therapy Dogs

A whole new breed of hospital visitor is brightening the lives of our patients – with the re-introduction of therapy dogs after the covid-19 pandemic. We are working alongside charity Therapy Dogs Nationwide who are, once again, visiting patients and staff with their trained dog.

Raphie the Chihuahua, who is a temperament-assessed therapy dog. These visits provide a much-needed boost for patients, particularly those who are in hospital for a prolonged period of time, with some patients spending six to nine months on the spinal cord injury rehabilitation ward. I would especially like to thank one of our Governors, Kate Betts, who is a Rehabilitation Technician and has worked so hard to make this possible.

8. Awards Recognition

We were delighted to be shortlisted in two categories at the **National Orthopaedic Alliance (NOA) Excellence in Orthopaedic Awards.** The Time to Care recruitment campaign has been shortlisted in the Workforce Recruitment Campaign category, while the Trust's cost-of-living support initiatives are finalists in the Workforce Retention Initiative category. Our teams are now going through the judging process, and the winners will be unveiled in October.

I am also thrilled that The Headley Court Veterans' Orthopaedic Centre has been shortlisted for **Social Infrastructure Project of the Year at the national British Construction Industry Awards**. Judging will take place later this month, with the awards ceremony in London in October. The environment that has been created is everything we envisaged and so much more. We have been inundated with positive comments from patients, visitors and staff alike since the Centre opened to the public in December last year. I am delighted that it has been shortlisted for this award.

9. Garden for Alice Ward Fundraising Appeal

Our Garden for Alice fundraising appeal continues to progress nicely, with the aim of creating a beautiful inclusive sensory garden for paediatric patients and their families. Our paediatric patients deserve a private, safe and stimulating environment which not only promotes health and wellbeing but will also offer a calming escape from their hospital ward. Money has been coming in from many sources for this appeal, with one of the larger recent donations coming from a charity golf event at Llanymynech Golf Club, which was organized by Gemma Brett, our Specialist Unit General Manager; and Mike Ferguson from Archwood Ltd. Their efforts raised £4,375 and we are very grateful.

9. Praise for London Marathon Stars

We had 21 people run the London Marathon 2023 in aid of our hospital charity earlier this year, and it was a delight recently to get to publicly thank them for their efforts. They collectively raised more than £43,000 for our charity, which is an incredible total. Having taken part in the marathon myself I know what a huge challenge it is – my congratulations go to each and every runner for their outstanding achievement. The funds raised by the team will go into our wider charitable funds pot, which is used to fund projects across the hospital to support patient care and improve staff experience.

10. Amazing Staff – Jeanette Jones

We all know we have some amazing staff here at RJAH, and I just want to take a moment to call out one of them who has recently won a national award. Jeanette Jones has been a Generic Worker on the Midland Centre for Spinal Injuries for almost 40 years, having joined us in 1988, but she also spent 20 years working with the GB Wheelchair Rugby Team, travelling the world to places such as Sydney, Atlanta and Beijing at the Paralympics. Now she has been presented with the Outstanding Service to Sport Award in recognition of her hard work. Jeanette is a true RJAH star!

11. RJAH Stars Award

Every month, I present an RJAH Stars Award to one individual or team, in recognition of outstanding achievement or performance.

There has been one winner of the RJAH Stars Award since our last public Board meeting:

- The August winners were Practice Development Nurses Jenny Llewellyn and Rebecca England, who both work in Theatres. They are responsible for developing training for new and current Theatre staff, and their efforts were so appreciated by Emma Thomas, our Theatre Scrub Manager, that she nominated them for this RJAH Stars Award. The effort they put into staff retention, induction, and education/training is valued and a firm priority for the Trust. We are extremely thankful for their hard work and dedication.

Congratulations to both of our latest winners!

12. Conclusion

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Freedom to Speak Up Briefing

Committee / Group / Meeting, Date

Executive Meeting, 22nd August 2023

Author:	**Contributors:**
Name: Paul Kavanagh-Fields Role/Title: Chief Nurse and Patient Safety Officer	Liz Hammond - Freedom To Speak Up Guardian (FTSUG) Dr Ruth Longfellow – Medical Director Samantha Young – Deputy Chief Nurse

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

The purpose of this paper is to provide assurance to the Board that following the trial and subsequent conviction of Lucy Letby and receipt of the associated letter from NHS England (Appendix A) that the Trust has reviewed its processes for raising concerns.

The NHS England letter requests that all NHS Leaders and Boards must ensure the Freedom To Speak Up (FTSU) process has proper implementation and oversight. Specifically:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

On 2nd August, the revised Fit and Proper Person Test (FPPT) Framework was published. This is in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT.

Fit and Proper Person Framework

All NHS organisations are also reminded of their obligations under the Fit and Proper Person (FPP) requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

How can we provide Assurance?:

On receipt of the NHS England letter the Chief Executive Officer cascaded this out to Executive colleagues and the Senior Management Teams of the Units. The Executive Team discussed the events surrounding the Lucy Letby case and considered the contents of the letter. Through discussion it was agreed that each member of the Executive would take every opportunity to raise awareness in relation to the Trusts raising concerns process, ensuring that all our staff understood how to access the FTSUG.

The Chief Nurse and Patient Safety Officer met with the FTSUG to seek assurance that the Trust was meeting its obligations as set out in the letter from NHS England (above):

1. **All staff have easy access to information on how to speak up.**

   Throughout the Trust there are posters displaying how to access FTSUG and FTSU Champions, the Chief Nurse and Patient Safety Officer is also included on these posters as Executive Lead for FTSU. There have also been several raising awareness campaigns managed via RJAH Communications team via social media channels and Trust website.

   External resources provide advice, guidance and support on raising concerns, these include The British Medical Association, Royal College of Nursing, the GMC Confidential Helpline, NHS Resolution Practitioner Performance Advice, Health and Care Professionals Council and the National Guardian's Office. These resources are free at the point of access to all staff, not just those professionally registered. Links to these resources are advertised on the Trust intranet site.

2. **Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.**

   Access to National Speaking Up Support Scheme is highlighted and advertised to all staff via FTSUG.

3. **Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.**

   The Trust has appointed several FTSU Champions who represent a broad spectrum of staffing groups. The FTSUG has emailed all Champions requesting that local meetings are set up with staff groups to raise the profile and purpose of the FTSUG. The FTSUG recognises the need for more gender diversity within the FTSU Champions team and representation from staff from ethnic minority backgrounds.

   The Trust has also provided a FTSU office (Room 101, Cottage 1) that is situated away from the main hospital and can be accessed discreetly by staff wishing to discuss any concerns they may have with the FTSUG or Champions. All FTSU polices are available to staff via the Trust's website. The national FTU policy has been adapted and implemented locally.

4. **Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.**

   The FTSUG provides regular updates to the People and Culture Committee which are then reported through to Board.

5. **Boards are regularly reporting, reviewing and acting upon available data.**

   There is a planned training session for all Board members on 6th September which will be led by the FTSUG. All Board members must complete online FTSU modules.

   Members of the Board are 'buddied' with specific areas throughout the Trust which provides the Board with an opportunity to test staff knowledge in relation to how to raise concerns. Staff are also encouraged during these buddy visits to raise any concerns they may have; which are in turn reported back to Board. All concerns are fed back to the relevant managers/teams and actions completed.

Fit and Proper Person Framework
NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

The Framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member. It has been designed to be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations. However, ensuring high standards of leadership in the NHS is crucial and the Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

Recommendations:

The Board to review and reflect on the contents of this briefing paper.

Next steps:

Chief Nurse and Patient Safety Officer will visit all clinical areas to check in with staff and raise awareness in relation to raising concerns.

Chief Nurse and Patient Safety Officer and FTSUG have developed a joint statement to be circulated via Trust communication channels to all staff.

The Trust have commenced reviewing the current practices in place against the revised FPP Framework. A briefing paper is to be presented to the Board of Directors outlining the proposed changes to ensure a robust and effective process is embedded, which in turn, will provide assurance and ensure the Trust is complaint with the framework.

When the NHS Leadership Competency Framework (LCF) for board level roles is released later this year, the Trust will work to implement the framework to develop a diverse range of skilled and proficient leaders to deliver the best outcomes for our patients, workforce and wider communities.

The Trust will also ensure that the new board appraisal framework is implemented when that becomes available to promote core leadership and management standards for managers.

Acronyms

CQC	Care Quality Commission
FPP	Fit and Proper Person
FPPT	Fit and Proper Person Test
FTSU	Freedom To Speak Up
FTSUG	Freedom To Speak Up Guardian
LCF	Leadership Competency Framework
NHS	National Health Service
RJAH	Robert Jones Agnes Hunt
GMC	General Medical Council

Appendices

Appendix A: **NHS England Letter re Verdict in the trial of Lucy Letby**

PRN00719_Letter re Verdict in the trial o

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Draft Corporate Objectives 2023/24

Committee / Group / Meeting, Date

Board of Directors, 6th September 2023

Author:	Contributors:
Name: Nia Jones Role/Title: Managing Director for Planning and Strategy	Executive Directors

Report sign-off:

Craig Macbeth, Chief Finance Officer

Is the report suitable for publication?

Yes

Key issues and considerations:

The corporate objectives are fundamental element in the delivery of our organisational strategy and enable the Senior Leadership Team to align their proposed programme of activity for the financial year to the Trust's ambitions.

The recommendations following discussion at the private board meeting have been considered by the executive team as a subsequent meeting in August.

- The corporate objectives have been simplified to maximise staff engagement.
- Workforce is contained within our high level objectives description
- Productivity has bee reflected in our measures

The Board are to note that the corporate objectives are supported through the delivery of our enabling strategies with their own deliverables contained within each strategy.

The Trust's overarching corporate objectives for 2023/24 are as follows:

- Deliver high quality clinical services.
- Develop our Armed Forces and Veterans service as a nationally recognised centre.
- Integrate MSK pathways across STW
- Grow our services and workforce sustainably.
- Innovation and research at the heart of what we do.

Each of the overarching corporate objectives is underpinned by detailed objectives and how they will be measured.

Recommendations:

That the Board:

1) Approves the corporate objectives and measures for 2023/24.
2) Consider whether to approve the corporate objectives for 2 years with the measures of success to be updated in 2024/25.

Report development and engagement history:

Prior to presentation at this Board meeting, the objectives have been considered at Executive team meetings and the private board meeting during July 2023 and August 2023.

Next steps:

The Trust will commence cascade to staff following Board approval.

Appendices

Appendix A Corporate Objectives 2023/24

STRATEGIC THEMES	
How we will do it	**Measure**
1. Deliver high quality clinical services	
Ensure the highest standards of care for our patients.	• Delivery of Trust's Quality Improvement Priorities for 2023/24. • Implementation of Quality accreditation programme. • Roll-out of PSIRF. • Nursing & AHP Strategy and Quality strategy signed-off.
Empower departments to develop services	• Departmental-led implementation of clinical strategies. • Annual Departmental Business Plan in place for each Clinical service.
Optimise productivity and efficiency within our services	• Delivery of the performance, workforce, productivity and transformation schemes set out as part of the Trust's Operational plan. • Deliver Elective Hub efficiency standards.
Ensure a fair, equal and inclusive culture across the Trust	• Delivery of the Trust's Inclusion priorities for 2023/24.
2. Develop our Armed Forces and Veterans service as a nationally recognised centre	
Increase or workforce capacity to reflect service demand.	• Delivery of Consultant recruitment plan • with targeted consultant recruitment to reduce waiting times.
Develop our rehabilitation facilities	• Develop Business case for Veterans Rehabilitation service.
Maintain Veterans Accreditation standards	• Veterans accreditation training for new starters.
Strengthen partnerships with armed forces and veteran friendly organisations.	• Consider opportunities for future working with Headley Court charity and Ministry of Defence. • Develop links with GIRFT in line with the Improving Veterans MSK Rehabilitation Report.
3. Integrate MSK pathways across STW	
Lead the MSK Transformation Board and contributing to the delivery of the transformation programme.	• Establishing RJAH as the lead provider for MSK services through the development of a provider collaborative agreements. • Governance structure in place for the MSK transformation programme. • Work collaboratively to standardise pathways and equity of access for STW patients.
Work towards Elective Hub Accreditation.	• Self-assessment completed against the Elective Hub accreditation criteria.
4. Grow our services and workforce sustainably	
Recruit, support, retain and provide an exemplar experience for our staff	• Delivery of year 1 objectives contained within the RJAH People Strategy.
Optimise use of estate through capital investment & partnership working.	• Review opportunities to utilise estates and facilities within our geographical catchment to deliver services locally and in line with our Green Plan.
Expanding our reach and specialist expertise to other providers and sectors.	• Scope the appropriate resources and skills required to strengthen commercial and business expertise within the organisation.
5. Innovation & research at the heart of what we do	
Create the cultural environment to promote continuous Improvement.	• NHS Improvement Impact self-assessment to be completed. • Roll out continuous improvement training across all staff groups. • Establish Digital Education, Research and Innovation Committee.
Enhance capability and opportunities for research across all professions	• Increase Nurse and AHP led research. • Delivery of in-year objectives contained within the RJAH Research Strategy.
Optimise the potential of digital technologies to transform care	• Implementation of the EPR programme. • Appropriate digital training & awareness programme in place

Collaboration with Peer Providers

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Committee / Group / Meeting, Date

Board of Directors (Public Meeting), 06 September 2023

Author:	Contributors:
Name: Stacey Keegan Role/Title: Chief Executive Officer	Royal Orthopaedic Hospital, Executive Team

Report sign-off:

Name: Stacey Kegan
Role/Title: Chief Executive Officer

Is the report suitable for publication:

No.

Key issues and considerations:

Although the formal framework for collaboration between orthopaedic providers across the country is through the National Orthopaedic Alliance, additional conversations have been instigated between the three main specialist orthopaedic organisations around a more informal approach to sharing best practice and joint working.

This paper sets out some of the areas to date that have been agreed as useful to discuss further between the specialist providers.

Royal Orthopaedic Hospital (ROH)

The first of the joint meetings between the Executive Teams of ROH and RJAH was held on 27 June 2023. The teams welcomed the opportunity to meet and provide ideas for areas which may benefit in some further exploration for joint working or sharing best practice.

The key areas agreed as priorities for further discussion were:

- Model Hospital
- Non-Medical roles
- Training and Education and Medical Staffing
- Productivity
- Implementation of the Patient Safety Incident Response Framework
- Peer Review

In recognition of the significant operational pressures both at a national and local level for both organisations at present, limited progress has been made with advancing the discussions and work around the priorities above. A summary to date is however provided below.

Model Hospital - ROH are regular attenders at the Model Hospital Club meetings and are making useful contributions and offering some best practice in relation to a number of specialities. The meetings were paused for some time but are now rescheduled so it is anticipated that there will be further valuable discussions around areas where there is common ground. This is a valuable source of benchmarking information that the Board is always keen to see.

Non-Medical roles – some early discussions have been held between the Chief Nurses of the two organisations around some new non-medical roles and how these can add value to the workforce and be used to drive attraction, recruitment and retention into the organisations. The possibility of rotations or secondments between the two organisations is also being explored.

Training and Education and medical staffing – discussions to date have centred on the possibility of sharing skills and expertise in terms of medical staffing. This is an element of the workforce team that has historically posed a challenge, so there is clear benefit in some joint expertise and resource in this area. An additional opportunity being explored is around joint spinal and orthopaedic training courses, where there is clear synergy between the work of the two organisations.

Productivity – a joint session was planned for 23 August which had to be cancelled, however this is now rearranged for 30 October 2023. This will focus on three areas of high impact where there would be benefit in joint working. Initial thoughts are around length of stay, theatre utilisation and outpatients' services.

Patient Safety Incident Response Framework (PSIRF) – the implementation of the PSIRF is a fundamental change to the way incidents are reported, investigated and lessons learned. Despite the wealth of national guidance, each organisation is likely to be assessing the implications of adopting this and tailoring their approach to best fit. As such, there is benefit in sharing the approaches being developed between the two organisations and early discussions have been held ready for the nationally mandated deadline of implementation of autumn 2023.

Peer review – discussions are planned around the areas where there is benefit in peer review. Initial thoughts include review of the Trust's preparedness for a CQC inspection or a well led review. In the light of the recent Lucy Letby case, it would also be worth considering a peer review around the Trust's speaking up framework.

Strategic objectives and associated risks:

This work will support the draft objective to:

1. Deliver high quality clinical services.
2. Grow our services and workforce sustainably.
3. Innovation and Research at the heart of what we do.

Recommendations:

The Board is asked to consider and approve the update and the collaboration between the RJAH and ROH.

NHS England Midlands

To:
- Stacey Keegan, Chief Executive
  Paul Kavanagh-Fields, Director of IPC & Chief Nurse
  Robert Jones and Agnes Hunt

cc.
- Nina Morgan – Regional Chief Nurse
- Rebecca Farmer – Director of S&T
- Jacqueline Barnes – Director of Nursing
- Alison Bussey – CNO STW ICB

NHS England
NHS England - Midlands
Regional Chief Nurse
Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT

9 July 2023

Dear Stacey and Paul,

NHS England Visit 30 March 2023

I would like to thank you for organising the formal review visit of the Trust, this took place on 30 March 2023. The visit took place in March as scheduled; this was part of the follow up to the undertakings and agreed as part of the improvement and support offer. Tracey Whittaker, Infection Prevention and Control (IPC) Specialist Nurse, Shropshire, Telford, and Wrekin (STW) Integrated Care Board (ICB) joined me for the visit as agreed. This letter has been drafted as a single report representing both the NHSE and the ICB view of the visit. I would like to apologise for the delay in getting this letter to you, please note that all the feedback was provided at the time of the visit.

As this visit was part of the formal review process to assess the Trusts progress, I have taken the opportunity to review the Trust against the NHSE Midlands Infection Prevention and Control internal escalation matrix. Since the previous visit we have changed the terminology within the matrix to align with the terminology within the National Oversight Framework, moving from Red, Amber, and Green ratings to Routine, Enhanced and Intensive monitoring and support. Following the sustained improvement that was observed and the demonstration that areas for improvement are known and are part of the action plans, I can confirm that the Trust are rated as **routine monitoring and support** on the new matrix, previously a green rating.

Across the day we visited Sheldon ward, Kenyon ward, Wrekin ward, the High Dependency Unit and Theatres. This was followed by a presentation/discussion from the team outlining the work that has been completed since the previous visit and the next actions that are in progress. The day demonstrated the Trusts ongoing commitment to

IPC and to ensuring the changes that have been made are embedded within processes and the learning continuing to be implemented.

During the visit we were accompanied by various members of your multidisciplinary team, including the IPC team, Matrons, and ward leaders for each of the areas that were visited. I would like to pass my thanks to the teams in these areas who were happy to show us around. Tracey and I provided detailed feedback to each area immediately where good practice or improvements required were identified.

At the end of the visit, Trust level feedback was provided to the wider team of Senior Leaders, including the Trust Chief Executive, this demonstrates the level of ownership and ongoing commitment to the improvement journey within the Trust. Ongoing and continued engagement was observed across the organisation on this visit, and the previous visit, highlighting that the new ways of working are becoming embedded within the culture of the organisation.

Below is the high-level summary of the key findings shared on the day. The improvements we have observed on all previous visits were still in place. Improvement was observed across the organisation and within each area visited.

Key areas of improvement identified:

- Estates work:
  - Small works have been commenced within the theatre department, there is a list of works that can be undertaken without causing too much disruption to the theatre workings and not posing a risk to the patients undergoing procedures.
  - The work completed in the kitchen on Kenyon ward has designed out the possibility of storing items underneath the sink whilst allowing the estates team access. This is a positive improvement and should be rolled out as part of all new kitchen refurbishments.
  - The changes made to add bay doors onto Sheldon ward have been completed to a high standard, from observing the ward you would not be aware that the walls and doors are a new edition to the unit.

- We observed a high level of compliance with the bare below the elbow's initiative, across all staff groups.

- Examples where teams have engaged with the IPC working group were provided as part of the presentation/discussion. We were advised that the teams generated

discussions, were engaged with the process, and then respected the decisions that were made by the working group. This is further evidence of positive cultural improvements in the organisation.

- All the commodes that were checked across the course of the visit were visibly clean.
- A new wipe system is being rolled out in the trust, this will support the ongoing cleaning improvements and will reduce the current discolouration that is being experienced on certain items within the Trust.

Key themes where improvement is identified, and work needs to continue:

- There are ongoing estates works that are required, most of the estates works that were observed during the visit were known to the teams and on a programme of work. For example:
    - The small area of damage on the wall in the rehab area of Sheldon ward.
    - There are several hand wash basins which need to have the seal across the back of the basin replaced, these were all noted by the teams at the time and the team who accompanied us agreed they would ensure these were added to the estates list.
    - The kitchen cupboards on Sheldon ward require the child locks to be fully removed and other options should be investigated with the Estates teams.
    - The sluice on Kenyon ward required further refurbishment works, I am aware that new racking is on order. The floor is peeling from the wall in areas of the sluice.
- The physio bars in the rehabilitation area on Sheldon ward had been painted prior to the visit in September, these were already chipped and in need of being repainted at the December visit and were still in need of repair during the March visit. We discussed whether there is a need to replace these or to consider a different coating due to the need for repair in such a short space of time.
- There are several foot stools on wards that are slightly damaged, they are on a replacement list. I would recommend an audit of all these items across the Trust to identify how many require replacement to support with the development of a rolling replacement plan.

- Tape residue on equipment continues to be an ongoing theme, this is especially evident within theatre, where there is tape residue on props and on the surfaces within the barn theatre.

- Improvement was identified in the consumables storeroom, although it is acknowledged that there is still work required within this room, there was improvements noted. There were also improvements evident in the prop cupboard.

- Hand hygiene was observed throughout the visit and, whilst there was a high level of compliance, compliance with hand hygiene and using the alcohol hand gel or hand washing on the entry to wards was frequently missed.

Key themes where improvement is still required:

- Estates work is still required in the theatre department. I am aware that we have discussed this, and it has been included in each of the letters following the visits that have been completed. I know this has been reviewed and the estates team have begun the process of identifying and costing the works that need to be completed. As previously discussed, I recommend ongoing system discussions around additional mitigations or mutual aid to support the planning and completion of this work.

- Cleaning standards for Intravenous Infusion pumps need to be reviewed, there is attention to detail required including on the inside of the pumps and the underneath. This was a theme observed across most areas visited.

- Documentation of invasive devices requires further improvement; this includes both catheter care plans and peripheral vascular access devices. Insertion reasons were missing from most of the catheter care plans that were reviewed, this has the potential to result in catheters not being removed in a timely manner. The scoring of the visual infusion phlebitis (VIP) score is not routinely completed and that the requirement for the cannula is not always checked. It is noted that there are multiple systems that are still in use, both paper and electronic, it is likely that this is impacting on the completion of the documentation.

I am aware that there is concern around the current service level agreement for microbiology support, I know that the ICB have offered to support with this discussion, please let me know if there is anything that we can do to support.

Given the significant work that has been completed, the previously separate IPC assurance meeting is now merging back with the Quality Committee, we would support this approach following the visit.

Next Steps

As part of the continued support offer and to ensure that the improvement is embedded within the organisation, we have agreed to complete a:

- Quarterly desktop review of SSI data, themes and trends and review of the processes are continuing for 2023/24, these have been arranged by the ICB.

- Follow up visit to the Trust at the six-month interval, provisional dates in September/October will be shared separately to this letter, in line with the agreement as part of the removal of the formal undertakings.

- For awareness, I have contacted Kirsty Ditcher to identify time to write up the MRSA outbreak on MCSI for publication and submission for presentation at conferences to showcase the work that has been done and the changes within the organisation as a result of this work, I am looking forward to working with yourself and the team to complete this piece of work.

Please use this to continue to develop your IPC action plan around the “Hygiene Code” to address the concerns identified. This should work alongside your action/improvement plan.

Finally, please discuss share this report with your Trust Board and confirm by email that this has been completed.

Yours sincerely,

Kirsty Morgan
Assistant Director of IPC – NHS Midlands

Trust Board - Quality & Safety

July 2023 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

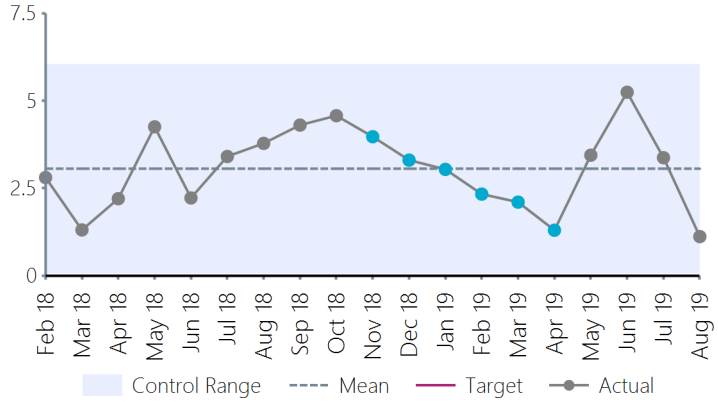
Some examples of these are shown in the images to the right:

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

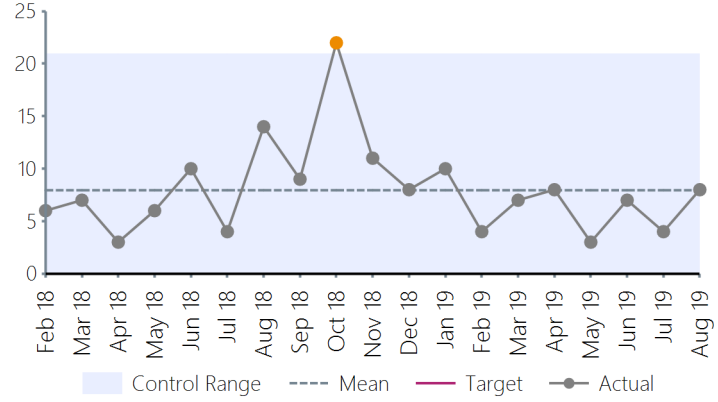
b) shows a point of concern sitting above the control range.

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.

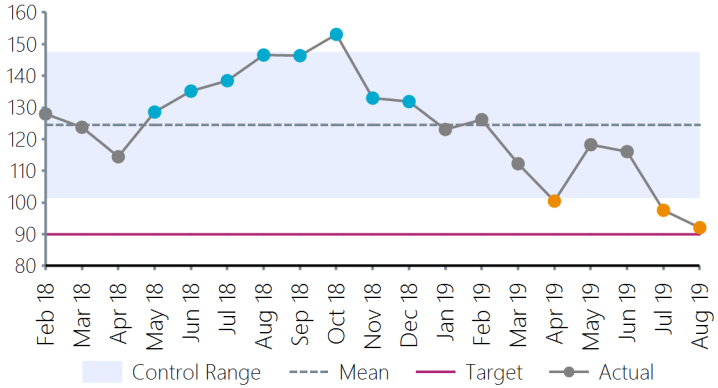
a)



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.

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Serious Incidents	0	1		N/A to SPC	?	+	16/04/18
Never Events	0	0		N/A to SPC	P		16/04/18
Number of Complaints	8	5			?		11/05/18
RJAH Acquired C.Difficile	0	0		N/A to SPC	?		24/06/21
RJAH Acquired E. Coli Bacteraemia	0	2		N/A to SPC	?	+	24/06/21
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		24/06/21
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	?		
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		
Surgical Site Infections	0	0			?		

Summary - Caring for Patients

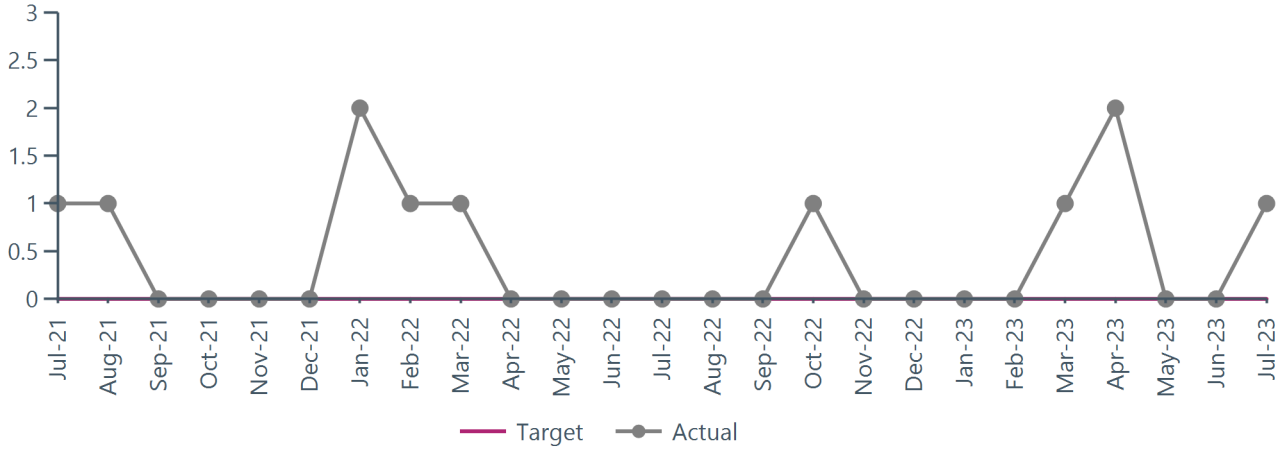
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Outbreaks	0	0		N/A to SPC	P		
Total Deaths	0	1		N/A to SPC	?	+	
WHO Quality Audit - % Compliance	100.00%	100.00%			P		

Serious Incidents

Number of Serious Incidents reported in month 211160

Exec Lead:
Chief Nurse and Patient Safety Officer

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



Trajectory

What these graphs are telling us

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

Narrative

A case review meeting was held on the 17th of July 2023, where it was identified that there were missed opportunities in the management and escalation of a patient and therefore this was declared as a Serious Incident under the category Unexpected / potentially avoidable death, sub-optimal care of the deteriorating patient meeting SI criteria.

Actions

This case was referred to a coroner due to the safeguarding concerns and a coronial investigation was opened. Since referral, a post-mortem and pathologist has confirmed that the absence of CPAP has not contributed to the patient's cause of death and therefore the coronial investigation has now been closed and the patient's family informed. The trusts internal investigation has commenced.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
0	0	0	1	0	0	0	0	1	2	0	0	1

- Staff - Patients - Finances -

RJAH Acquired E. Coli Bacteraemia

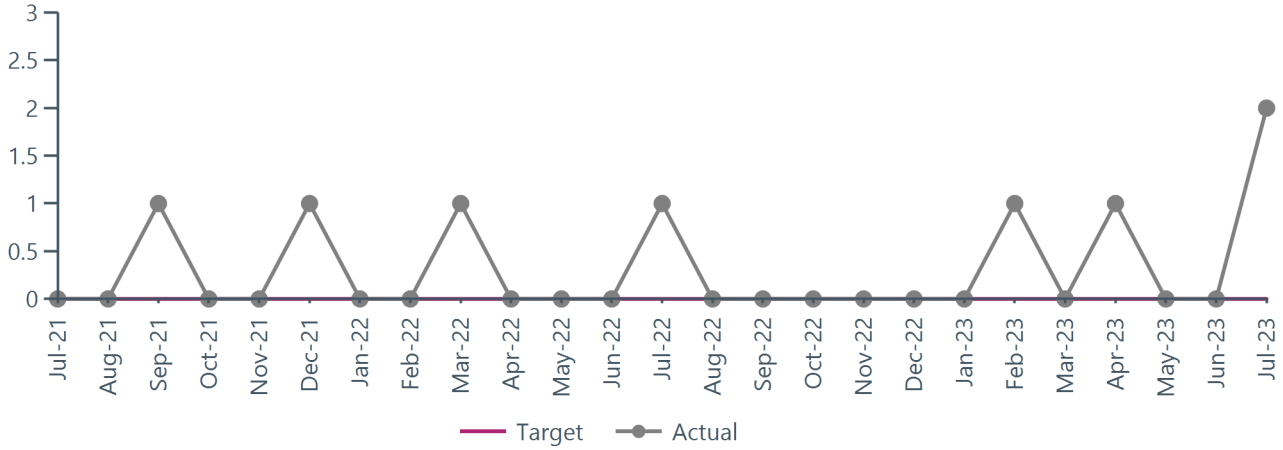
Number of cases of E. Coli Bacteraemia in Month. 211150

Exec Lead:
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	2	N/A to SPC	?

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

There were two cases of E. Coli Bacteraemia reported in July.

One post infection review has been carried out on 10th August where key points were no clear documentation from referring Trust around care of catheter. At time of IPR production, the second post infection review is scheduled.

Actions

Agreed actions from the post infection review that has been carried out include:
* To get feedback from the regional collaborative around the catheter passport trial
* Relevant staff to be trained in intermittent catheterisation
* E-Learning from Future Learn to be completed by relevant staff
* Trust decision around replacement of invasive devices if no clear documentation can be found from referring Trust – IPC Lead to take to IPCCWG
* Urinary catheterisation policy to be updated

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
1	0	0	0	0	0	0	1	0	1	0	0	2

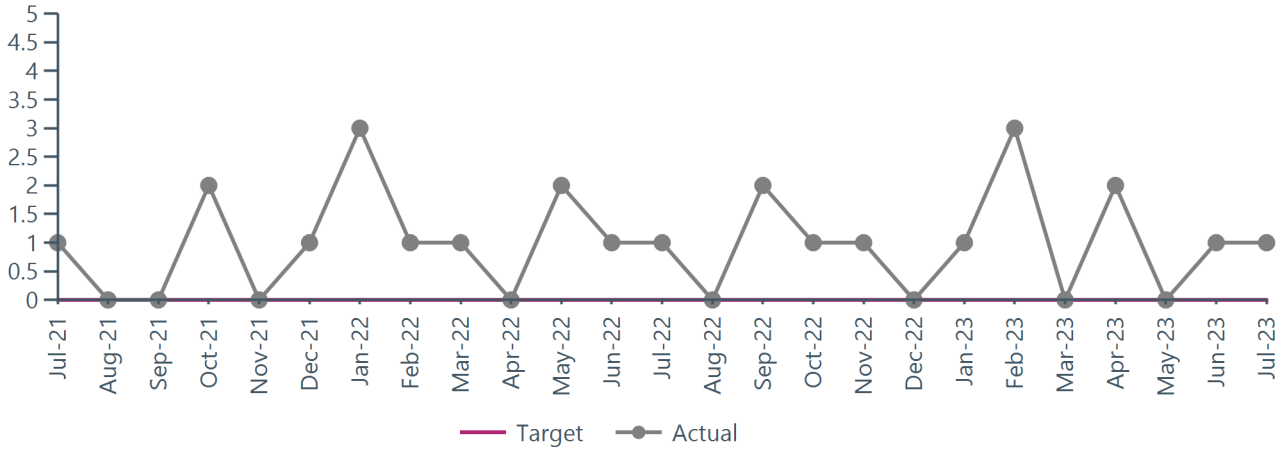
- Staff - Patients - Finances -

Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

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



Trajectory

What these graphs are telling us

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

Narrative

There was one death within the Trust in July; this has been categorised as an 'expected death'.

Actions

All deaths are reviewed by the Trust's Mortality Lead.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
1	0	2	1	1	0	1	3	0	2	0	1	1

- Staff - Patients - Finances -

Committee / Group / Meeting, Date

Trust Board, 06 September 2023

Author: **Contributors:**

Name: Kirsty Foskett
Role/Title: Head of Clinical Governance,
Quality and Patient Safety Specialist

Executive Director sign-off:

Paul Kavanagh-Fields, Chief Nurse and Patient Safety Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

1. **Does the policy take account of relevant:**

   a) **Legislation** **NO**

   b) **Regulatory requirements** **YES**

   NHSE Patient Safety Incident Response Framework, which forms part of the NHS Patient Safety Strategy

   c) **Statutory guidance** **YES**

   NHSE Patient Safety Incident Response Framework, which forms part of the NHS Patient Safety Strategy

   d) **Good practice** **YES**

   Supports the Trust to promote a systems based approach to learning from patient safety events. Ensuring as a Trust we;

   1. Compassionate engagement and involvement of those affected by patient safety incidents
   2. Application of a range of system-based approaches to learning from patient safety incidents
   3. Considered and proportionate responses to patient safety incidents and safety issues
   4. Supportive oversight focused on strengthening response system functioning and improvement.

2. **Has appropriate expert / professional advice been sought and taken into account?** **N/A**

3. **Have the relevant advisory / decision-making groups within the Trust been involved in its production and does it reflect their views / comments?** **YES**

A formal project implementation group was established in January 2023 to lead on the implementation of the Patient Safety Incident Framework. The project team has worked through specific phases as outlined by NHSE guidance documents to establish the Trusts Patient Safety Incident Response Policy and Patient Safety Incident Response Plan.

The Trusts Patient Safety Meeting and Quality and Safety Committee have received monthly updates on the implementation of PSIRF. The Patient Safety Incident Response Policy and Patient Safety Incident Response Plan were presented to both the Patient Safety Meeting and Quality and Safety Committee in June 2023 and endorsed to be presented at Trust Board for final approval.

4. Have key external stakeholders been engaged in the production of the policy and does it reflect their views / comments? **YES**

The Patient Safety Incident Response Policy and Patient Safety Incident Response Plan has been shared with the Quality Team at Shropshire, Telford and Wrekin ICS and Patient Safety Specialists within the ICS.

5. What arrangements are in place to ensure / monitor adherence to the policy?

As outlined in the policy, the Trust are required to review our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months.

The Trust is also required to Ensure an overall review of the patient safety incident response policy and plan is undertaken at least every three years alongside a review of all safety actions.

Strategic objectives and associated risks:

2022/23 Trust Objectives

1. Developing and Maintaining Safe Services
5. Maintaining statutory and regulatory compliance

Recommendations:

The Trust Board are asked to approve the Patient Safety Incident Response Policy and Patient Safety Incident Response Plan.

Next steps:

If approved it is proposed that the Trust adopt the Patient Safety Incident Response policy and plan in place of the current Serious Incident Framework from the 01 October 2023, in line with guidance from NHS England.

Patient Safety Incident Response Plan

Effective date: 01 October 2023

Estimated refresh date: 01 April 2025

Contents

Introduction

This patient safety incident response plan sets out how The Robert Jones & Agnes Hunt Orthopaedic Hospital intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

The RJAH Patient Safety Incident Response will cover the services outlined above, except for those services marked with a *.

Defining our patient safety incident profile

Stakeholder Engagement

A project group was established in August 2022, to implement the Patient Safety Incident Response Framework. To establish the group key stakeholders were identified as the following:

- Patient Safety Specialists
- Clinical Governance Team
- Nursing and AHP (Allied Health Professionals) representation from the delivery units
- Information and Performance Team
- Quality Improvement Practitioner
- Subject matter leads relating to;
    - Infection Prevention Control
    - Falls
    - Tissue Viability
    - Medicines Safety
    - Resus and Deteriorating Patient

Data Sources

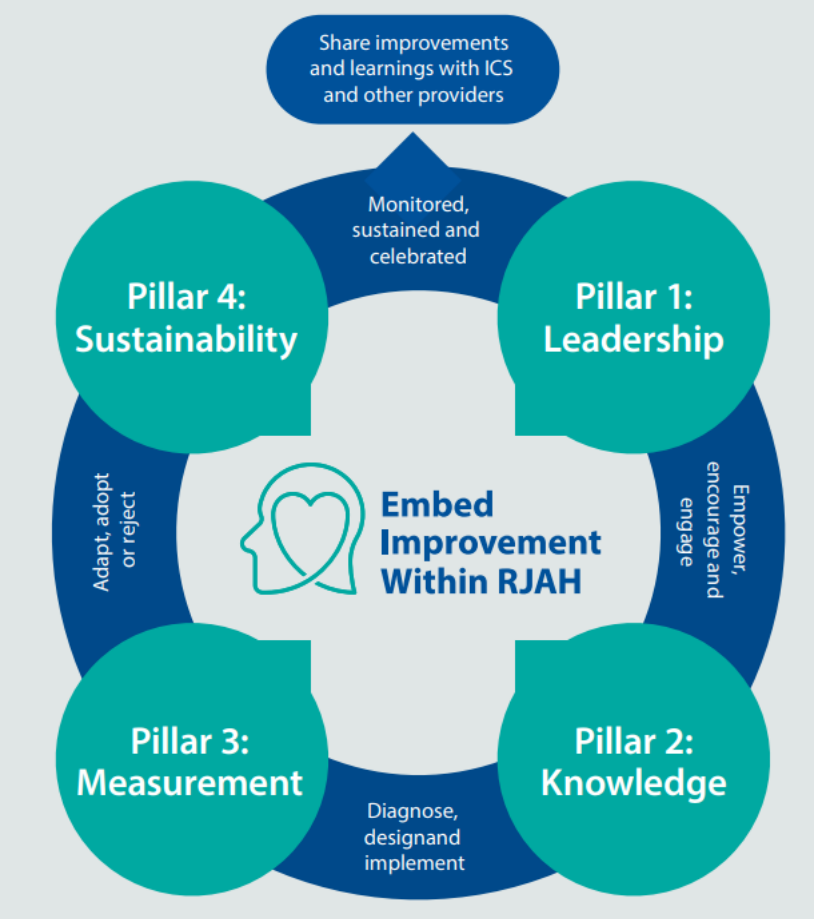
The group used a variety of sources to identify the safety incident profile, reviewing information from the previous two to three years. This included:

- Datix incident profiles
- Key performance indicators
- Reported Serious Incidents or Never Events
- Patient experience data
- Clinical Audit
- Trust Risk Registers

Defining our patient safety improvement profile

When defining our patient safety improvement profile, the group explored local, regional, and national improvement work that was already taking place. Through this review it was decided patient safety events relating to falls and medications would be viewed through the lens of improvement based on the Trust's learning response. The group acknowledged that the Trust are aware of these incident types and factors were understood but improvement needed to focus on recurrent themes.

During 2022/23 the Trust have also developed a Quality Improvement Framework which describes how quality improvement will support the Trust in striving towards our vision of aspiring to deliver world class patient care. World class does not come easy; therefore, it is vital we pick up the pace in moving towards embedding continuous improvement throughout every aspect of RJAH. The framework recognises that all staff have a part to play at RJAH in delivering that vision, and that part includes improvement. The below diagram sets out an improvement model to embed improvement within RJAH:



Our patient safety incident response plan: national requirements

There are several national priorities outlined by NHS England, however as RJAH is a specialist orthopaedic Trust, the national priorities outlined below are those considered specific to this Trust.

Patient safety incident type	Required response	Anticipated improvement route
National Priorities		
Incidents meeting the national Never Events criteria 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan
A patient death thought more likely than not due to problems in care, as indicated by NHS England Learning from Deaths guidance. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan

National priorities are outlined below, require an external escalation, where the Trust may need to contribute to an investigation. A locally led Patient Safety Incident Investigation (PSII) may be required dependent upon the circumstances surrounding the patient safety event.

- Child Death should be reviewed to the Child Death Review Panel
- Death of persons with Learning Disabilities, need to be referred to the Learning Disability Mortality Review (LeDeR) programme.
- Safeguarding, under the following categories must be referred to local authority safeguarding lead.
    - babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence.
    - adults (over 18 years old) are in receipt of care and support needs from their local authority.
    - If the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response*	Anticipated improvement route
Unplanned admissions to critical care due to clinical deterioration from inpatient wards or theatre	Datix investigation and MDT (multidisciplinary team) Review at the HDU (High Dependency Unit) Well-Led Meeting, reporting findings to the Patient Safety Working Group.	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.
Nosocomial Outbreaks	After Action Review	Co-production of safety improvement actions managed through the IPC (Infection Prevention and Control) improvement plan.
Surgical Site Infections	Individual cases assessed against the 'One together' audit tool, with a bi-annual review of the information collected and co-production of improvement actions	Co-production of safety improvement actions managed through the IPC improvement plan.
Falls	Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Medication Events	Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Incidents of VTE (Venous Thromboembolism)	Data collection and bi-monthly MDT Review of findings and co-production of improvement actions	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.
Assessment of incidents outside of the identified priorities	Proportionate response dependent upon the circumstances surrounding the patient safety event	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.

*The Systems Engineering Initiative for Patient Safety (SEIPS) model will be used as a framework to guide all learning responses.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Patient safety incident response policy

Effective date: 01 October 2023

Estimated refresh date: 01 October 2026

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The RJAH approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across clinical services at RJAH.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The

principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

The learning response methods described in the RJAH Patient Safety Response Plan (PSIRP), whilst specific to exploring events regarding patient safety incidents, can be used to support learning and improvement in relation to other non-patient safety incident types, providing their application complies with any wider requirements.

Oversight roles and responsibilities

Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. When working under PSIRF, NHS providers should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures."

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports.

The Trust board is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. The executive Lead for PSIRF is the Chief Nurse and Patient Safety Officer.

The Trust Board have a responsibility, the through the PSIRF Executive Lead to;

1. Ensure the Trust meets the national patient safety response standards
   - Policy, planning and oversight
   - Competence and capacity
   - Engagement and involvement of those affected by patient safety incidents
   - Proportionate responses

2. Ensure PSIRF is central to overarching safety governance arrangements
   - The Board must have access to relevant information about their organisation's preparation for and response to patient safety incidents, including the impact of changes following incidents.
   - Through the safety improvement plan the board (or committee with delegated responsibility) will monitor and review the delivery of safety actions and improvement ensuring there is clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement.

   - Ensure an overall review of the patient safety incident response policy and plan is undertaken at least every three years alongside a review of all safety actions.

3. Quality assures learning response outputs
    - A final report for individual PSIIs should be reviewed and signed off as complete. Sign off is the responsibility of the Board (or designated sub-committee) and the CNO (or designated individual in their absence), is responsible for ensuring the reports are in line with the PSIRF standards.

    - Recognising a full report for submission to the Board may not be produced for every learning method other than a PSII. Learning response will be collectively evaluated every 12-18 months to monitor the quality of all response methods.

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- The Safety Improvement Plan ensures that the Trust has a process to ensure that all safety actions implemented in response to learning are monitored, to check they are delivering the required improvement.

Individual Roles and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for the safety of the Trust's patients, staff, and visitors. The systems and process management responsibilities for the Patient Safety Incident Response Framework are delegated by the Chief Executive as follows:

Chief Nurse and Patient Safety Officer /Chief Medical Officer

The Chief Nurse (jointly with the Chief Medical Officer) is responsible for patient safety in the organisation.

Further, the Chief Nurse has responsibility for:

- overseeing the quality of the PSIRF process which includes the development, implementation, and review of this policy.
- ensuring the processes are in place so that meaningful information about incident reporting and management is presented to and reviewed by the Board.
- ensuring processes are in place for triangulating incident information for early identification of themes and trends.
- ensuring there are adequate mechanisms for learning and feedback of outcomes of incidents.
- overseeing compliance with the duty of candour
- Leading the assessment of incidents that fall outside of the local priorities for new and emerging themes (to be undertaken by the Chief Medical Officer in the Chief Nurse absence)
- ensuring that the Chief Executive (CEO) is kept fully informed about any national priorities aligned to PSIRF reporting the details of the incident to the Quality and Safety Committee.

In conjunction with the Chief Medical Officer, the Chief Nurse is responsible for identifying an appropriate learning response lead undertake a proportionate response.

Head of Clinical Governance, Quality and Patient Safety Specialist

- Ensuring the implementation and adherence to this policy and the Trust's Patient Safety Incident Response Plan and set timescales.
- Advise the CNO/CMO on a proportionate response method in relation to patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's patient safety incident response plan.
- Liaising with external bodies in relation to national priorities as required. This responsibility may be delegated where appropriate.
- Support learning response leads where required but in particular, where a full PSII Investigation is needed.
- Advising on the adequacy of safety actions following an investigation and for bringing urgent risk matters to the attention of the CNO and CMO.
- To monitor completion of organisational safety improvement actions, working with the Quality Improvement Facilitator.
- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool
- To lead on revising the Trust PSIRP and full PSIRF review as stipulated in the policy, including an evaluation of learning responses and effectiveness of safety actions.
- Provide training on PSIRF as required.

Patient Safety Specialist(s)

- Patient Safety Specialists are individuals in healthcare organisations who have been designated to provide dynamic senior patient safety leadership.
- Patient Safety Specialists, play a key role in supporting the development of a patient safety culture, safety systems and improvement activity.
- As well as coordinating and supporting local patient safety priorities, Patient Safety Specialists will help the trust to review their PSIRP and a full review of the PSIRF policy.
- Support learning response leads where required but in particular, where a full PSII Investigation is needed.
- Patient Safety Specialist will also ensure the rapid dissemination of key learning from patient safety events.

Delivery Unit Triumvirate, Matrons and General Managers

The triumvirate of the delivery units are responsible for:

- Ensuring that local and organisational safety actions are implemented and monitored.
- Dissemination of learning is facilitated using the SHARE debrief tool.

- As minimum Level 1 & 2 of the patient safety training is completed.
- Assistant Chief Nurses, Clinical Chairs and Matrons will be expected to have completed oversight training.
- Monitor through their respective Unit Governance Meetings any new or emergent themes for their areas, that may require a learning response.

Clinical Governance Managers

- The Clinical Governance Leads are responsible for ensuring that all adverse incidents and near misses are reported and managed within the units in line with this policy; are discussed at unit governance meetings and shared with staff as required.
- With regard to a PSII, the clinical governance managers are responsible for providing support and advice on process to the learning response lead and to keep the central governance team updated on progress and any potential issues.
- Ensure that any patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan are bought to the attention of the Head of Clinical Governance, Quality and Patient Safety Specialist.
- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool
- Act as the engagement lead for patients and families

Learning Response Leads (Consultants / Ward & Departmental Managers/Matrons/ACN's / Chief Pharmacist)

- The Learning Response Lead for local priorities will work with subject matter experts (as defined in the PSRIP) to use the defined learning method and frequency to review patient safety incidents, reporting their findings to the Patient Safety Meeting.
- Learning response leads for National priorities will be responsible for completing a PSII. They will be responsible for identifying all staff, departments and key teams who have some involvement in the incident and for informing all appropriate managers of the investigation.
- Areas for improvement and findings from learning responses should be shared with those involved and the wider team, to share learning and gain feedback from patients and staff members in the involvement of patient safety incident.
- Safety actions must be produced in collaboration with those who understand 'work as done' the most.
- Ensure the relevant training has been completed and competencies acquired to be a learning response lead (see appendix 1).

Subject Matter Leads

- Subject matter leads within the Trust are expected to support the Learning Response Leads as indicated in the PSIRF priorities.

Engagement Leads (Staff /Manager - Patient & Family / Clinical Governance Manager)

- ensure that the patient is informed of the incident and is kept informed during the investigation process to ensure that Duty of Candour is followed. However, the Consultant in charge of the patient's care will be responsible for giving this information where appropriate. Nominated next of kin will also be informed with the patients consent, or if the patient is unconscious or otherwise incapacitated.
- facilitate a face-to-face meeting and / or a response to any queries the patient or their next of kin may have.
- Support the Learning Response Lead, to gain the patients perspective if appropriate to do so.
- ensure that should the patient or nominated next of kin so wish, they are provided with the outcomes and improvements identifiedupon conclusion of the learning response.

Quality Improvement Facilitator

- The quality improvement facilitator is expected to engage in the safety improvement plan, to understand the priorities for QI from a patient safety perspective.

All Managers

- Line Managers are responsible for ensuring staff can access support following a patient safety event, should this be required, including giving the employee details of services available through Occupational Health and TRiM.
- Line Managers are required to support the release of staff to provide statements or attend interviews or meetings relating to the patient safety event.
- All managers are expected to complete Level 1 & Level 2 of the patient safety training syllabus.

All Staff

- All staff have a responsibility to report via DatixWeb all incidents and near misses, both patient safety and non-patient safety.
- All staff are required to co-operate with learning responses and provide any requested information, including statements and attend interviews when required.
- All staff are expected to complete Level 1 Patient Safety training.

Our patient safety culture

The RJAH is on a journey to promote an environment that fosters a positive safety and just culture.

During the implementation of PSIRF phase two of the project focused on diagnostic and discovery, an opportunity to review current systems and processes and through them how the Trust already responds to patient safety incidents for the purpose of learning and improvement.

Through this process, several strengths as well as areas of improvement were identified that will support the requirements and transition to PSIRF.

- Over the last 12- 18 months the Trust have moved to ensuring that investigation training provided to individuals is focused on System Based Analysis (SBA), and those asked to lead investigations are required to have completing completed SBA training.
- The Trust template for formal investigations reflected the human factors system model of Systems Engineering Initiative for Patient Safety (SEIPS), to ensure all contributing factors are explored.
- Introduced an MDT review process for significant incidents, that would have previously had the potential to meet the definition of a 'Serious Incident.' If significant learning were identified, the same level of resource would still be applied, focusing on learning to inform improvement.
- The Trust has transitioned away from the traditional format of RCA investigation (unless required to do so under the Serious Incident / Never Event framework) recognising that these investigations can be timely, and evidence now suggests that the process is limited when exploring patient safety events in complex socio-technical systems such as healthcare. Despite best intentions, RCA prompts simple linear cause and-effect analysis and has consistently failed to deliver benefits of the scale and quality needed to thoroughly identify all contributing factors and generate effective safety actions.
- Mandated Patient Safety Level 1 training to all staff in the organisation and Patient Safety Level 2 training to those who have a responsibility to investigate patient safety events.

Areas for improvement are identified.

- Development of Datix system to ensure a systems-based approach to patient safety events at all levels of the organisation.
- More robust feedback to staff who submit Datix incidents.
- Effective ways to communicate shared learning from patient safety events, capturing all levels between Ward to Board.
- Engagement of staff when a patient safety event occurs, promoting a Just and Learning Culture.

Patient safety partners

A patient safety partner (PSP) is actively involved in the design of safer healthcare at all levels in the organisation.

This includes roles in safety governance – for example sitting on relevant committees to support compliance monitoring and how safety issues should be addressed and providing appropriate challenge to ensure learning and change – and in the development and implementation of relevant strategy and policy.

The PSP should ensure that any committee/group of which they are a member considers and prioritises the service user, patient, carer, and family perspective and champions a diversity of views.

The Trust has recruited two Patient Safety Partners who attend the Patient Safety Meeting and Patient Safety Working Group. Both meetings have a responsibility to design and develop incident response processes, as well as monitor patient safety events for new and emerging issues and ensure that safety actions are being monitored and progressed to improve patient safety across the Trust.

Addressing health inequalities

The Trust is currently completing their Equality Diversity and Inclusion assessment, where one of the domains is to assess that patients/service users that access and use our services, do so free from harm. Once this assessment is complete, this section of the policy will be updated to reflect any recommendations/improvement.

The Trust is committed to ensure that all our staff have a 'systems-based approach to patient safety' and have implement Level 1 and Level 2 of the patient safety syllabus training, in line with the NHS Patient Safety Strategy. Further the Trust Human Factors faculty are updating the training content, moving on from previously discussing non-technical skills and situational awareness, to teach people to understand a systems-based approach to patients' safety and performance influencing factors that increase the likelihood of patient safety events occurring.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

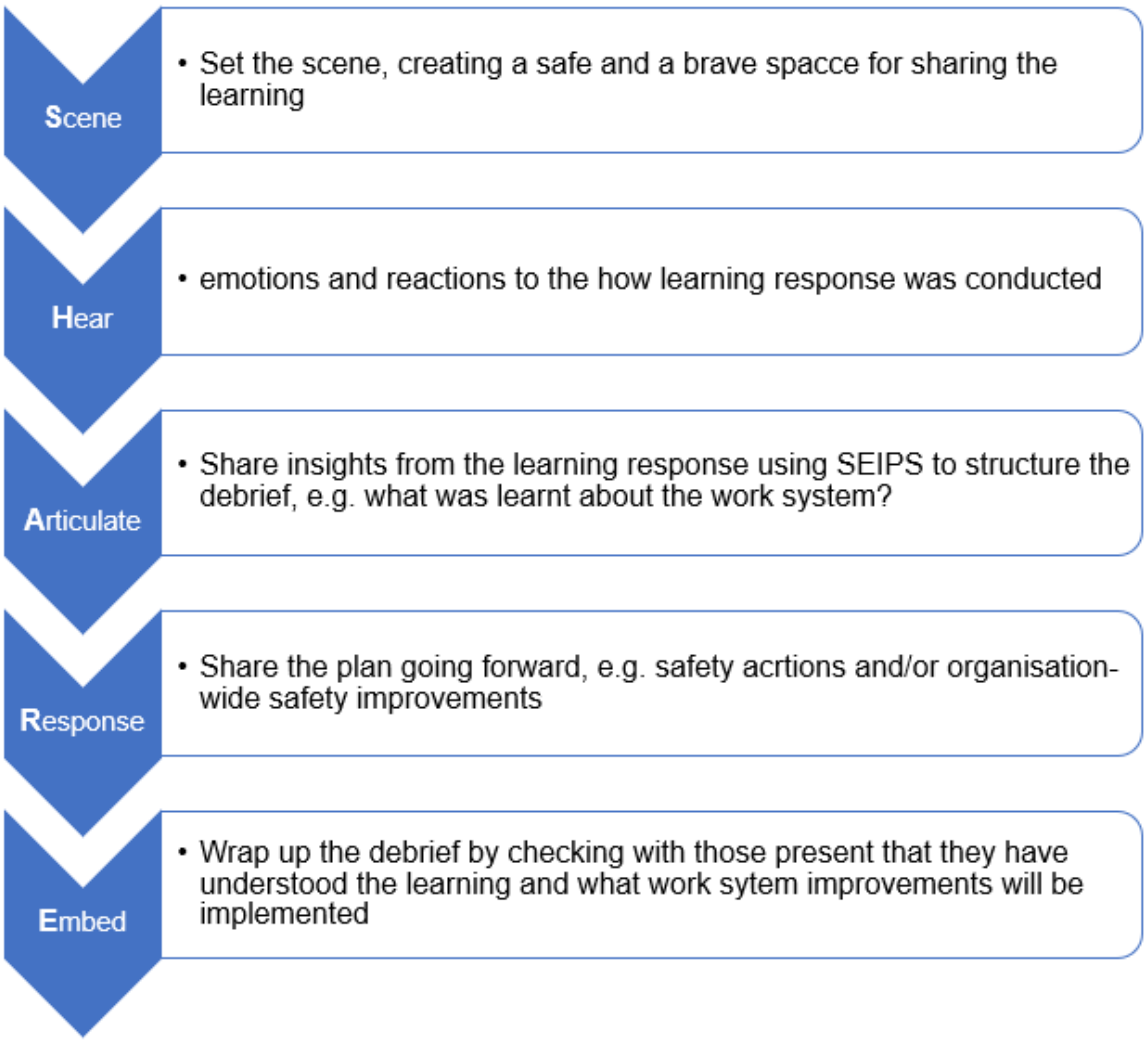
In line with the PSIRF standard, engagement and involvement of those affected by patient safety incidents. The trust is required to ensure;

1. **Compassionate Engagement with those affected**
    - Duty of candour obligations are upheld - Duty of Candour Policy - Percy (interactgo.com)
    - those affected by patient safety incidents should be fully informed about what happened, given the opportunity to provide their perspective and ask questions and to be communicated with in a way that meet their needs, including any form of learning response and subsequent findings.

2. **Meaningful involvement of those affected in a learning response**
    - Provided with a named main contact within the organisation with whom to liaise about any learning response and support.
    - Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in.
    - Informed who will conduct any learning response and of any changes to that arrangement.
    - Given the opportunity to input to the terms of reference for the learning response, including being given the opportunity to request the addition of any questions especially important to them (note this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
    - Given the opportunity to agree a realistic period for any learning response.
    - Informed in a timely fashion of any delays with the learning response and the reasons for them.
    - Updated at specific milestones in the learning response should they wish to be.

- Given the opportunity to review the learning response report with a member of the learning response team while it is still in draft and there is a realistic possibility that their suggestions may lead to amendments. Note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them.
- Invited to contribute to the development of safety actions resulting from the learning response.
- Given the opportunity to feedback on their experience of the learning response and report (e.g., timeliness, fairness, and transparency).

Learning Response and Engagement Leads should use the SHARE debrief tool to not only share findings, areas for improvement and discuss safety actions but also gain feedback from the individuals involved as to how the learning response was conducted.



More information on how the standards described above will be actioned and monitored are included in; responding to patient safety incidents section of the policy.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The PSIRF sets out national priorities, such as incidents meeting the Never Events criteria (2018) and deaths thought more likely than not to have been due to problems in care (i.e., incidents meeting the learning from deaths criteria) where there are mandated responses, which are detailed in the Trust's Patient Safety Incident Response Plan.

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, as organisation are now able to balance effort between learning through responding to incidents or exploring issues and improvement work and the patient safety priorities for RJAH are detailed in the Trust's Patient Safety Incident Response Plan.

Resources and training to support patient safety incident response

All staff in the trust are required to complete the Level 1 Patient safety training and for those staff who have a responsibility for managing and investigating patient safety incidents at a local level, must complete Level 2 of the patient safety training.

For PSIRF - learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. The standards are as followed;

1. **Learning Response Lead Training**
   - Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
   - Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
   - Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
   - Learning response leads contribute to a minimum of two learning responses per year.

2. **Competencies for Learning Response Leads**
   All staff leading learning responses should be able to:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate complex matters and in difficult situations.

3. **Engagement and Involvement training**
   - Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
   - Engagement leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
   - Engagement leads undertake continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
   - Engagement leads contribute to a minimum of two learning responses per year.

4. **Competencies and behaviours for engagement leads**
   - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
   - Listen and hear the distress of others in a measured and supportive way.
   - Maintain clear records of information gathered and contact with those affected.
   - Identify key risks and issues that may affect the involvement of patients, families, and staff.
   - Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

5. **Oversight training**
   - All patient safety incident response oversight is led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.
   - Those with an oversight role on a provider board or leadership team (e.g., an executive lead) have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
   - All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

6. **Competencies for individuals in oversight roles**
   All staff in oversight roles can:
   - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
   - Apply human factors and systems thinking principles.

- Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report form.

The Trust has a responsibility to ensure that training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses. Accreditation with a recognised organisation is preferred.

A detailed training analysis is available in appendix one.

Our patient safety incident response plan

Our plan sets out how RJAH intends to respond to patient safety incidents over 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Link to PSIRP

The RJAH PSIRP is in line with the following standards.

- Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.
- Responses are insulated from remits that seek to determine avoid ability/preventability/predictability; legal liability; blame; professional conduct/competence/fitness to practise; criminality; or cause of death.
- With reference to the just culture guide, referral for individual management performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.
- Patient safety incident investigation reports are produced using the standardised national template.
- Patient safety incident investigation reports are written in a clear and accessible way.
- National tools (or similar system-based tools) are used, and guides followed for learning response methods.

- Learning and improvement work are adequately balanced – the organisation does not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incidents are recorded and monitored through the Trusts Datix System, and this will remain the same under PSIRF.

The trust has Quality Assurance Framework in place provide assurance to the Trust Board that there are effective processes in place to monitor, action and improve quality and safety at RJAH.

As part of the implementation of PSIRF the governance framework has been reviewed and meeting functions and terms of reference have been updated to support PSIRF – a visual aid is detailed in appendix 2

Monitoring of patient safety incidents at a local level, through the delivery unit's governance meetings will remain the same, supported by their respective Clinical Governance Managers

For incidents identified as cross-system issues, these will be reported via the NHS-to-NHS Concern process, and dependent upon the nature of the incident with our Quality Lead

partners at STW ICS. In addition, the ICS Quality Lead for RJAH is in regular attendance at the Trusts Quality and Safety Committee.

Patient safety incident response decision-making

The PSIRP supports proactive allocation of patient safety incident response resources, but it is recognised there will always need to be a reactive element in responding to incidents.

An assessment of incidents that fall outside of our local PSIRF priorities should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

Reactive Issues

Where a patient safety event is reported that that signifies an unexpected level of risk/harm and/or potential for learning and improvement an MDT Review meeting will be scheduled by the Clinical Governance Team, chaired by the Chief Medical Officer (CMO) / Chief Nursing Officer (CNO) or designated deputy, where the incident will be reviewed, and proportionate learning response agreed and learning response lead allocated.

Emergent Issues

It will be the responsibility of the Patient Safety Meeting chaired by the CNO or CMO to monitor for emerging issues regarding patient safety. Collectively the attendees of the meeting will agree a proportionate learning response agreed and learning response lead allocated. Responding to cross-system incidents/issues

Timeframes for learning responses

Patient safety learning responses start as soon as possible after the incident is identified.

- Patient safety learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.
- Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months.

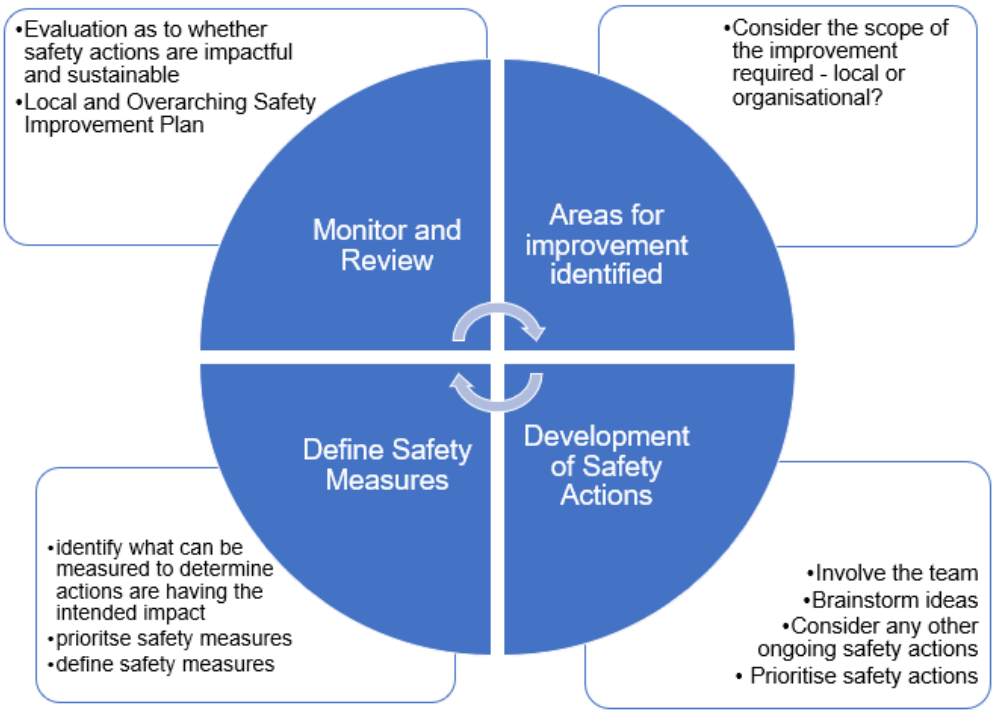
Safety action development and monitoring improvement

As part of a learning response, areas for improvement will be identified. These should set out where an improvement is needed rather than define how that improvement should be achieved. Once areas for improvement have been identified, then safety actions in collaboration with the relevant teams should be identified.

The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutioning at an early stage of the safety action development process. Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The process emphasises a collaborative approach throughout, including involvement of those beyond the 'immediate and obvious' professional groups and working closely with those with improvement expertise. Imposed solutions often fail to engage staff and lack sustainability as a result.

The below diagram sets out the principles for the development and monitoring of safety actions for improvement.



Writing Safety Actions

Safety actions should be SMART (specific, measurable, achievable, relevant, timebound). They should also: •

- Be documented in a learning response report or in a safety improvement plan as applicable.
- Start with the owner, e.g., “Head of patient safety to...”.
- Be directed to the correct level of the system: that is, people who have the levers to activate change (ideally this should include the person closest to the work and who has been empowered to act).
- Be succinct: any preamble about the safety action should be separate.
- Standalone: that is, readers should know exactly what it means without reading the report.
- Make it obvious why it is required (i.e., given evidence in the learning response report or safety improvement plan).

When finalising safety actions, continue to work with those to whom they are directed to ensure they are on board and willing to implement change.

The number of safety actions for implementation is often high. Monitoring their implementation and tracking the resulting changes can be onerous and therefore under PSIRF it is recommend that safety actions are prioritised into low, medium and high priority based on their potential to minimise risk to patient safety and improve patient experience.

An iFACES criteria and scoring rubric is included, as a suggested guide to help prioritise safety actions.

Criterion	Low	Medium	High
	1 — 2 — 3 — 4 — 5		
Inequality Does the intervention ensure fair treatment and opportunity for all?	The intervention is not accessible to the diverse population that will use it.	The intervention accommodates some inequalities but further investigation is needed.	Inequalities are reduced by this intervention.
Feasibility Can the change be implemented relatively easily or quickly?	The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation.	The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be used.	The intervention is readily available and could be implemented in a relatively short period of time without much effort.
Acceptability Will those being impacted by the intervention readily accept the change?	The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change.	The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be wide spread.	The intervention will be readily accepted by those it impacts. People are likely to welcome the change and make every attempt to ensure it works.
Cost/Benefit Does the benefit of the intervention outweigh the costs?	The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance.	The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost.	The cost of the intervention is nominal relative to the expected impact on safety and performance.
Effectiveness How effective will the intervention be at eliminating the problem or reducing its consequences	The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly.	The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change.	The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly.
Sustainability How well will the intervention last over time	The impact of the intervention will diminish rapidly after it is deployed and/or will require extraordinary effort to keep it working.	The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits.	The impact of the intervention will persist over time with minimal efforts being required to maintain its benefits.

Safety improvement plans

Areas for improvement can relate to a specific local context or to the context of the wider organisation. Whilst areas for improvement and developed safety actions, will align to the outcome of a learning response, a safety improvement plan will bring together findings from various responses to patient safety incidents and issues, allowing the Trust to monitor the improvements that are required, ensuring that these link and meet the same priorities as that of the Quality Improvement Team.

The Patient Safety Meeting will be responsible for the delivery of the Trust Safety Improvement Plan, providing assurance to the Quality and Safety Committee that the improvements identified are being actioned and monitored for their impact.

Quality Assurance

As part of reviewing the Trusts Patient Safety Incident Response Plan, an evaluation of learning response completed and their methods to assess their quality and recommendations for improvements required.

Complaints and appeals

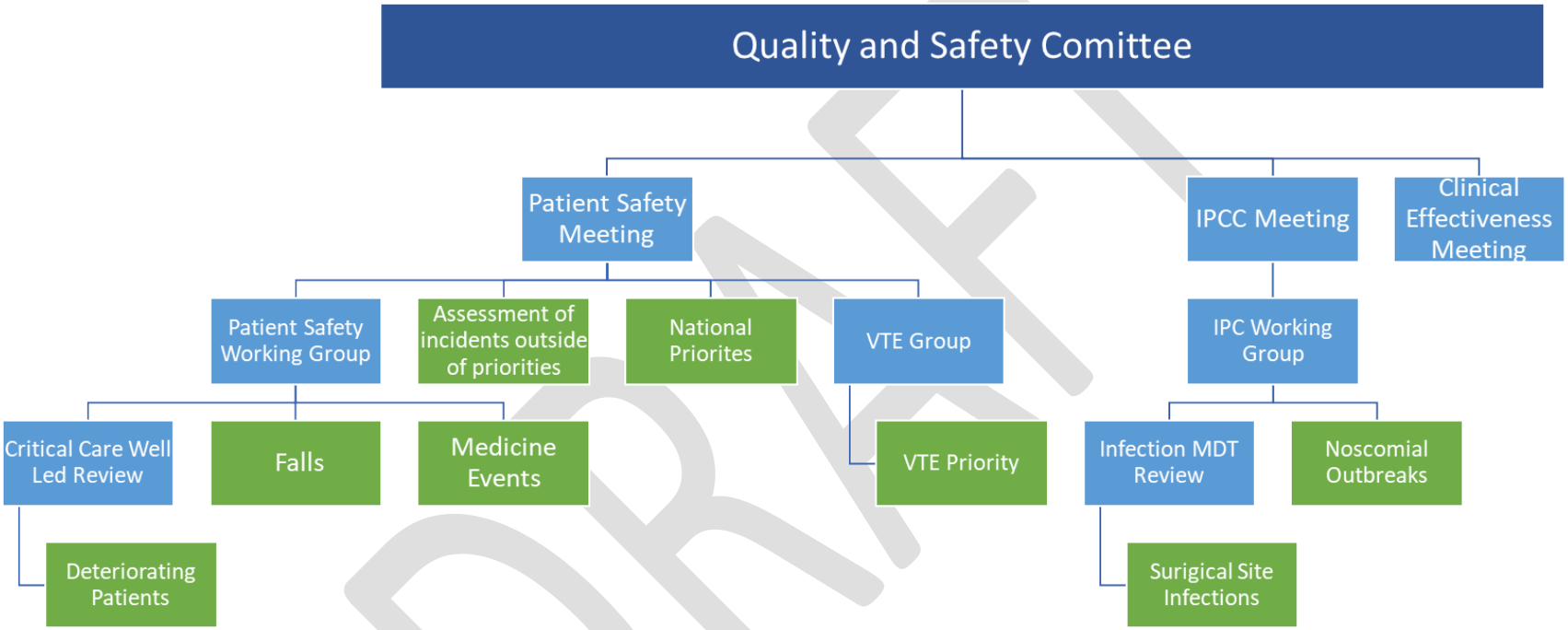
For any complaints or appeals relating to the Trusts response to patient safety incidents, these should be referred to the Trusts, Complaint Policy Complaints Policy - Percy (interactgo.com).

Appendix 1 – PSIRF Training Needs Analysis

RJAH PSIRF Training Requirements					
Training Topic	**Duration/ Frequency**	**Identified Training**	**Learning Response Leads**	**Engagement Leads**	**Oversight Roles**
Systems approach to learning from Patient Safety Incidents	2 days/12 hours	Systems Based RCA Training Human Factors Study Day **OR** HSIB Level 2 Safety Investigation	✓		✓
Oversight of learning from patient safety incidents	1 day/6hrs	To be confirmed			✓
Involving those affected by patient safety incidents in the learning process	1 day/6hrs	To be confirmed / Engagement Development Day, hosted by Governance and FTSUG		✓	✓
Patient Safety syllabus level 1: Essentials for patient safety	E-learning	E-learning module	✓	✓	✓
Patient Safety syllabus level 2: Access to practice	e-learning/ 1.5hrs	E-learning module **OR** Facilitated Session / HF Day	✓	✓	✓
CPD	Annually	Contribute to a minimum of 2 learning responses	✓	✓	✓

Lead	Definition	Role
Learning Response Leads	Individuals who will take a lead of a learning response	Consultants / Ward & Departmental Managers/Matrons/ACN's / Chief Pharmacist
Engagement Leads	Individuals who will support both staff and patients through a learning response	Ward Managers, Clinical Governance Team, People Services
Oversight Role	Individuals who have a responsibility for overseeing patient safety for the Organisation	Chief Nurse & Chief Medical Officer, ACN's, Head of Clinical Governance, Clinical Chairs NED Chair for QSC

Appendix 2 – Governance Framework for PSIRF



Duty of Candour and LFPSE

Committee / Group / Meeting, Date

Board of Directors (Public Meeting), 06 September 2023

Author:

Name: Kirsty Foskett
Role/Title: Head of Clinical Governance, Quality and Patient Safety Specialist

Contributors:

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Clinical Governance Manager

Report sign-off:

Paul Kavanagh-Fields, Chief Nurse and Patient Safety Officer
Quality and Safety Committee, 20 July 2023

Is the report suitable for publication?:

YES

Key issues and considerations:

The purpose of the report is to provide the committee with an update on performance in relation to Duty of Candour (DoC) compliance.

In summary the audit results demonstrate that we apply professional duty of candour well and are open with our patients, when things go wrong. As a Trust we are compliant with standards 1 to 4 of the regulation however further work is required to ensure that we formally update our patients following an investigation for patient safety event that meet the definition of a notifiable safety incident.

The report also provides a brief overview of the new Learning From Patient Safety Events (LFPSE) system and the new definitions of harm levels that will be used, once the Trust has transitioned to LFPSE which will replace the National Reporting and Learning System (NRLS) and STEIS.

Strategic objectives and associated risks:

Regulatory Compliance

Recommendations:

The following recommendations outline the actions that are required, to ensure that the Trust is meeting it's statutory requirements.

1. Provide education to individuals to ensure there is a clear understanding in the difference between the being open principles and when the statutory requirement of duty of candour applies.
2. Update Datix to reflect the three questions as detailed in section 1 of the report, to ensure statutory duty of candour is applied to notifiable safety incidents and can therefore be easily monitored.
3. Review of our duty of candour policy and harm levels in line with the transition to LFPSE.
4. Produce a SOP for recording patient safety events on LFPSE, which provides a guide on definitions and examples on the level of harm.

1. Background / context

CQC Regulation 20: Duty of candour stipulates that as a Trust registered providers must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

There are two types of duty of candour, statutory and professional. Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. However when a notifiable safety incident occurs the Trust have a responsibility to ensure that all aspects of duty of candour are completed.

A notifiable safety incident, is a specific term defined in the duty of candour regulation and is defined when a incident meets all three of the following criteria.

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of an activity we regulate.
3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

If a patient safety event is deemed as a notifiable safety incident, then the following steps should be followed.

Standard 1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.

Standard 2. Apologise

Standard 3. Provide a true account of what happened, explaining whatever you know at that point.

Standard 4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.

Standard 5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.

Standard 6. Keep a secure written record of all meetings and communications with the relevant person.

2. Compliance Audit Results

An audit has been completed by the clnical governance team to understand compliance against the required standards.

From 01 November 22 to 31 March 23 there were 83 moderate harm incidents reported across the Trust, that have been included in the audit. The findings are as follows;

- Following all incidents patients were offered an apology and the Trust were open in informing the patients that an incident occurred.
- 70 incidents document that verbacl DoC had taken place and this documented on Datix and in the patient record on EPR.
- 13 incidents documented on Datix only, that DoC had taken place.
- Of the 83 incidents reported, only three provided a formal update to the patient on the investigation that had taken place (these incidents relate to the SI/NE process).

In summary the audit results demonstrate that we apply professional duty of candour well and are open with our patients, when things go wrong. As a Trust we are compliant with standards 1 to 4 of the regulation however further work is required to ensure that we formally update our patients following an investigation for patient safety event that meet the definition of a notifiable safety incident.

3. Proposed next steps

The Trust are currently progressing work in transitioning to Learning From Patient Safety Events (LFPSE), this is the external reporting system that will replace the National Reporting and Learning System (NRLS) and STEIS.

At present, when a moerate or above harm level is recorded as a result of a patient safety event, the current format on Datix does not distinguish between when being open principles apply and when the statutory requirements of a notifiable safety incident apply.

The Clinical Governance Team have recently introduced a weekly moderate + harm review meeting, which in the interim will help identify those incidents where we need to ensure compliance against the statutory duty of candour regulation.

It is proposed that the following recommendations are progressed as part of that work stream, which is monitored under the patient safety strategy action plan.

For information, the NHS England guide on LFPSE and proposed harm levels moving forward are detailed in appendix 2 of the report.

4. Recommendations

The following recommendations outline the actions that are required, to ensure that the Trust is meeting it's statutory requirements.

1. Provide education to individuals to ensure there is a clear understanding in the difference between the being open principles and when the statutory requirement of duty of candour applies.
2. Update Datix to reflect the three questions as detailed above, to ensure statutory duty of candour is applied to notifiable safety incidents and easily monitored.
3. Review of our duty of candour policy and harm levels in line with the transition to LFPSE.
4. Produce a SOP for recording patient safety events on LFPSE, which provides a guide on definitions and examples on the level of harm.

Appenix 1 – Action plan

Action	Responsbile Lead	Action Owner	Target completion date	Progress Rating
Update Datix to reflect the three questions as detailed above, to ensure statutory duty of candour is applied to notifiable safety incidents and easily monitored	Kirsty Foskett	Ashling Donohoe-Harrison	30/9/2023	
Review of our duty of candour policy and harm levels in line with the transition to LFPSE	Kirsty Foskett	Kirsty Foskett	30/10/23	
Produce a SOP for recording patient safety events on LFPSE, which provides a guide on definitions and examples on the level of harm.	Kirsty Foskett	Clnical Governance Managers	30/10/23	
Provide education to individuals to ensure there is a clear understanding in the difference between the being open principles and when the statutory requirement of duty of candour applies. This will be facilitated via Moderate harm review meeting, patient safety working group, unit clinical governance meetings and relevant clinician, nursing and AHP forums	Kirsty Foskett	Kirsty Foskett, Clinical Governance Managers, ACNs & Matrons	31/11/23	

Progress Rating	
Not started	
In progress	
Behind plan	
Complete	

Appendix 2 – LFPSE Guide and new definitions of Harm

What is LFPSE?

The Learn from Patient Safety Events (LFPSE) service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer.

What Service does LFPSE provide?
LFPSE initially provides two main services:

Record a patient safety event – organisations, staff and patients will be able to record the details of patient safety events, contributing to a national NHS wide data source to support learning and improvement.

Access data about recorded patient safety events – providers can access data that has been submitted by their teams, in order to better understand their local recording practices and culture, and to support local safety improvement work.

Provides an opportunity for staff members to report episodes of Good Care.

How LFPSE will improve patient safety learning?
The new LFPSE service is a major upgrade, creating a single national NHS system for recording patient safety events. It introduces improved capabilities for the analysis of patient safety events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.

When fully functional, LFPSE will:

- make it easier for staff across all healthcare settings to record safety events, with automated uploads from local systems to save time and effort, and introducing new tools for non-hospital care where reporting levels have historically been lower
- collect information that is better suited to learning for improvement than what is currently gathered by existing systems
- make data on safety events easier to access, to support local and specialty-specific improvement work
- utilise new technology to support higher quality and more timely data, machine learning, and provide better feedback for staff and organisations.

New Harm Grading

The below table sets out the new categories for harm grading. The guidance also provides more information on defining levels of harm, with examples to guide decision making.

More information is available 230424 LFPSE - Policy Guidance on Recording Patient Safety Events and Levels of Harm V1.1 - NHS Patient Safety - FutureNHS Collaboration Platform.

Duty of Candour and LFPSE

Previous harm grades	New physical harm grades	New psychological harm grades
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Committee / Group / Meeting, Date

Board of Directors (Public Meeting), 06 September 2023

Author:	Contributors:
Name: Sara Ellis-Anderson Role/Title: Assistant Chief Nurse and Named Nurse for Adult Safeguarding	Suzanne Marsden, Named Nurse for Childrens Safeguarding.

Report sign-off:

Virtual sign off by Safeguarding Committee members.
Paul Kavanagh-Fields, Chief Nurse and Patient Safety Officer
Quality and Safety Committee, 20 July 2023

Is the report suitable for publication?

YES

Key issues and considerations:

The annual safeguarding report provides a summary of the work which has been undertaken and Trust performance during 2022/23 in relation to children and young people and adult safeguarding and outlines key priorities for 2023/24. This report should be read in conjunction with the Shropshire Safeguarding Community Partnership (SSCP) annual reports. A link to these documents will be available on the safeguarding web page.

- Summary of children safeguarding incidents and referrals noting an increase in LADO referrals and subsequent learning from these cases
- Summary of adult safeguarding referrals to local authority has increased from 18 in 2021/22 to 25 in 2022/23 noting increases in neglect (including self-neglect) and domestic abuse cases.
- Notable increase in inpatients with complex mental health needs and increased contact from outpatients resulting in 28 incidents reported during 2022/23.
- Increase in DoLs referrals from 45 in 2021/22 to 54 in year following increased prevalence and a change in complexity of patients received on Sheldon Ward.
- Significant improvement in Adult Safeguarding level 3 training from 37% to 67%
- Summary of children's and adults safeguarding training with compliance at level 1,2, and 4 with level 3 safeguarding, MCA and DoLS remaining an area of focus for the year ahead
- Summarises the objectives that have been fully and partially achieved for 2022/23
- Outlines key priorities for 2023/24 which include, training with focus on Domestic Abuse, Mental Health, Learning Disabilities, improved communication across the patient pathway and development of a digital safeguarding dashboard to triangulate data.

Strategic objectives and associated risks:

1. Developing and Maintaining Safe Services
2. Maintaining Statutory and Regulatory compliance

BAF 10 - Compliance with Strategic Oversight Framework

Recommendations:

That the Board:

1. CONSIDER the content of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust's Annual Safeguarding Report for 2022/23;
2. APPROVE the Safeguarding Annual Report on behalf of the Trust, including any minor revisions required prior to Trust Board and publication on RJAH internet.

Report development and engagement history:

- The Annual Safeguarding priorities for 2023/24 were agreed at Quality and Safety meeting on 22nd of June 2023.
- The Annual Safeguarding report has been circulated to all members of the Trust Safeguarding Committee including ICS Safeguarding professionals.

Next steps:

- Annual Safeguarding Report to be submitted to Trust Board following approval at Quality and Safety Committee.
- Progress against the safeguarding priorities identified will be monitored through Adult and Childrens Safeguarding quarterly meeting.
- The Trust will continue to provide assurance on training compliance and themes and trends to the SSCP on a quarterly basis.

Acronyms

CAMHS	Child and Adolescent Mental Health Services
CQC	Care Quality Commission
DA	Domestic Abuse
DHR	Domestic Homicide Review
DNA	Did Not Attend
DoLS	Deprivation of liberty safeguards
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FGM	Female Genital Mutilation
ICD	Intercollegiate Document
ICS	Integrated Care System
LADO	Local Area Designated Officer
LD	Learning Disabilities
LPS	Liberty Protection of Safeguards
MCA	Mental Capacity Act
MCSI	Midlands Centre for Spinal Cord Injury
MDT	Multi-Disciplinary Team
MPFT	Midlands Partnership Foundation Trust
MRI	Magnetic resonance imaging
NHSE	NHS England
NSSO	Nominated Safeguarding Senior Officer
PLACE	Patient Led Assessment of the Clinical environment
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
SAR's	Safeguarding Adult Review
SLA	Service Level Agreement
SGC	Safeguarding Committee
SSCP	Shropshire Safeguarding Community Partnership
STING	Shropshire and Telford Implementation Network Group
WNB	Was Not Brought

Appendices

Appendix A - Annual Training Report for Child Safeguarding & Adults at 31st of March 2023

1. The Main Report

1.1 Introduction

The Robert Jones & Agnes Hunt Orthopaedic Hospital (RJAH) NHS Foundation Trust is an organisation which has an ethos that prioritises quality of care having robust leadership and focus, and effective partnership working to endorse the well-being, security and safety of children and young people and adults (adults with care and support needs) who are under our care. For the purpose of this document, we define children and young people as those who have not yet reached their 18th birthday.

Part of the organisation's commitment is to work alongside both the Shropshire Safeguarding Community Partnership (SSCP) and other partner agencies, to ensure there are effective systems in place to safeguard children and young people and adults with care and support needs.

RJAH is committed to meeting the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (July 22) and provides evidence on how the trust meets the requirements. An action plan to demonstrate compliance against the standards has been developed. This is monitored by the safeguarding team reporting on the actions and continual improvements.

The Trust is required to meet the Care Quality Commission (CQC) fundamental standards which is the independent regulator to ensure health and social care services are safe, effective, compassionate and of high-quality care. CQC Regulation 13: Safeguarding service users from abuse and improper treatment is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act (MCA) 2005.

1.2 Our Vision

Children and young people

The welfare of the child is paramount (children Act 1989 & 2004) and it is imperative that staff are able to recognise a child in need and support and signpost them effectively. Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, we must ensure our staff put the needs of children first. Working in partnership with the child, their family and community teams to get the most appropriate support and intervention as soon as practicable.

Adults with care and support needs

Adults with care and support needs have the right to live in safety, free from abuse and neglect (Care Act, 2014)

All practitioners need to work together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action ensuring we are making safeguarding personal.

Safeguarding as core business

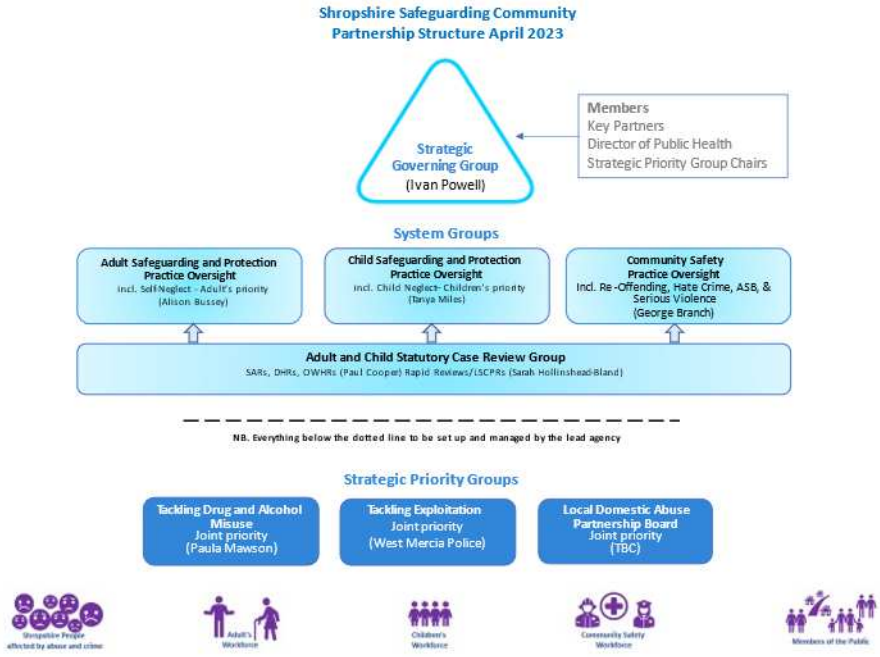
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is committed to safeguarding children and young people and adults with care and support needs, to ensure their welfare needs remain paramount whilst in our care, making safeguarding everybody's responsibility. We achieve this by;

- Ensuring the Trust is compliant with statutory responsibilities, national and local guidance, CQC registration and standards. Evidence of compliance is reported quarterly and annually to the Integrated Care System (ICS)
- Ensuring the Trust provides evidence on how the organisation meets the requirements of the Safeguarding Accountability and Assurance Framework (Aug 2019).
- Having clear lines of accountability in place, which are accessible and promoted to all staff.
- To have a commitment to ensure all staff are compliant with their safeguarding training depending on their role and responsibilities.
- Having safeguarding children and young people and adult policies and procedures in place that are aligned with national and local guidance including safe recruitment policies and procedures.
- Ensuring there are processes in place for the management of allegations against staff.
- Encouraging staff to raise concerns.
- Reviewing and monitoring incidents and complaints to identify trends or patterns.
- Ensuring that we are aligned to and committed to delivering the SSCP annual objectives and contributing to the SSCP annual report.

2. Shropshire Safeguarding Community Partnership (SSCP) Priorities 2020-2023

On the 3rd February 2023 the SSCP held a strategic planning and priority meeting – the purpose of this meeting was to review achievements over the last three years and agree structures and priorities going forward from April 2023. Following this meeting there has been a significant restructure of the partnership with an aim to improve outcomes for children and young people.

The New Shropshire Safeguarding Community Partnership Structure – from April 2023



Strategic Governing Group will meet monthly and will include the current Key Partners, the Director of Public Health and the chairs of groups, apart from the Child and Adult Statutory Case Review Group. This group will be directly linked into and informing the work of the Practice Oversight Groups.

The Practice Oversight Groups include:

- **Adult Safeguarding and Protection Practice Oversight Group (including Self-Neglect)** – Chaired by Alison Bussey
- **Children's Safeguarding and Protection Practice Oversight Group (including Child Neglect)** – Chaired by Tanya Miles
- **Community Safety Practice Oversight Group (with a focus on reducing re-offending, hate crime, anti-social behaviour and serious Violence)** – Chaired by George Branch

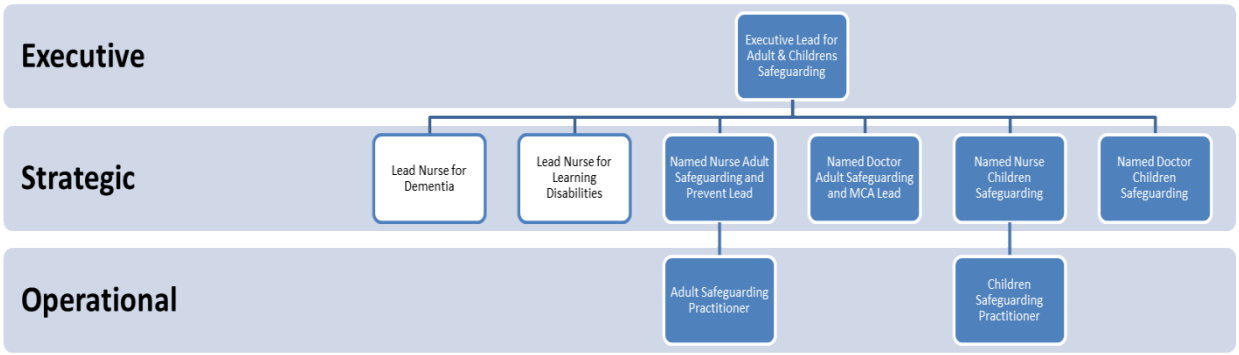
Child and Adult Statutory Case Review Group – Although it's described as one group, it will be split and we would like to try holding the meetings on the same day. This group is to be chaired by Paul Cooper (Adults) and Sarah Hollinshead-Bland (Children)

This year's Strategic priorities are:

- **Tackling Drug and Alcohol Group** – chaired by Paula Mawson
- **Local Domestic Abuse Partnership Board** - TBA
- **Tackling Exploitation Group** – West Mercia Police

It's important to emphasise that all work associated with the Strategic Priority Groups will need to be supported and managed by the lead agencies and the partners involved in those groups.

3. Safeguarding accountability structure across the RJAH



Trust safeguarding Team April 2022-March 2023

Executive Lead for Safeguarding Children and Adults	Sara Ellis Anderson (Interim Chief Nurse and Patient Safety Officer)
Non-Executive lead for Safeguarding Children and Adults	Paul Kingston
Named Doctor for safeguarding children and young people	Dr Richa Kulshrestha, Consultant Paediatrician allocated 1PA per week protected time, to undertake this role.
Named Nurse for safeguarding children and young people	Suzanne Marsden - The Children's Unit Manager works one day a week (7.5 hrs Band 8a) As the Named Nurse for Safeguarding Children and young people. Supported and supervised quarterly by the /Designated Nurse for Safeguarding Children Telford ICS
Children's Safeguarding Practitioner	Vicki Jones Alice Ward Sister left this role in Aug 2022 and this position has since been vacant. There is no funding attached to this post. Plan for 2023 to incorporate this role into the new Transition nurse post for young people moving into adult care. This post will cover young people aged 0-25yrs.
Named Doctor for adults	Mr Srinivasa Budithi has 1 PA per week allocated and works alongside the lead nurse for adult safeguarding monitoring of referrals/cases and providing support and expert advice to staff.
Named Nurse for adults	Sara Ellis-Anderson, supported and supervised quarterly by Sarah Dempsy, Deputy Designated Safeguarding Lead Nurse at NHS Redditch and Bromsgrove CCG.
Adult Safeguarding Practitioners – Safeguarding practitioners are responsible for delivering safeguarding training; monitoring of	1.2 FTE Band 7 Job share by Anne Worrall and initially Katie Harris followed by Rebecca Wright-Powell in Aug 2022

referrals/cases and advice/support to staff. Promotion of good professional practice within the organisation and a culture that all staff are aware of their personal responsibility to report concerns.	
Lead Nurse for Dementia	Ward Manager Lorna Edwards leads on Dementia care alongside her ward manager role supported by the Named Nurse for Adult Safeguarding and Assistant Chief Nurse Nicki Bellinger
Lead Nurse for Learning Disabilities	Assistant Chief Nurse Nicki Bellinger
Lead Nurse for Mental health (new for 2022/23)	The Trust has seen an increase in patients contacting the hospital with significant mental health concerns and these have been managed by the Adult safeguarding practitioners. The plan was to recruit a senior manager to lead on this role in 2022/23, however this remains outstanding. This will be a key focus for 2023/24.

4. Meetings

Interagency children's meetings attendance:

- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Chief Nurse. The Named and County Designated Professionals, Matrons Adult Safeguarding Practitioners and Learning and Development Manager attend this meeting.
- Regional Named Nurse meeting children – this is held twice a year and normally has level 4 training incorporated into the afternoon session of the meeting. This meeting has now been opened up to adult colleagues.
- SSCP Training pool Meetings attended by the Named Nurse children; however these meeting were stopped for several months due to illness and attendance from Trust has been minimal this year due to other work pressures.
- SSCP Learning and Development systems Group – Unfortunately limited attendance this year due to clinical priorities and this group is ceasing as part of the new strategic plan.

Information from the county meetings is cascaded through the Paediatric Forum, Children's unit meetings as well as the Trust Safeguarding committee.

Interagency adult's meetings attendance:

- Bi-monthly Trust Adult and Child Safeguarding Committee. This meeting is chaired by the Chief Nursing Officer. The Named and County Designated Professionals, Matrons Adult Safeguarding Practitioners and Learning and Development manager attend this meeting.
- SSCP learning and development sub-group – limited attendance this year due to availability of safeguarding team.
- SSCP MCA and DoLS sub-group attended by Adults Named Nurse or Adult Safeguarding practitioner.
- SSCP Assurance and Improvement System group attended by Named Nurse or Adult Safeguarding practitioner.
- STING - Shropshire and Telford Implementation Network Group "STING" for Mental Capacity Amendment Act including - Liberty Protection Safeguards attended by Adult Safeguarding Practitioner
- Responsible Bodies group for LPS attended by Adult Safeguarding Practitioner

The STING and Responsible Bodies Group meetings were meetings to prepare organisations for Liberty Protection Safeguards (LPS). In view of the announcement in April 23 to delay the implementation of the Liberty Protection Safeguards beyond the life of the current Parliament the meetings have been stood down with proposals for the MCA/DoLS operational group to be reinstated for 2023/24.

Information from the interagency meetings is cascaded through Link meetings chaired quarterly by Adult Safeguarding Practitioners as well as the bimonthly Trust Safeguarding Committee.

The Trust intranet safeguarding pages are regularly updated and have links to the SSCP website and national safeguarding applications. The Safeguarding team also produces a bi-monthly Safeguarding bulletin to disseminate key messages and information.


Volume 1 - Issue 7
28/07/2021

Safeguarding Bulletin

Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

Welcome to this seventh edition of the Safeguarding Bulletin.

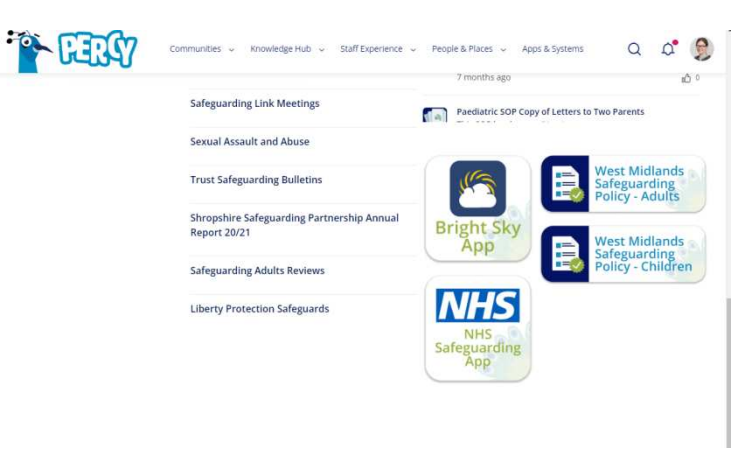
The purpose is to support all clinical staff and other practitioners whose job it is to help safeguard the adults and children we come into contact with. We aim to use this bulletin to provide staff with the necessary support and information and a resource for signposting staff for further information.

Please let us know if there is anything specific you would like covering by contacting the safeguarding team: rjah.safeguardingingadultsandchildren@nhs.net

Different types of power of attorney

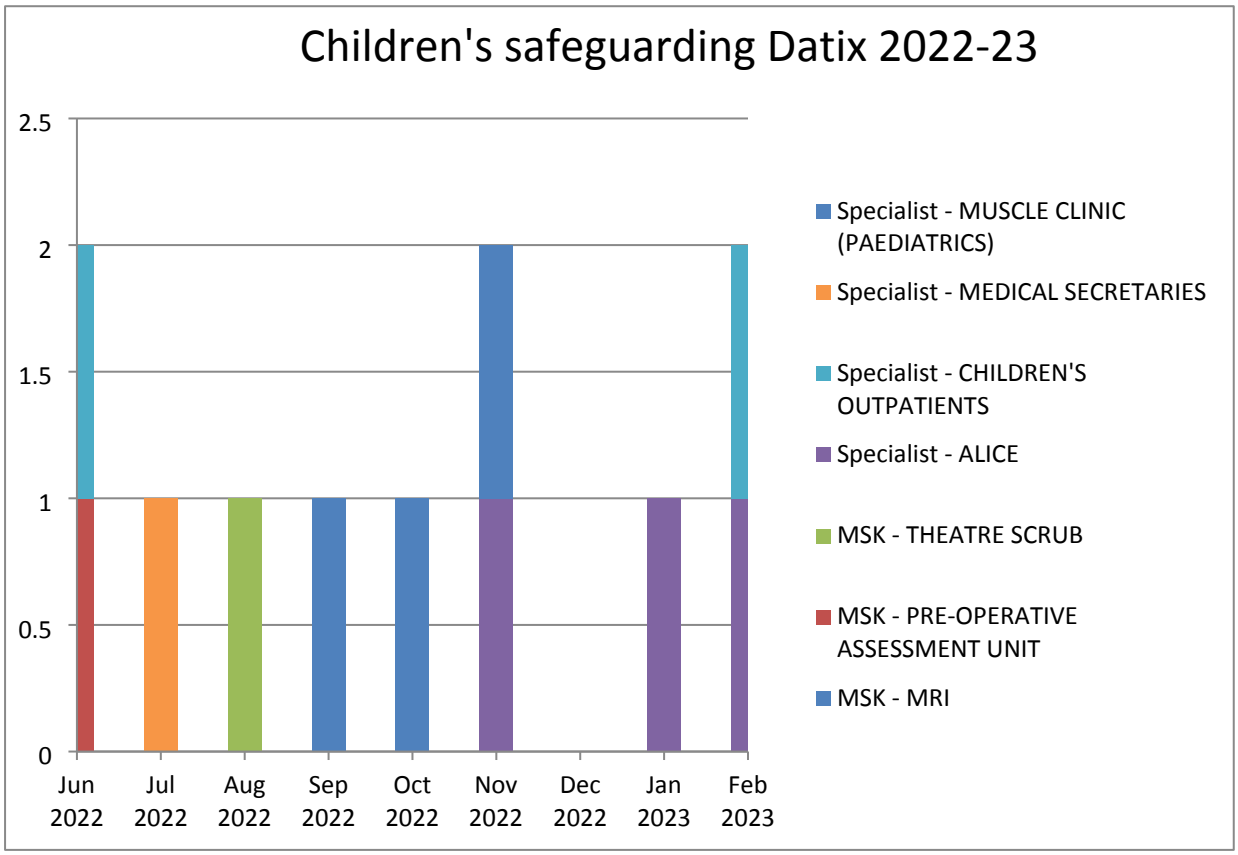
Different types of power of attorney can be used in different situations. A patient may sometimes want to set up more than one type.

- General power of attorney – gives an attorney the authority to make decisions or take actions about person's finances while they still have mental capacity. This is sometimes also called an ordinary power of attorney
- Lasting power of attorney (property and financial affairs) – gives an attorney the authority to make decisions about person's finances with their permission or if they lose mental capacity



5. Referrals and incidents

5.1 Children's Safeguarding Activity (2022/23) Summary:



There have been a total of 11 Children and Young People safeguarding incidents reported in 2022/23.

Early help

2 incidents resulted in referral to the patient's local authority for child in need / early help. One was a joint adult and child referral (South Stafford & Shropshire).

Managing Allegations - Local area designated Officer – LADO referrals

1 LADO investigation relating to a member of staff – Case led by Shropshire LADO & West Mercia police. Case closed with learning from incident instigated.
1 LADO referral that did not meet threshold.

4 Datix completed in relation to attendance to safeguarding professionals meeting & section 47 conferences – these are recorded to aid completion of the Safeguarding quarterly dashboard.

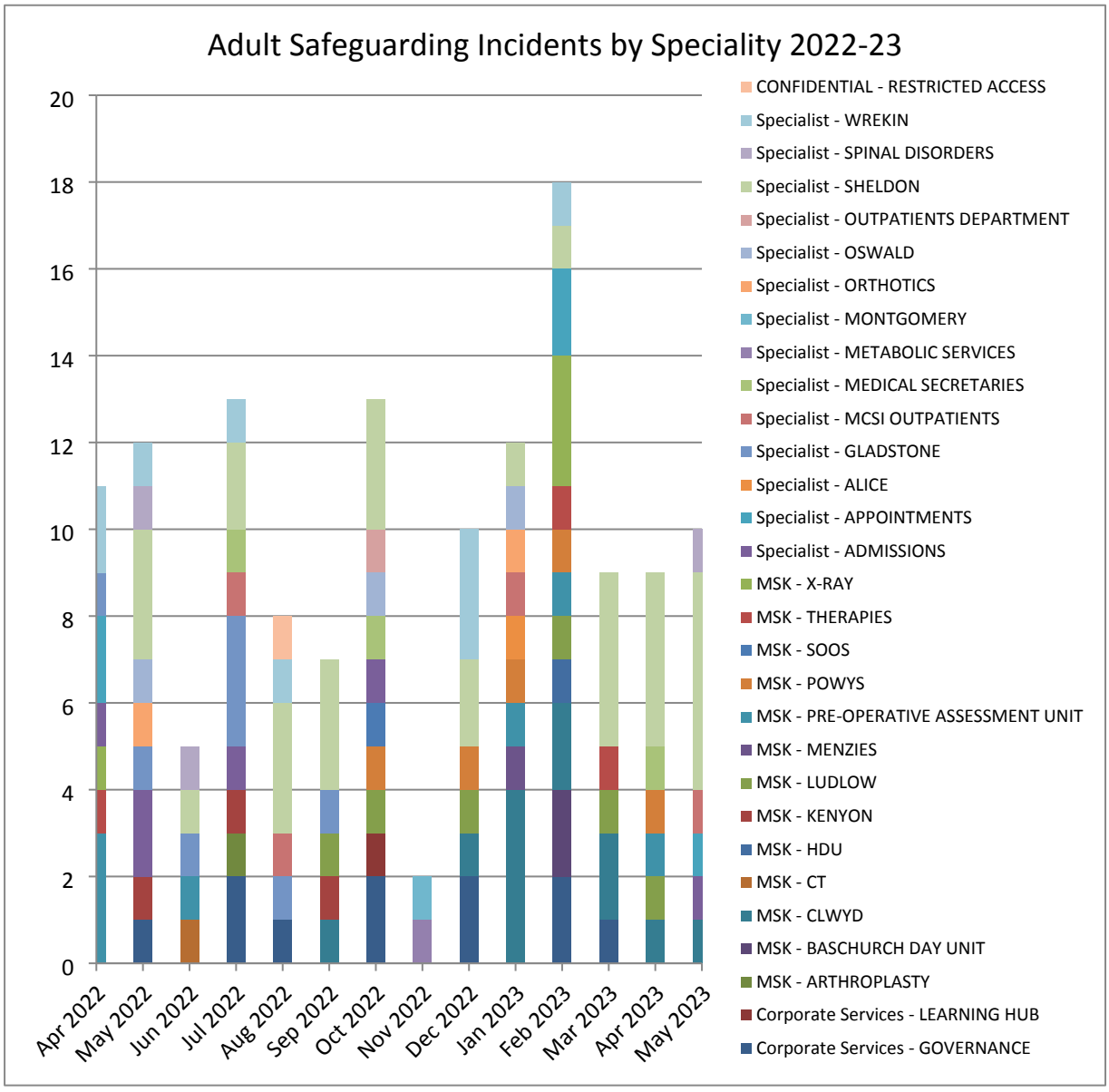
3 children with mental health concerns

- One concerned raised in MRI, intervention arranged from Play Team and School. Positive outcome.
- one concern raised on the ward, young person had recent suicidal thoughts, had previously been referred to CAMHS, but awaiting appointment. MDT discussion prior to discharge. CAMHS appointment brought forward and mum received a call from the team post discharge to discuss emergency plan if required. Family very grateful for intervention.
- One concern raised by medical secretary, mum reported daughter was self-harming due to knee pain. Young person contacted by paediatric charge nurse. Patient previously referred to CAMHS, not currently self-harming, offered further support in pre op assessment appointment.

There were no clear themes; however mental health and anxiety issues remain a concern and sadly some young people have a long wait to see a CAMHS practitioner post referral.

One managing allegation Datix highlighted a learning opportunity, and a learning review was completed and shared with the Team.

5.2 Adult Safeguarding Activity (2022/23)

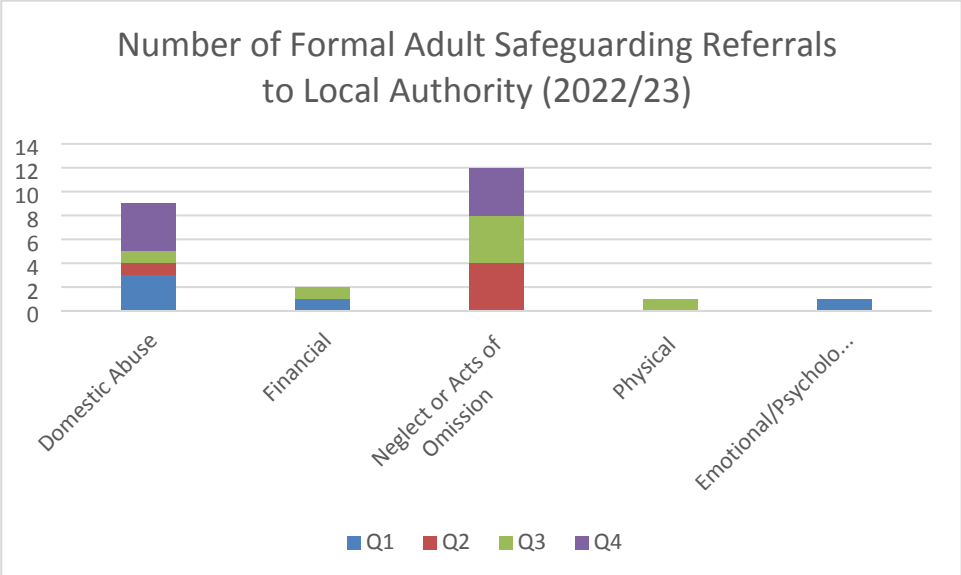


Summary:

There has been a total of 139 Adult Safeguarding Datix incidents including a subcategory of Deprivation of Liberty safeguards (DoLs) and adult safeguarding near miss and mental health issues reported in 2022/23. Out of the 139 Datix there has been a total of 54 Deprivation of Liberty safeguards (DoLs). The incidents are being reported across the organisation demonstrating a good prevalence of Safeguarding.

Out of the remaining 85 Datix the two highest categories reported were 28 incidents related to Mental Health concerns and 25 Adult Safeguarding incidents resulting in referral to local authority. There was one patient detained under the Mental Health Act in August 2022.

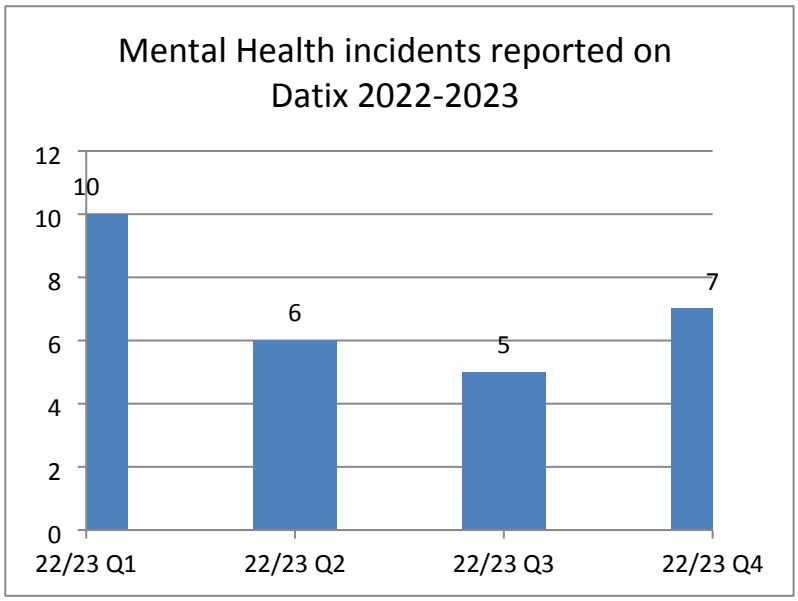
5.2.1 Adult Safeguarding referrals to local authority



The category/types for abuse for safeguarding referrals have varied throughout the year. However, the highest number has been the category of neglect and acts of omission (including self-neglect) and domestic abuse where many of the signs of abuse has been a combination of verbal abuse, physical and control and coercion. One referral made added to an open section 42 enquiry.

The Safeguarding team respond to initial scoping reports in response to Safeguarding Adult Review (SARs) and Domestic Homicide Reviews (DHR) requests from the SSCP. Information and learning from the SAR and DHR are disseminated at Safeguarding link meetings and available on the Trust intranet pages. The Safeguarding team may then be invited to the Safeguarding Adult Review Decision Making mutli-agency meeting where the team are asked to summarise analysis of practice and the learning that has been identified for the individual case.

5.2.2 Mental Health



The Trust has also seen a significant increase in the number of patients being admitted with complex mental health needs. This is something which as an organisation we have not been well equipped to comprehensively manage, and previously many staff have not been regularly exposed to patients with mental health diagnoses working within an elective orthopaedic hospital.

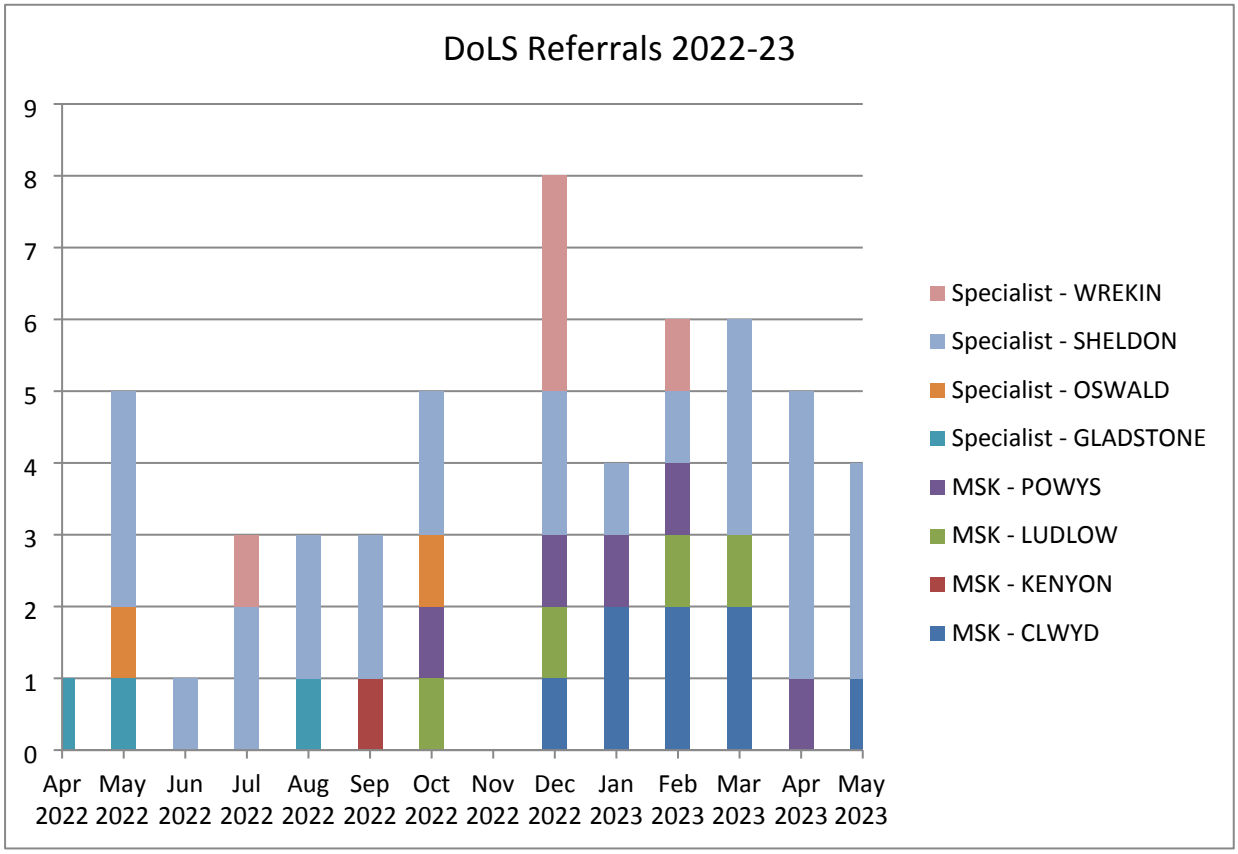
Having identified a gap, and recognising the impact of this, a number of actions were taken to increase staff awareness and education, including;

- Tier 1 eLearning training package has been designed and developed by members of the task and finish group. This is now a requirement for all staff to complete every three years.
- Tier 2 face to face bespoke mental health training programme has been set up for clinical staff to attend. This programme is being delivered by the Liaison Mental Health Team based at Shrewsbury Hospital.
- A review of the Service Level Agreement between the Robert Jones and Agnes Hunt Orthopaedic Hospital and Midland Partnership NHS Foundation Trust (MPFT) has been undertaken. This is to ensure there is ongoing support and a service from the relevant specialist professionals offered to patients which includes staff training.

This important work will continue to develop in 2023/24 with a focus on:

- Review of policies and procedures in relation to Mental Health.
- Review of Mental Health First aider's role and consider mental health champions across the organisation. Ensuring their role promotes the 'Think Family' approach in relation to parent/carers with mental health challenges, which may affect there ability to care for their children

6. Deprivation of Liberty Safeguards (DoLS) Referrals (2022/23)



Summary:

There have been a total of 54 Deprivation of Liberty (DoLs) applications made in 2022/23. There has been a continuing increase in staff awareness of what constitutes a DoLs through education and training throughout the year resulting in a steady increase in Q3 and Q4.

A number of improvement actions were taken to increase awareness:

- Staff safeguarding webpage has a section on DoLS and LPS
- Staff safeguarding bulletin focussed on the MCA
- All DoLS applications have MCA documented
- Patients subject to DoLS are discussed daily in the site safety meeting
- Safeguarding practitioners visible on wards daily to give advice and support

The Liberty Protection Safeguards (LPS) was introduced by the Mental Capacity (Amendment) Act 2019 to replace the DoLS as the system that authorises arrangements amounting to a deprivation of liberty to provide care or treatment to an individual who lacks the relevant mental capacity, in England and Wales. The new system was designed to be more streamlined and will put the person at the centre of the decision-making process. The Trust was notified in April 2023 that the government had taken the decision to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament.

In 2022/23 in readiness for the implementation of LPS the trust was a member of the STING Shropshire and Telford Implementation Group. The Trust participated as a member of the group working with key

stakeholders and is in the process of reviewing the new updated version of the code of practice and contributed to the consultation.

7. Prevent Referrals (2022/23)

There have been zero prevent referrals for 2022/23**.** The annual Prevent self-assessment was completed and the Prevent policy was updated. Quarterly returns are sent to NHSE to monitor training levels and incidents reported. The Trust has consistently shown high levels of compliance with Prevent training.

8. Safeguarding complaints (2022/23)

There have been no complaints recorded in 2022/23 that have resulted in a safeguarding referral being made.

9. Managing allegations / Local Authority Designated Officer (LADO)

There have been 3 LADO queries this year. However non met the threshold for referral. There have been no referrals to the Nominated Safeguarding Senior Officer (NSSO).

10. Training

10.1 Child safeguarding training

Training compliance continues to be monitored against the Trusts targets of 92%. Training figures for March 2023 were:

Level 1	**95%**
Level 2	**92.5%**
Level 3	**90.1%**
Level 4	**100%**

Please see appendix one for further detail

The Named Nurse coordinates and delivers level-one training for staff working in the Trust and provides all staff groups across the Trust with expert advice and support regarding safeguarding children issues. Clinical staff, undertake level-two training as an e-learning module and the vast majority of level three training is accessed via the Shropshire Safeguarding Children Partnership (SSCP) training pool and is delivered as multi agency training, this continues to be delivered as virtual training following COVID. This type of approach to training has proved to be more accessible and time efficient, and staff have found it easier to complete the necessary hours of training.

Whilst level 3 training figures appears red this relates to 4 staff. One incorrectly recorded by department, 2 that have completed and one who has not returned post maternity leave.

Both Named Professionals have completed level 4 training this Year, and Trust board training was completed in March 2022 by Named nurse for Safeguarding children and the adult safeguarding practitioner.

10.2 Adult safeguarding training

Training compliance continues to be monitored against the Trust target of 92%. Training figures for March 2023 were:

Level 1	**94%**
Level 2	**92%**
Level 3	**67%**
Level 4	**100%**
DoLs	**85%**
MCA	**81%**
Prevent	**92%**
Dementia	**95%**
Learning Disabilities tier 1	**92%**
Mental Health tier 1	**91%**

The Intercollegiate Document (ICD) Adult Safeguarding: Roles and Competencies for Health Care Staff states that one of the most important principles of safeguarding is that it is everyone's responsibility. Each professional and organisation must do everything they can to ensure that adults at risk are protected from abuse, harm, and neglect.

Level 1 & 2 Adult Safeguarding training – there has been a consistent level of staff compliance. The percentage throughout 2022/23 has been above 92% target.

Level 3 Adult Safeguarding Training is for all registered health care staff who engages in assessing, planning, intervening, and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). The requirement for Level 3 is a minimum of 8 hours of safeguarding learning over a 3-year period with a mixture of e-learning and face to face training expected.

The Adult level 3 Safeguarding training has been a continual focus during 2022/23 to improve the overall staff training percentage. There has been significant improvement from 36% in April 22 to 67% in March 2023.

The Adult safeguarding training passport is now in use across the trust and bespoke training sessions have already commenced across the trust to support improving staff competencies, knowledge, skills, attitudes & values in Adult Safeguarding Level 3. These are recorded in the training passports and on ESR.

Level 4 Adult training is for named professionals and is now at 100% compliance.

MCA/DoLS Training

DoLS training has increased to 85% at the end of March 2023 and MCA has increased slightly sitting at 81%. Although this has continued to be below target for 2022/23 there have been improvements made. The improvement is likely to be due to the implementation of the eLearning modules being available for clinical staff to complete. Application of knowledge is being tested via audit to understand areas for improvement.

A key focus will be continuing to improve compliance with combining MCA/DoLS training with level 3 for 2023/24.

Prevent training

Prevent training remains complaint with the 92% target for the end of 2022/23.

11. Quality assurance and audits

11.1 Audit

Assuring the quality of both professional practice and organisational processes and structures, depends on robust internal and cross-agency audit systems. The Trust's safeguarding web page is a great resource for staff and provides access to policies, procedures, contact numbers and up to date safeguarding information.

The following audits have been undertaken during 2022/23:

We continue to take part in the Monthly Female Genital Mutilation (FGM) Information Standard (1610 FGM prevalence data set collection) prevalence is checked monthly and should be uploaded onto their website. This Standard commenced in April 2014. However, to date no data has been uploaded from this Trust.

Monthly Paediatric documentation Audit - The aim of the audit is to provide assurance that we are highlighting on admission those children who may be high risk. Some aspects of the audit includes ensuring that we know if the child is on a protection plan; who the child's legal guardian is; that we are liaising with their social care workers and consent is gained to share information.

An DoLS documentation audit was completed in partnership with the ICS in 2022/23 across the Trust. The purpose of the audit was:

- To understand the extent to which the MCA/DoLs Policy has embedded in the organisation.
- To be able to provide assurance to the ICS and CQC that we are following the correct procedures.

The result from the DoLs documentation audit showed a wide variety on how well staff documented the steps needed to ensure the functional assessment of capacity is undertaken.

Since the audit further measures have been implemented to support staff. This has been through formal training and the safeguarding team feeding back to Ward Managers/Ward Sisters and attending ward meetings. In addition, the safeguarding team reviews the DoLs paperwork when an application has been submitted and is followed up with individual wards and practitioners.
The quality of Mental capacity assessments has varied, and it is proposed a separate audit on MCA forms is completed in 2023/24. The DoLs process is being followed but it was noted that some applications were not always being sent to the correct local authority. To provide more clarity for staff a DoLS application process sheet has been devised for staff to follow. By having a continual focus through audit there has been a significant improvement noted.

2022/23 saw the introduction of 6 monthly audits on Tendable (an electronic audit tool):

Tendable is an app based smart inspection tool for use in a variety of clinical settings, which allows users to complete quality inspections digitally and receive instantaneous reporting based on inspection results. The tool provides live automated reporting which enables users to immediately understand and report on the quality and safety of patient care, what is being done well and where improvements need to be made.

Under the heading of Safeguarding there are five audits

- General safeguarding audits - completed by the adult safeguarding practitioners to assess staff knowledge on how to make a referral and where to find relevant information.
- MCA/DoLS - completed by the adult safeguarding practitioners to assess staff knowledge on how to conduct a capacity assessment and when DoLS would be applied.
- Dementia Care – to assess staff knowledge of carer's passports and the butterfly scheme.
- Learning Disabilities – to assess staff knowledge of reasonable adjustments and awareness of the hospital passport.
- Paediatric Safeguarding completed monthly by nursing staff on paediatric ward to assess staff knowledge, completion of check list regarding any concerns, and whether there are involvement of services.

Tendable allows staff review and measure quality and safety standards through questioning and observations; it assists staff to continually monitor practice, create action plans to address gaps and identify themes and trends so that further improvements are undertaken, and shares best practice.

11.2 Assurance and Performance monitoring:

Quarterly safeguarding children and adult dashboard – the dashboards are populated quarterly and are shared with the ICS for them to monitor the Trust's safeguarding compliance.

Themes and trends analysis for safeguarding referrals and incidents recorded at RJAH are discussed quarterly with Shropshire ICS Adult Safeguarding lead.

An action plan has been developed to meet the requirements of the Safeguarding, Accountability & Assurance Framework (2022). This is reviewed by the Trust Safeguarding Committee quarterly.

12. Associated Risks

There are a total of eight related safeguarding risks on the Trust risk register a reduction of 2 from the previous year. All related risks are monitored through the Trust Safeguarding Committee on a quarterly basis.

13. Associated policies

Name of Policy	Owner/Author	Policy Review Date
Recruitment & selection	SP	01/06/2025
Employment checks policy	SP	01/03/2026
Wellbeing policy	SP	01/03/2026
Missing child & adult policy	SM/AW	01/01/2024
When a child dies	SM	30/04/2026
Managing Allegations	HR/SM/NB	16/09/2024
Guidelines for children who were not brought to appointments	SM	01/12/2024
Prevent Policy	SM/RK	01/04/2026
Restrictive intervention and clinical holding of children and young people	SM	18/11/2024
Protection and Safeguarding of Vulnerable Adults (Adults with care and support needs) Policy	KH/AW	01/01/2024
Shropshire multi Agency guidance and procedure (DOLS)	System	
Guidelines for Deprivation of liberty Safeguards (DOLS)	AW/KH	01/01/2025
Assessing Patient's Mental Capacity Policy	AW/KH	01/01/2025
Management of serious incident policy	D	31/10/2023
Chaperone Policy	LR	01/07/2024
Care of Adults with a Learning Disability on admission to RJAH	AW	01/03/2024
Safeguarding Supervision Policy (new)	AW	18/03/2024
Restrictive Practices Policy		01/07/2024

All associated policies are within date and available on the Trust Intranet.

14. Progress with the Key priorities for 2022/23

Update on Joint Adult & Children's Safeguarding Priorities for 2022/23		
Priority	**Objectives**	**Achieved**
Continue to Improve compliance with Level 3 Adult safeguarding training	• Update the safeguarding training directory to make it user friendly for staff to meet level 3 safeguarding training compliance. • Continue to monitor training levels monthly and develop an updated trajectory for achieving compliance target • Develop an administration role to assist in the coordination and recording of training	**Improved compliance seen in monthly safeguarding training report from 36% Apr 2022 to 67% Mar 2023. Further increase expected with decision to include MCA/DoLS.**
Continue to Improve Pre-operative pathway communication to identify Safeguarding and related concerns	• Increased training and education for pre-op MDT • Audit of pre-operative alert system and communication to wider organisation • Engage with implementation of new EPR system	**Partially achieved. Bespoke training provided. Pre-op alerts are now sent to Safeguarding team. Audit to be completed and further engagement with alert system on Apollo required.**
Monitoring our WNB and DNA policy	• Review administration process for sending out appointments • Conduct a repeat audit of processes followed when children are not brought to clinic • Continue to monitor figures in the paediatric forum and report to ICS in the safeguarding Dashboard	**Improved WNB % Monitored through safeguarding dashboard.**
Implementation of LPS	• Establish implementation group with upward reporting to Safeguarding Committee (SGC) • Increase organisational awareness of LPS in Q1/Q2 • Attend system wide multi-professional meetings to ensure collaborative approach • Review key documents (Impact assessment, Code of Practice, Training and Workforce strategy) and submit response to consultation	**Implementation of LPS paused nationally.**

Prioritise Domestic abuse training for this year's level 3 compliance for both adults and children	• Embed updates from the domestic abuse bill 2021 • Training should be accessed via Leap for Learning & Shropshire Joint training	**DA training to be included in Level 3 Safeguarding training.**
Nominate lead professional for Mental Health:	• Nominate a Lead practitioner for Mental Health • Consider mental health champions	**SLA agreed with MPFT for mental health liaison services and specialist advice.** **Policies require updating and training for mental health champion roles.**

14.1 Joint Adult and Children's Safeguarding Priorities for 2022/23

Two out of the six objectives were fully achieved for 2022/23. Three objectives were partially achieved. Implementation of LPS was delayed nationally.

- The Adult level 3 Safeguarding training has continued to be a challenge due to the number of staff requiring 8 hours training. Compliance has significantly increased from 36% in April 22 to 67% in March 23. A review of the Training Needs Analysis has agreed for MCA and DoLS training to count towards the Safeguarding L3 training hours for 2023/24 so further improvements are expected.

- Improve Pre-operative pathway communication to identify Safeguarding and related concerns has made some progress with safety questions being asked to patients and pre-op alerts include any safeguarding information and are now sent to the Safeguarding team. There is further education and training required for all members of MDT in pre-op to embed the changes in process. This is priority is being extended for 2023/24 to include early involvement of the Safeguarding team in MCSI admissions.

- The monitoring our WNB / DNA policy priority has progressed well and we have seen improvement overall. Administration processes are improved for sending out appointments and text reminders as well as ensuring the safeguarding systems are robust and followed through. The Alice ward clerk is also calling 72 hours before appointments to ensure attendance. The aim is to repeat the WNB audit in 2023/24.

- Domestic Abuse (DA) training has not been mandatory for staff during 2022/23 however this is being built in to the full day Adult Safeguarding training. Bespoke DA training sessions have been delivered in 2022/23 by the safeguarding team at teams request.

- Mental Health priority has been partially achieved with SLA being agreed and implemented in 2022/23. It remains a priority for 2023/24 with a focus on reviewing policies and considering the roles of Mental Health First Aiders/Mental Health champions.

14.2 Key Safeguarding priorities for 2023/24

Joint Adult & Children's Safeguarding Priorities for 2023/24		
Priority	**Objectives**	**Lead**
Continue to improve compliance with safeguarding training and to include Domestic Abuse training across the organisation to meet the target. **(rolled over from 2022/23 and extended)**	• Update the safeguarding training directory to make it user friendly for staff to meet level 3 safeguarding training compliance – MCA/DoLS training to be included in level 3 training from July 2023. • DA training sessions to be delivered by Safeguarding team. • New page on DA with updated resources for staff on intranet. • Consider joining MPFT safeguarding training dashboard	**Sara Ellis-Anderson**
Continue to improve communication to identify Safeguarding and related concerns across the patient pathway. Support enhanced communication using digital tools **(rolled over from 2022/23 and extended)**	• Audit of pre-operative alert system and communication to wider organisation to capture safeguarding concerns. • Safeguarding team involvement at MCSI safety meetings • Engage with implementation of new EPR (Apollo) and requirement for flagging system	**Sara Ellis-Anderson**
Ensure Mental Health policies are up to date and staff receive relevant training. **(rolled over from 2022/23 and extended)**	• Nominate a Lead practitioner for Mental Health on MCSI • Consider mental health champions across the organisation. • Review training available for Mental Health Champions • Ensure policies relating to Mental Health are up to date and disseminated	**Sara Ellis-Anderson supported by Anne Worrall**
Compliance with NHSE Learning Disabilities standards	• Improved scores in the disability and dementia domains on the PLACE audit for 2023 • Continued compliance with tier 1 LD and Autism awareness training and review of staff groups to undertake Oliver McGowan training. • Increased feedback from patients with LD, Autism • Increased access to specialist advice for LD and Autism	**Sara Ellis-Anderson supported by Rebecca Wright-Powell**
Increase awareness of Early help referrals	• Increase awareness for all professional groups of importance of early help referrals and the 'Think Family' approach. • Make every contact count. • Tabletop review of the 5 cases presented at the children's safeguarding summit.	**Suzanne Marsden**
Development of Safeguarding digital dashboard	• Safeguarding training and audit compliance as well as incidents reported monitored in one dashboard. • Support triangulation of safeguarding data	**Sara Ellis-Anderson**

Conclusion

This annual report provides evidence of progress with regard to safeguarding priorities in 2022/23, although we recognise that there is always more work to be done. Whist level 3 safeguarding adult training figures remain below target we have made significant improvements since last year. Increased availability of training and the addition of MCA/DoLS training hours will see further improvements in 2023/24.

The report demonstrates an increase in both adult and children safeguarding referrals in 2022/23 and an increase in contact with the organisation from distressed patients thought to be linked with increased waiting times for surgery as well as seeing an increase in complex mental health needs with our inpatients. Domestic abuse cases have seen an increase and therefore we have included domestic abuse training as one of our key priorities for 2023/24.

Leadership and governance arrangements continue to be strengthened with actions regularly monitored giving accountability within the Assurance Framework. We will continue to forge links with other local partnership agencies and contribute to cross board initiatives. The aim for 2023/24 is to have an integrated safeguarding digital dashboard where incidents, training and audits can be triangulated.

Our aspiration is to raise the profile of safeguarding within the organisation and work collectively towards becoming outstanding for 'Safe' within the CQC framework. This will ensure our staff are confident to access the right service at the right time, to ensure we play our part in keeping children and adults with care and support needs safe from harm.

Appendix A: Annual Training Report for Child Safeguarding & Adults at 31st of March 2023

Safeguarding Children and Young People Training Compliance - 31 March 2023

	Completed "in date" Child Protection Training Level 1			Completed "in date" Child Protection Training Level 2			Completed "in date" Child Protection Training Level 3			Completed "in date" Child Protection Training Level 4			Completed "in date" EPALS			Completed "in date" Prevent Training		
	3 yearly training			3 yearly training			3 yearly training			3 yearly training			4 yearly training			3 yearly training		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Finance and Planning Total	195	181	92.8%	0	0		0	0		0	0		0	0		199	178	89.4%
MSK Delivery Unit Total	641	616	96.1%	564	526	93.3%	27	25	92.6%	0	0		37	31	83.8%	659	608	92.3%
Nursing and Patient Safety Total	24	21	87.5%	9	6	66.7%	3	2	66.7%	0	0		0	0		24	23	95.8%
Office of the CEO Total	17	16	94.1%	2	2	100.0%	0	0		0	0		1	1	100.0%	17	16	94.1%
Office of the Medical Director Total	43	40	93.0%	6	6	100.0%	0	0		0	0		0	0		44	40	90.9%
Specialist Delivery Unit Total	439	421	95.9%	355	326	91.8%	49	44	89.8%	2	2	100.0%	19	16	84.2%	461	426	92.4%
Operations Total	153	144	94.1%	0	0		0	0		0	0		0	0		156	142	91.0%
People Total	42	40	95.2%	20	19	95.0%	2	2	100.0%	0	0		0	0		44	44	100.0%
Covid-19 Vaccination Centre	0	0		0	0		0	0		0	0		0	0		0	0	
TRUST WIDE TOTAL (Including Medical Staff)	**1554**	**1479**	**95.2%**	**956**	**885**	**92.6%**	**81**	**73**	**90.1%**	**2**	**2**	**100.0%**	**57**	**48**	**84.2%**	**1604**	**1477**	**92.1%**
Bank Staff	155	145	93.5%	116	107	92.2%	0	0		0	0		0	0		176	152	86.4%
TRUST WIDE TOTAL (including Medical and Bank Staff)	**1709**	**1624**	**95.0%**	**1072**	**992**	**92.5%**	**81**	**73**	**90.1%**	**2**	**2**	**100.0%**	**57**	**48**	**84.2%**	**1780**	**1629**	**91.5%**

Annual Safeguarding Report 2022/23

	Completed "in date" Adults Safeguarding Awareness Training Level 1			Completed "in date" Adults Safeguarding Training Level 2			Completed "in date" Adults Safeguarding Training Level 3			Completed "in date" DOLS Training			Completed "in date" Mental Capacity Act Training			Completed "in date" Prevent Training		
	3 yearly training			3 yearly training			3 yearly training			3 yearly training			3 yearly training			3 yearly training		
Unit	Number to complete	No's completed	% complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Finance and Planning Total	195	173	88.7%	0	0		0	0		0	0		0	0		199	178	89.4%
MSK Delivery Unit Total	641	614	95.8%	564	525	93.1%	285	183	64.2%	243	202	83.1%	349	274	78.5%	659	608	92.3%
Nursing and Patient Safety Total	24	20	83.3%	9	6	66.7%	4	4	100.0%	8	8	100.0%	8	8	100.0%	24	23	95.8%
Office of the CEO Total	17	16	94.1%	2	2	100.0%	1	1	100.0%	1	1	100.0%	2	2	100.0%	17	16	94.1%
Office of the Medical Director Total	43	36	83.7%	6	6	100.0%	0	0		16	15	93.8%	16	16	100.0%	44	40	90.9%
Specialist Delivery Unit Total	439	427	97.3%	355	330	93.0%	172	130	75.6%	164	138	84.1%	207	171	82.6%	461	426	92.4%
Operations Total	153	142	92.8%	0	0		0	0		0	0		0	0		156	142	91.0%
People Total	42	40	95.2%	20	20	100.0%	0	0		10	10	100.0%	10	9	90.0%	44	44	100.0%
Covid-19 Vaccination Centre	0	0		0	0		0	0		0	0		0	0		0	0	
TRUST WIDE TOTAL (Including Medical Staff)	**1554**	**1468**	**94.5%**	**956**	**889**	**93.0%**	**462**	**318**	**68.8%**	**442**	**374**	**84.6%**	**592**	**480**	**81.1%**	**1604**	**1477**	**92.1%**
Bank Staff	155	138	89.0%	116	100	86.2%	25	11	44.0%	0	0		4	3	75.0%	176	152	86.4%
TRUST WIDE TOTAL (including Medical and Bank Staff)	**1709**	**1606**	**94.0%**	**1072**	**989**	**92.3%**	**487**	**329**	**67.6%**	**442**	**374**	**84.6%**	**596**	**483**	**81.0%**	**1780**	**1629**	**92.0%**

	Completed "in date" Learning Disability and Autism Awareness			Completed "in date" Mental Health Tier 1			Completed "in date" Dementia Workshop		
	One Off training			3 Yearly			3 Yearly		
Unit	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete	Number to complete	No's completed	% Complete
Finance and Planning Total	199	183	92.0%	0	0		0	0	
MSK Delivery Unit Total	659	624	94.7%	570	532	93.3%	521	497	95.4%
Nursing and Patient Safety Total	24	23	95.8%	10	10	100.0%	9	9	100.0%
Office of the CEO Total	17	15	88.2%	2	2	100.0%	1	1	100.0%
Office of the Medical Director Total	44	41	93.2%	7	7	100.0%	5	5	100.0%
Specialist Delivery Unit Total	461	439	95.2%	361	337	93.4%	301	285	94.7%
Operations Total	156	148	94.9%	0	0		0	0	
People Total	44	41	93.2%	20	17	85.0%	20	19	95.0%
Covid-19 Vaccination Centre	0	0		0	0		0	0	
TRUST WIDE TOTAL (Including Medical Staff)	**1595**	**1497**	**93.9%**	**963**	**893**	**92.7%**	**857**	**816**	**95.2%**
Bank Staff	176	148	84.1%	114	98	86.0%	107	95	88.8%
TRUST WIDE TOTAL (including Medical and Bank Staff)	**1779**	**1643**	**92.4%**	**1084**	**991**	**91.4%**	**964**	**911**	**94.5%**

Learning From Deaths

0. Reference Information

Author:	Dr James Neil	Paper date:	20-7-2023
Executive Sponsor:	Dr Ruth Longfellow	Paper Category:	Governance and Quality
Paper Reviewed by:	Mortality Steering Group	Paper Ref:	To be inserted by the person collating the agenda
Forum submitted to:	Quality and Safety	Paper FOIA Status:	Full / Partial / Non-disclosure Delete as appropriate

1. Purpose of Paper

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

Learning from Deaths summary report to Q and S.

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

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

Deaths are reported through the Board of Directors.

They are also reported and discussed at the Multi-disciplinary Clinical Audit Meeting.

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

MSG report discussed at Patient Safety committee.

2. Executive Summary

2.1. Context

To report the current numbers and trends in Q1 for In-patient Learning from Deaths (LFD).

2.2. Summary

See Numbers Below.

2.3. Conclusion

No concerns or trends identified.

Learning from deaths (see below).

3. The Main Report

3.1. Introduction

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

3.2. Learning From Deaths Summary.

Date	Total In-patient Deaths	Number for case record (SJR) review	Death likely due to problems with care	Themes/Family feedback.	Coroner review.
April 2023	2	2	0	Both sudden deaths. No concerns.	One post-mortem: Natural causes unrelated to surgery. One form 100A.
May 2023	0	0	0	n/a	0
June 2023	1	1	0	Daughter stated he had had fantastic care in ME paperwork.	None required.

3.3. Associated Risks.

None.

3.4. Next Steps

Discussions complete with SATH concerning a link with their Medical Examiner and Bereavement system. This service likely to commence 2023. SATH is currently awaiting overall clearance from NHSE to expand to trial group including us, a GP practice and the hospice. Date to start service 1st June 2023.

LFD lead now working as a Medical Examiner at SATH.

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

1st Death using ME service processed late June.

Also attends Shropshire LFD group and West Midlands LFD forum (currently west midlands only due to staffing issues at ICS in Shropshire). (This meeting has been stood down by ICS due to lack of staff).

3.5. Conclusion

Positive learning:

1: Excellent use of the MDT including nursing staff, physiotherapists, and clinical psychologists in complex case.

Special mention for organising the remote access viewing of his mother's funeral and involvement of the psychology team to deal with issues around this.

2: Excellent care from admission onwards. Good documentation of effective consent and RESPECT discussions carried out in a timely manner.

Procedural care of a high standard and approach to patient deterioration also timely and following guidelines.

3: Good MDT assessment. Good liaison with family. Appropriate and realistic plans for discharge. No issues related to death.

This is planned to be re-enforced by a new EOL group to firm up policies and links with hospice etc for training. (Run by Karen Shepherd).

Negative learning:

Nil.

Plan going forward to use NHSE dashboard to generate LFD reports, although these are not designed for our limited numbers per se. (Not currently available due to change in IT system over December).

Appendix 1: Acronyms

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

Chair's Assurance Report - Quality and Safety Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	06 September 2023
Executive Sponsor:	Paul Kavanagh Fields, Chief Nurse and Patient Safety Officer	**Paper written on:**	03 September 2023
Paper Reviewed by:	Lindsey Webb, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the Quality and Safety Committee. The Board is asked to consider the recommendations of the Quality and Safety Committee.

2. Context

2.1 Context

The Trust Board has established a Quality and Safety Committee. According to its terms of reference: *"The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes, and controls in place throughout the Trust to:*

- *Promote safety and excellence in patient care.*
- *Identify, prioritise, and manage risk arising from clinical care.*
- *Ensure efficient and effective use of resources through evidence based clinical practice".*

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Quality and Safety Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from Quality and Safety Committee

This report provides a summary of the items considered at the Quality and Safety Committee on 24 August 2023. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT – The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

Terms of Reference

Following a review of the Committee membership, the terms of reference were considered and supported by the Committee subject to amendments noted with in the meeting. The Committee recommends the Board approves the revised terms of reference for the Quality and Safety Committee.

Lucy Letby Case
The Committee heard an overview from the executive team discussions following the recent verdict in this case which will be further discussed at Board. The Learning from Deaths policy has been recently reviewed and updated. The Committee requested a review of deaths over the past twelve months to gain further assurance of compliance with this policy. This will include an overview of the process following all deaths.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Integrated Performance Report
Following a discussion relating the key performance indicators, the Committee asked for further assurance on the following areas:

- Delayed discharges - whether there are any themes across the system regarding delayed discharges. Assurance was provided on the process in place for delayed discharges and that relationships are being built across local areas, the most challenging currently being Powys.
- Complaints - the Trust confirmed that meetings have been arranged with patients who have re-opened complaints.
- The Committee is awaiting the final report on the Never Event which occurred in July, this has been scheduled for presentation at the next meeting (September).
- Safe staffing – a group has been established to undertake a nursing skill mix review

CIP Quality Impact Assessment
It was noted that all CIP QIA have been completed for Specialist Unit and after completion of MSK CIP QIAs, there are no areas of concern to escalate. Following discussion of the report, the Committee asked for the following to be considered ahead of the next report:

- Relate the report more to the quality and safety agenda as the current report primarily relates to finance and including the risks and mitigations identified.
- There is concern around the timely completion of QIAs for CIPs and for the next budget setting review the committee requested completion of QIAs prior to implementation.

IPC Quality Report (Q1)
The Committee considered the circulated report and noted the following:

- PIR conducted for C. Diff case with actions identified.
- IPC Fayre was held in May which was well attended.
- 6 SSIs declared in Q1.
- Outlier letter received regarding hip replacement SSIs all of which have been reviewed with no concerns identified.
- Concerns around cleaning standards in TSSU A and B which were addressed within a week with reauditing scores sustained at 95%.

IPC Report Submission Review
The oversight of IPC had been realigned to the Quality and Safety Committee to oversee the recent improvement programme. In light of the progress made and also due to timing of meetings, the reports received are 1 month behind the Committee agreed to revert to quarterly reports from IPC with exceptions reported in month.

Chair Report | IPC Meeting
The Committee asked for further assurance relating to staff raising concerns around IPC and that if financial support is required to address an issue, a process is in place for quick and efficient access.

Chair Report | Patient Safety Meeting
Further information on pressure ulcers to clarify which were hospital acquired and avoidable/unavoidable are to be included within the future reports.

3.3 Areas of assurance

ASSURE - The Quality and Safety Committee considered the following items and did not identify any issues that required escalation to the Board.

Corporate Risk Register
The Committee received the revised Corporate Risk Register along with assurance relating to the review and reporting process of risks. To accommodate further progress and assurance, the Committee suggested the report should include which risks have been reduced since the previous report with a recommendation for made to the Committee for consideration.

Specialist Unit Quality Presentation and MSK Unit Quality Presentation
The Committee were content with the information presented. It was agreed that in future only exceptional items are presented to the committee via the IPR as currently there is duplication with the Trust Performance and Operational Improvement Group.

Harms Review Presentation
The Committee were assured with the processes in place to review patients and commended the collaborative working with ROH. It was noted that methods for clinical prioritisation is being discussed within the different units. Due to the low numbers of moderate harms being identified, the Trust have reviewed the process from 3-week to 6-week review for patients on a PIFU pathway. The committee agreed for the presentation to be shared on a 6-monthlybasis.

Visual Infusion Phlebitis Scores (VIPS)
There has been a significant improvement in the completion of VIPS scores over the last 3 months, it was noted that scores have increased from 26% to 95.7% to date. An action log has been created to support the compliance. It is recommended this report goes back to IPCC Meeting and any escalations to be brought to this Committee.

CQUIN Update
The Committee were assured with the CQUIN update, with the Trust reported that all the relevant CQUINs were achieved within Q1.

Serious Incidents, Never Events and Learning from Incidents
The Committee took assurance that from the 22 open actions there are none overdue and all are on track for completion and presentation at the Committee in due course. The committee were reassured that training is implemented into areas which have reported a serious incident or never event and it was noted that training and education are being reviewed for the whole Trust and whether anything more could be provided.

Assurance was provided that there is an MDT approach to completion of neurological assessments on wards to ensure patients have the right examinations at the right times.

PSIRF Implementation
The Committee were assured with the process in place for the PSIRF launch. The Committee will continue to gain verbal updates at future meeting. The PSIRF framework and policy will be presented to the Public Board of Directors meeting in September.

Patient Experience Report (Q1)
The Committee welcomed the first quarterly report for patient experience and were assured by the detail provided within the paper. It was noted that all complaints have an action place in place, friends and family test results were high with 98% of patients rating experience as good or very good. The top theme for complaints remains cancellations.

National Inpatient Survey 2022
The information was shared with the Committee however the results are currently embargoed and will be shared via the Public Board meeting in due course.

IPC Improvement Plan
The Committee noted the action plan. There is one action currently behind plan which relates to fit mask testing, an options appraisals have been submitted for consideration.

Chair Report | Clinical Effectiveness Meeting
Clinical Audit and Clinical Effectiveness Meetings will be combined from October 2023 to improve attendance. The meeting will seek to gain assurance around clinical audit and NICE Guidance.

Chair Report | Health Inequalities Group
The first meeting was held with a focus on reviewing progress to date and establishing programmes of work for the future. The Committee were assured with the progress against the action plan which was compiled following the 2022/23 self-assessment. The Trust confirmed that a collaborative meeting has been scheduled with Powys.

The following items were **deferred** to the next meeting:

- Modern Slavery Act 2015
- Quality Spot Checks (internal audit report)

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps.
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.

1. Constitution

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

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors (including the Associate Non-Executive Directors) and the Executive Directors of the Trust and shall consist of:

- Up to four Non-Executive members
- Chief Medical Officer
- Chief Nurse and Patient Safety Officer
- Chief Operating Officer ~~or Unit Assistant Chief Nurses~~

Non-~~e~~Executive members may be drawn from the Non-Executive Director membership of the Board or the Associated Non-Executive Directors.

In exceptional circumstances a deputy may attend in place of an Executive Director. The nominated deputy can act on behalf of the absent Executive Director. This is to be noted at the beginning of the meeting.

The Board of Directors will appoint a Committee Chair from the Non-Executive Director members of the Committee. In the absence of the appointed Chair, the Committee will appoint another Non-Executive member to chair the meeting.

A quorum will be two Non-Executive members and two Executive members. Deputies representing Executive members will count towards the quorum but at least one of the Executive members must be drawn from the listed membership.

3. Attendance

The Trust Secretary and the Head of Clinical Governance and Quality will be expected to attend each meeting.

The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Chief Executive Officer will receive a standing invitation to attend.

The ICB will receive a standing invitation to send a representative of the ICB Quality Team.

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

4. Frequency of meetings and meeting administration

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

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

5. Authority

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

6. Reporting

A written Chair's Assurance Report will be presented to the Board no later than the Board meeting the following month (or the soonest available meeting if a Board meeting does not fall that month). The Chair's Report shall:

1. Alert the Board to any issues that:
   - Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address; OR
   - Require the approval of the Board for work to progress.
2. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
3. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

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

7. Key responsibilities

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".

- The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust to:

- Promote safety and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care
- Ensure efficient and effective use of resources through evidence based clinical practice

- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.

- To consider NHSE Quality Governance Framework in the delivery of its key responsibilities

- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.

- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.

- To receive reports from the following assurance meetings:
  - Safeguarding Meeting
  - Infection Prevention and Control Meeting
  - Clinical Effectiveness Meeting
  - Patient Safety Meeting
  - Patient Experience Meeting
  - Medical Devices Meeting
  - Health and Safety Meeting
  - Paediatric Meeting
  - Drugs and Therapeutics Meeting
  - EPRR Group

- The Quality and Safety Committee shall review the draft Quality Accounts before submission to the Trust Board

- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.

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

- Incident reporting and investigation
  - Monitoring the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.

- Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.

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

- Review of CQUIN requirements

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

Trust Board - People & Workforce
July 2023 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

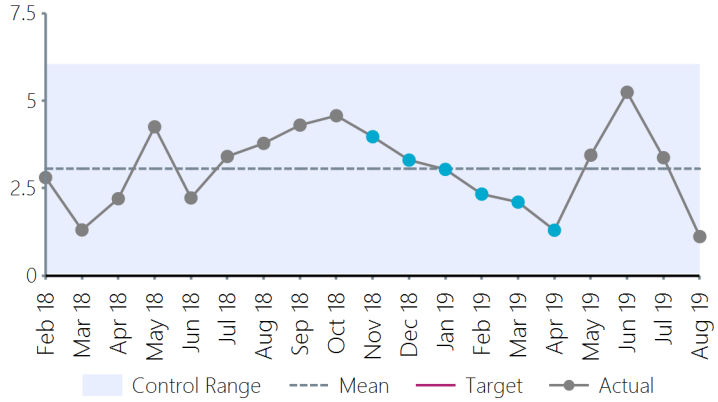
Some examples of these are shown in the images to the right:

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

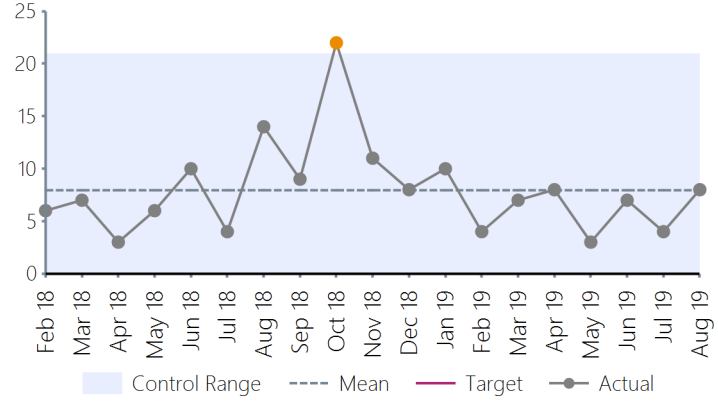
b) shows a point of concern sitting above the control range.

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.

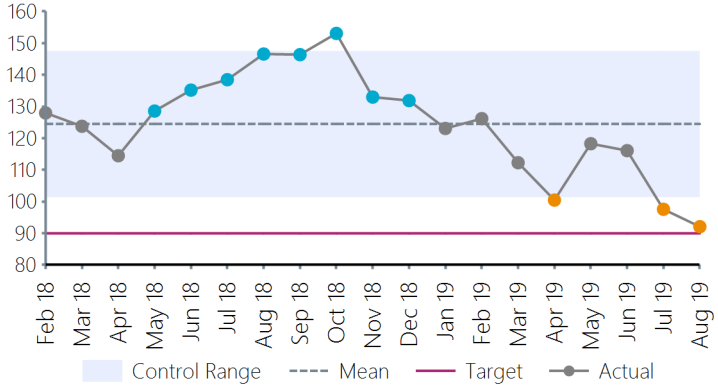
a)



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.

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Staff

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Sickness Absence	5.59%	4.66%		L	Moving Target	+	
Staff Turnover - Headcount	12.00%	10.29%			Moving Target		
In Month Leavers	15	21			Moving Target	+	
Vacancy Rate	8.00%	6.40%			?		14/03/19

Summary - Caring for Finances

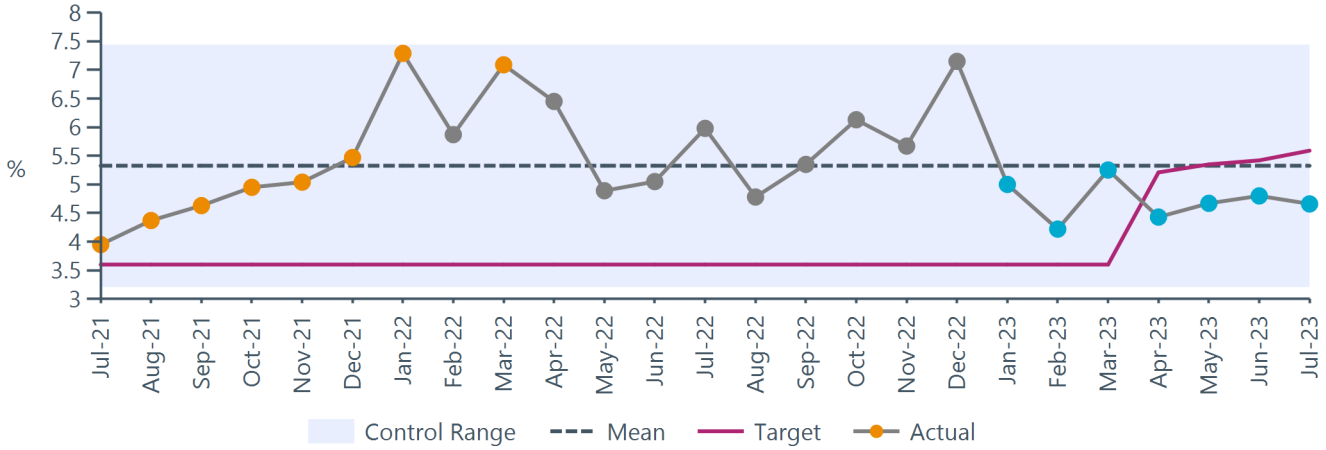
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Agency Core - On Framework	258	185		N/A to SPC	Moving Target		
Agency Core - Off Framework	0	44		N/A to SPC	F	+	

Sickness Absence

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

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
5.59%	4.66%		Moving Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Metric has had a target change from April-23.

Narrative

The sickness absence rate for July is reported at 4.66%. It is included as an IPR exception this month as the SPC graph indicates special cause variation of an improving nature with the last seven data points, since January, all consecutively below the mean.

The top three reasons for absence Trust-wide were:
* Anxiety/stress/depression/other psychiatric illnesses
* Other musculoskeletal problems
* Back Problems

Actions

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
5.98%	4.78%	5.35%	6.13%	5.67%	7.15%	5.00%	4.22%	5.25%	4.43%	4.67%	4.80%	4.66%

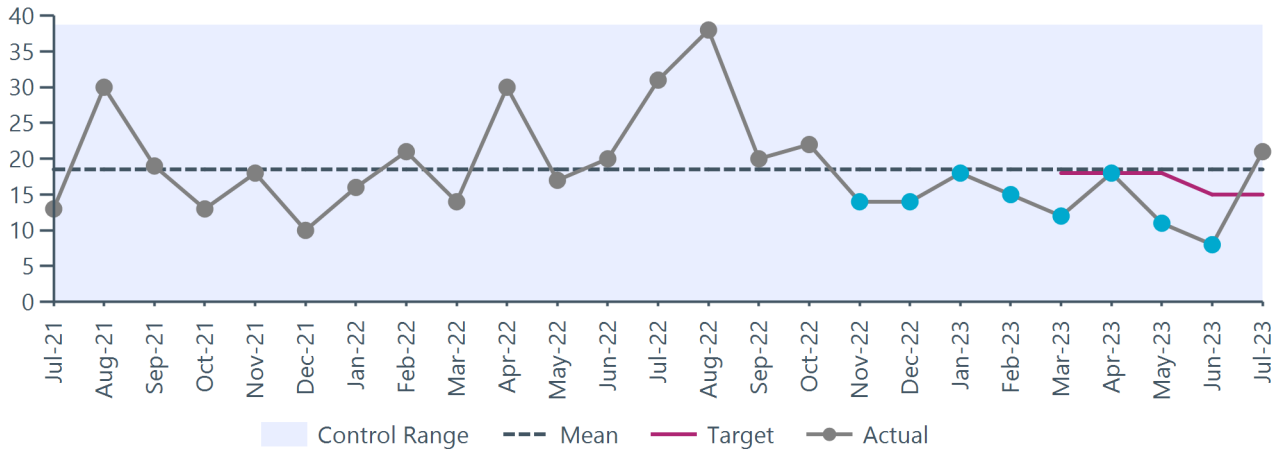
- Staff - Patients - Finances -

In Month Leavers

Number of leavers in month 217809

Exec Lead:
Chief People Officer

Target/Plan	Latest Value	Variation	Assurance
15	21		Moving Target



Trajectory

What these graphs are telling us

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

Narrative

There were 21 staff that left the Trust in July. They were from the following areas: MSK Unit (10), Specialist Unit (8), Corporate Areas (3).

The reasons for leaving were:
* Retirements with no return to work (5)
* End of fixed term contracts (3)
* Voluntary resignations (13) - Of these, 2 were due to health reasons, 2 were to undertake further training and 2 were due to work life balance. The remaining were due to "Other/not Known" reasons.

Actions

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
31	38	20	22	14	14	18	15	12	18	11	8	21

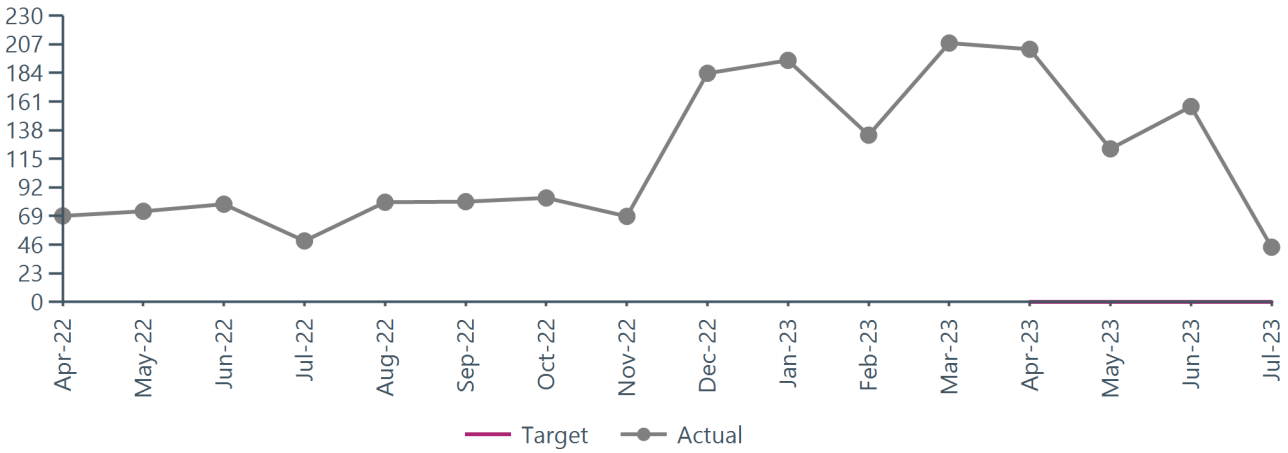
- Staff - Patients - Finances -

Agency Core - Off Framework

Annual ceiling for total agency spend introduced by NHS Improvement - Core Agency Off Framework 217817

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
0	44	N/A to SPC	F



Trajectory

What these graphs are telling us

This measure is not appropriate to display as SPC. Metric is consistently failing the target.

Narrative

Off framework usage continues to reduce and now 19% of total in month.

Actions

Enhanced sign off arrangements for off framework agency shifts. Task and Finish group established to oversee agency reduction plan.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
49	80	80	83	68	183	194	134	208	203	123	157	44

- Staff - Patients - Finances -

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

0. Reference Information

Author:	Liz Hammond, FTSU Guardian	Paper date:	06 September 2023
Executive Sponsor:	Paul Kavanagh-Fields Chief Nurse & Patient Safety Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee – July 2023	Paper Ref:	N/A
Forum submitted to:	Board of Directors – Public Meeting	Paper FOIA Status:	Partial

1. Purpose of Paper

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

This paper is provided as a summary on Freedom to Speak Up (FTSU) activity for Q1 2023/24. The Board is asked to note the content and agree any subsequent recommendations / actions.

The report was considered at the People and Culture Committee meeting in July 2023.

1.2. Context

The Trust Board should seek assurance from the FTSU Guardian and Executive Lead that staff are confident in the process of Speaking Up and that appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues and that learning is being identified and shared across the Trust.

2.2. Summary

The number of cases raised, this year, has remained in line with the previous year's quarter. An additional 7.5 hours has been allocated for the FTSUG since the beginning of May. The FTSU Champions have reported four concerns raised in accordance with the National Guardian guidelines.

This quarter FTSU has received a total of 6 concerns. Five concerns required advice and direction. Theses are recorded as 'other' on the national Guardian data base. One case of bullying and harassment has been raised.

2.3 Conclusion

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

2. The Main Report

2.1. Introduction

The Trust board should seek assurance from the FTSUG and Executive Lead that staff are confident in the process of Speaking Up and that appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues and that learning is being identified and shared across the Trust.

2.2. Assessment of cases

This 1st Quarter, we have received six concerns. Five of the concerns raised were looking for advise around processes. The sixth concern related to bullying and intimidation by colleagues.

Four of the concerns were raised via the Champions.

Data For Quarter	April 2023- March 2024			
Organisation	Robert Jones & Agnes Hunt Orthopedic NHS Foundation Trust			
Size of organisation	Small Under 5,000			
Region	Midlands			
	April-June	**July-Sept**	**Oct-Dec**	**Jan-March**
Number of cases brought to FTSUGs per quarter	6			
Numbers of cases brought by professional group				
Allied Health Professionals	0	0	0	0
Medical and Dental	0	0	0	0
Registered Nurses and Midwives	2	0	0	
Administrative and clerical	4	0	0	0
Additional professional scientific and technical	0	0	0	0
Additional clinical services	0	0	0	0
Estates and ancillary	0	0	0	0
Healthcare scientists	0	0	0	0
Students	0	0	0	0
Not Known	0	0	0	0
Other	0	0	0	0
Of which there is an element of				
Number of cases raised anonymously	0	0	0	0
Number of cases with an element of patient safety/quality	0	0	0	0
Number of cases with an element of worker safety or wellbeing	0	0	0	0
Number of cases with an element of bullying or harassment	1	0	0	0
Number of cases with an element of other inappropriate attitudes or behaviours	0	0	0	0
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (	0	0	0	0
Response to the feedback question,				
'Given your experience, would you speak up again?				
Total number of responses				
The number of these that responded 'Yes'	1	0	0	0
The number of these that responded 'No'	0	0	0	0
The number of these that responded 'Maybe'	0	0	0	0
The number of these that responded 'I don't know'	0	0	0	0

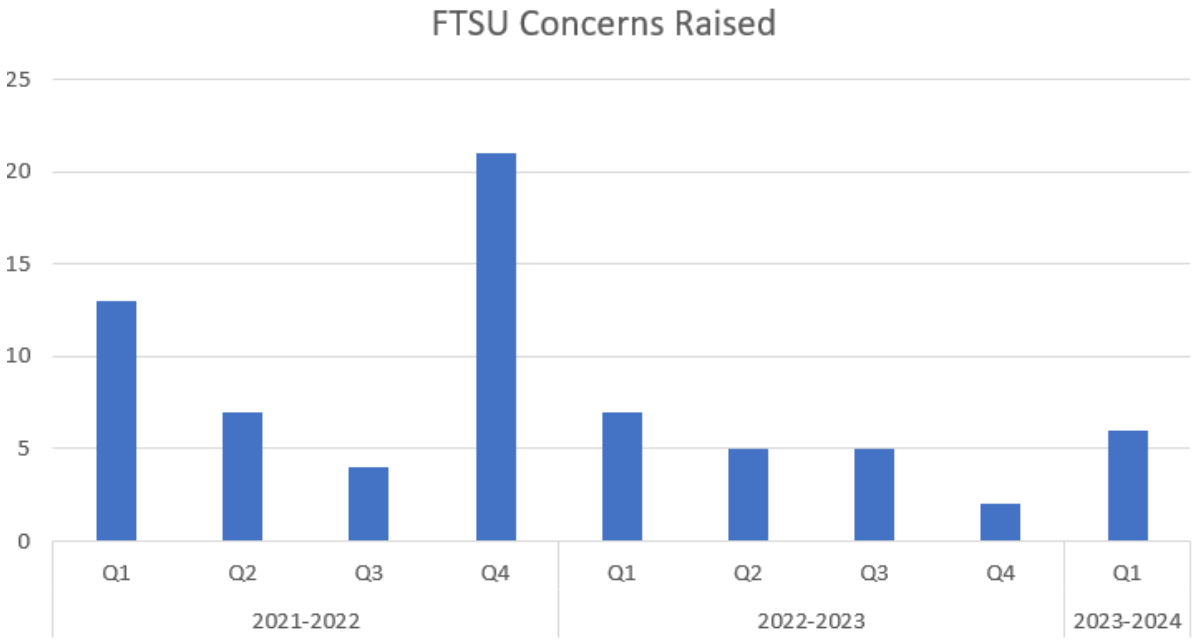
Until the end of Quarter 1, April – June 2023
there is one case that remain open from a previous quarter.

Reasons for cases remaining open are: -

The outstanding case is being actively addressed and awaiting the feedback from the investigations.

Comparison of data

The number of concerns raised, is in line with Q1 of last year where seven concerns where made There is only one case which remains live.



The National Guardian Data base for Q4 has not been updated and therefore the comparison with peer hospital could not be correlated.

The NGO have changed the type of information that they share. Instead of been able to see how many patient safety issues, bullying and harassment, worker safety and number of anonymous cases raised at each hospital they have changed this to the number of cases raised per quarter for each hospital.

The Model Health data for FTSU is only available for Q2, 2022, which has already been submitted in a previous report.

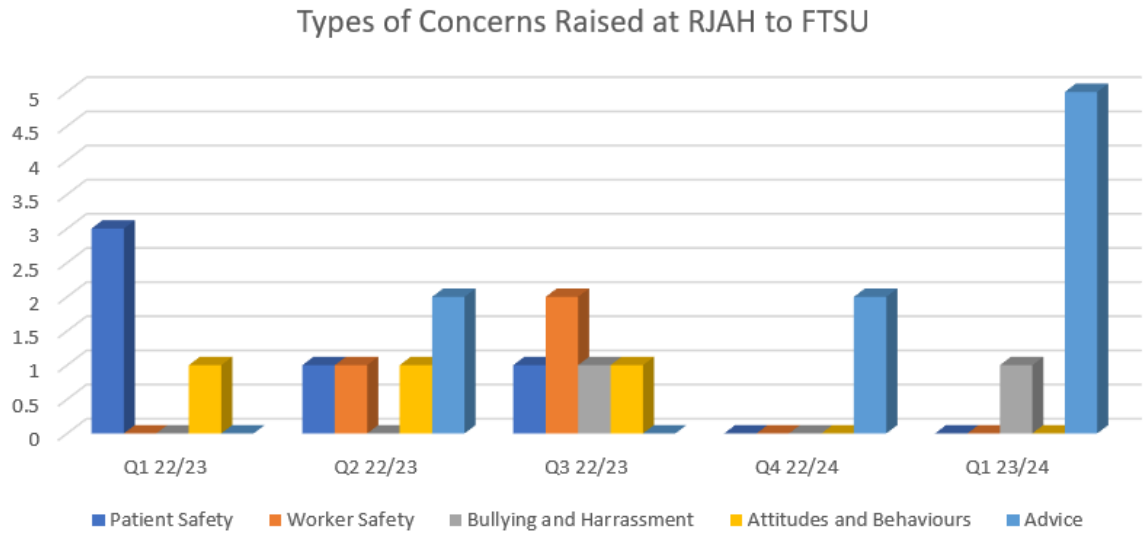
National, over 25,000 cases were brought to Freedom to Speak Up guardians throughout 2022/23 - a 25% increase on the previous year.

- Nearly a third of cases included an element of inappropriate behaviours and attitudes. A decrease in the percentage of cases related to bullying or harassment (31.8 percent in 2021/22 to 21.7 percent in 2022/23) can be attributed to cases being reported against this new category.
- Over a quarter of cases included an element of worker safety or wellbeing.

- Nineteen per cent of cases involved an element of patient safety/quality this year, up from 18.8% in 2021/22.

Themes /Triangulation with Datix

FTSU has been contacted by 6 members of staff this quarter. Five different staff concerns required advice. The sixth case related to a bullying and intimidation by colleagues, this has been addressed by their manager.



Patient Safety

There have been no patient safety concerns raised this quarter.

The datix system indicates that there have been 92 medication incidents, 42 Infection Prevention and Control incidents, 28 patient slips and 27 pressure ulcers.

Bullying and Harassment

There has been one bullying and harassment, concern raised this quarter.

The Trust Datix system has captured zero cases of bullying behaviour of staff to staff, within this quarter.

Worker Safety

RJAH FTSU has not received any worker safety concerns. The Trust Datix has had 54 Health and Safety incidents reported.

Learning and Improvement

Learning and improvement is a challenge as may concerns raised are often individual difficulties and queries.

A Speaking Up and Listening Up presentation has been developed for managers and can be adapted for all staff members. This presentation looks at the barriers to speaking up and the pitfalls when listening up. It also discusses the tools to use when listening up and encouraging Staff to speak up.

FTSU is triangulating the RJAH FTSU data with Datix.

It would be advantageous for the Trust to make it mandatory for all staff to complete the Feedback HEE training package. This gives the Trust assurance that all staff are aware of FTSU.

The FTSUG attends monthly regional meetings and events organised by the NGO. This, as well as the NGO bulleting enables the Guardian to keep up to date with developments in the FTSU area, which in turn supports the handling of concerns effectively.

All concerns raised have been responded to within 48hrs and escalated if required or signposted to the appropriate department.

FTSU face-to -face induction training has resumed since April 2023

Feedback

FTSU contact the person who raised the concern to check on how they are and to ascertain if they have received additional feedback from Managers.

Correspondence is also sent to the person dealing with the concern and asked to update and feedback actions and learning achieved.

One member of Staff supplied feedback in quarter 1. They were pleased with the support they received.

An intranet page, on Percy, specifically for FTSU is available for information and contact details of the Guardian and Champions.

Posters introducing our Champions and Executive leads have been produced and distributed around the hospital.

There have been no cases of anyone, who has raised a concern, reporting that they have suffered detriment due to speaking up in quarter one.

2.3. Actions to improve FTSU culture.

Improve the psychological safety around Speaking Up and No Blame Culture by Executives promoting the FTSU service, engagement with staff with walk abouts, and responding positively and productively when concerns are raised.

Posters identifying Exec Lead. Non-Exec, Guardian and Champions have been produced. Each department will receive a copy of these posters.

To improve the skills, knowledge, and capability of workers to speak up Speak up and Listen Up sessions are required in all departments. Staff need to be given the tools to enable them to Speak up.

Making HEE FTSU training mandatory would be advantageous for the Trust.

A visible presence of the FTSUG around the Trust. At the present time there is no designated area where Staff can confidentially speak to the Guardian or a Champion. A request for a dedicated room has been submitted.

Engagement with managers to support the FTSU Guardian to hold listening up and feedback sessions with all departments. Presentation, arranged for SNAP meeting.

Increased triangulation of data is required, with the quality and inclusion.

2.4. Recommendation

The Trust has a FTSU Action Plan pertaining to the self-assessment. However, with a renewed focus on improvement the speaking up culture of the Organisation, there are further recommendations to consider,

- All managers to feedback and liaise with the FTSUG about actions and learning to provide a feedback loop and share learning experiences.
- A visible presence of the FTSUG around the Trust and a dedicated office for FTSU so that staff can speak to the FTSUG or Champions.
- Consider whether FTSU HEE training packages should be mandated.
- Consider enhanced, bespoke FTSU training for all Managers and Staff.

- **2.5 Conclusion**

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

Safe Working Hours: Doctors in Training Q1 2023/24

0. Reference Information

Author:	Chris Marquis, Guardian of Safe Working	Paper date:	06 September 2023
Executive Sponsor:	Ruth Longfellow, Chief Medical Officer	Paper Category:	Governance and Quality
Paper Reviewed by:	People and Culture Committee – July 2023	Paper Ref:	N/A
Forum submitted to:	Board of Directors (Public)	Paper FOIA Status:	Full

1. Purpose of Paper

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

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

The paper was presented to the People and Culture Committee in July.

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 July 2023 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.

Safe Working Hours: Doctors in Training Q1 2023/24

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 and annual 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 June 2023

Specialty	Contract	Headcount
Orthopaedics	Training posts	18
	Of which Doctors in training on 2016 contract	17
Rehabilitation/Spinal Injuries	Training posts	2
	Of which Doctors in training on 2016 contract	0

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)

Mar 23	3
Apr 23	3
May 23	3
Jun 23	3

Vacant shifts

Mar 23	7
Apr 23	14
May 23	14
Jun 23	4

Total cost - £23190

Medicine

Number of Vacancies (12 posts)

Mar 23	1
Apr 23	1
May 23	1
Jun 23	1

Vacant shifts

Mar 23	9
Apr 23	20
May 23	18
Jun 23	9

Total Cost £28072.50

MCSI

Number of Vacancies (9 posts)

Mar 23	0
Apr 23	0
May 23	0
Jun 23	0

Vacant Shifts

Mar 23	14
Apr 23	0
May 23	0
Jun 23	0

Total cost - £ 3500

Long Term Vacant Shifts

MCSI has no vacancies

T&O has three vacancies

Medicine has a single vacancy

3.2.5 Fines

None – please see exceptions report section 3.2.2

3.3 Challenges

3.3.1 Engagement

Trust induction is attended.

Whilst the Juniors are happy with their working hours, concerns regarding training are significant. Cancelled lists and pressure on activity add to these concerns – this is ongoing.

Concerns have been raised regarding Juniors covering weekend work, now this is being

extended to Sundays. Careful discussions with Medical Staffing, relevant managers and the Juniors have taken place to ensure we are all fulfilling our contractual obligations. A draft flow chart to try and help decision making has been produced and is included in the appendix.

3.3.2 Software System

We still do not have a go live date.

Associated Risk

As previously discussed, appropriate focus on training needs to be ensured. Cancelled lists with sickness and staffing issues has significant impact not only on activity and waiting list issues, but also surgical training.

Juniors undertaking extra work both within and potentially external to the Trust need to ensure they are compliant with the terms of their contract. This applies equally to the Trust. We need to ensure that signed exemptios to EWTD are kept centrally and easily accessible.

Next Steps

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

3.4. Conclusion

The Trust continues to see no exception reports or fines.

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

Christopher Marquis

Guardian of Safe Working

EDI Strategy

Committee / Group / Meeting, Date

Board of Directors (Public Meeting), 06 September 2023

Author:	Contributors:
Name: Denise Harnin Role/Title: Chief People and Culture Officer	Caroline Nokes-Lawrence, Head of ICB People, OD and Inclusion, Staffordshire and Stoke-on-Trent ICB

Report sign-off:

Denise Harnin, Chief People and Culture Officer
People and Culture Committee, 24 August 2023

Is the report suitable for publication?:

Yes

Key issues and considerations:

The Board is presented with the final version of the Trust's EDI Strategy.

The Strategy is presented with an Action plan, which details objectives to be achieved over the next few years. The Strategy and Action plan ensures that the Trust's compliance with mandated EDI publictions and future development of Staff Networks and EDI developments, can be easily reviewed as part of the evolvement of EDI work objectvies.

Strategic objectives and associated risks:

The EDI Strategy presents an opportunity to deliver on strategic EDI objectives in line with the NHS Long Term Workforce plan and NHS equality, diversity, and inclusion improvement plan. This strategy will deliver against the system and Trust's strategic objectives.

- Effectiveness of engagement with the workforce
- ED & I capacity and capability

Recommendations:

The People and Culutre Commtee recommend the Board approved the EDI Strategy and Action Plan, with a view to launching to managers and staff.

Report development and engagement history:

The EDI Strategy sets out a clear vision for the Trust, but also links to the ICS for delivery of system wide actions and objectives

The Strategy was produced, following two staff listening events, which captured engagement and feedback from a variety of staff groups,and those with protected characteristics.

Next steps:

Further work to socialise the EDI Strategy will be required, and the intention is for a launch via all staff comms, with the introduction of regular EDI newsletters to keep staff up to date on the implementation of actions and objectives. Full engagement will continue throughout the year, so that the Strategy is owned, understood and embedded in the Trust's culture.

The Strategy and Action Plan will be regular reviewed at the Equality Meeting

Acronyms

Acronym A	**Equality Diversity and Inclusion (EDI)**

EDI Strategy

1. Background / context

1.1 The People and Culutre Committee have previously received an update on the development of the Inclusion Strategy

1.2 The Inclusion Strategy provides a basis for the development and maturity of the Trust's commitment to it's EDI objectives, providing a platform for continuous review and implementation of key workstreams

1.3 The Trust has identified that the EDI objectives are much wider than the mandated national requirements. The development of the Strategy and Action plan, provide great opportunity to build on wider achievements and support to the workforce on inclusion objectives.

2. Key Issues and Considerations

2.1 The Board is asked to note that the Inclusion Strategy has been developed as a result of staff engagement and feedback. This is supported by the People and Culture Commmittee following discussion at the August meeting.

2.2 Embedding and socialising the Inclusion Strategy and Action Plan, ensures the workforce are assured of an inclusive and open culture on which to develop future recommendations and actions

3. Proposed next steps

3.1 The Inclusion Strategy and Action Plan, needs to be approved or feedback incorporated from the Committee. Thereafter a specific objective around EDI is that it is published, shared widely and links in with the ICS system objectives.

4. Recommendation

The Board are asked to;

[I] Approve the Inclusion Strategy and Action Plan, with a view to any final comments before publication

[II] be assured that the Chief People and Culture Officer has priortised the Trust's work on EDI and developing a specific workstream around EDI, culture and engagement and learning and development, which will sustain and mature the Trust's strategic focus on these objectives

equality
diversity
inclusion

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

Inclusion Strategy

2023–26

www.rjah.nhs.uk

Contents

Foreword by the Chief Executive and Chair

Stacey Keegan and Harry Turner

It is a huge privilege to lead the Trust on our EDI journey. An exciting journey, and one we'd like to take everyone on, our colleagues, patients, visitors, and partners.

We are extremely proud of how we are embracing inclusion and of our achievements so far; however, there is always more that we can do. As we work together, we should continue to hold our belief that equality, diversity and inclusion is an intrinsic part of the Trust's organisational culture.

We believe that our Strategy will help to address inequalities, spread good practice, and improve outcomes for patients, carers, and staff across our Trust and local communities.

This strategy sets out our vision, aims and objectives to create a fair, and equal culture across the Trust in the next three years.

"Inclusive leaders take action to create, change and innovate while balancing everybody's views and needs. They have the courage to take conscious steps to break down barriers for all people in society" – this will be the Boards' promise as we work together.

"They actively seek difference, invite and welcome everyone's individual contribution, and take steps to seek out full engagement with the processes of decision-making and shaping reality" – this will be the Boards' mission as we work together.

Our Staff Listening Events in June 2023 have helped shaped this Strategy to be truly inclusive and accessible to all.

> *They have the courage to take conscious steps to break down barriers for all people.*
>
> **– Stacey Keegan**
> Chief Executive

Harry Turner, Chairman of the Board of Directors & Stacey Keegan, Chief Executive

Links to inclusion Strategy across the NHS

The NHS must welcome all, with a culture of belonging and trust. . .

We must understand, encourage and celebrate diversity in all its forms.

Source: NHS People Plan 2020

We are committed to providing a working environment that is welcoming, inclusive, respectful and is free from unlawful discrimination.

Our Inclusion Strategy will continue to align to the National NHS Inclusion agenda through the work of the NHS People Promise and aligned to the regional Integrated Care System (ICS).

NHS People Plan

The People Promise in the NHS People plan is 'Our People Promise are what we should all be able to say about working in the NHS, by 2024'. A pledge has been made to ensure that colleagues, line managers, employers and central bodies work together to make our ambitions a reality for all of us, within the next four years.

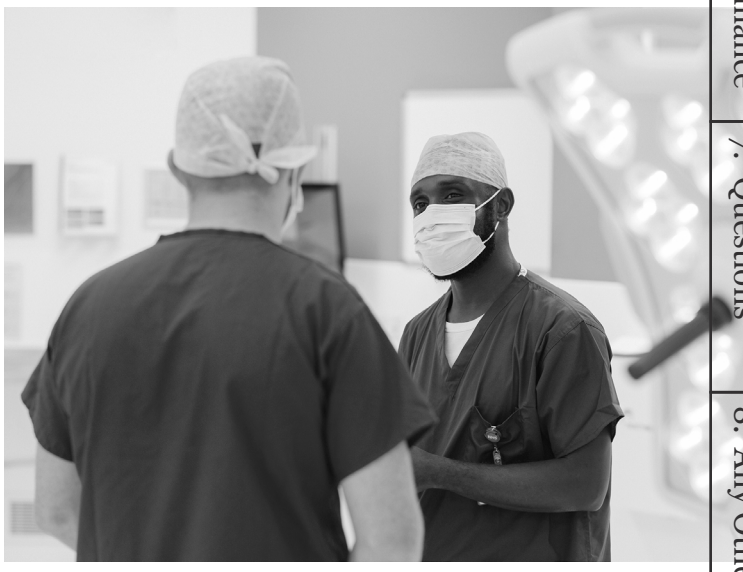
The RJAH Inclusion strategy will continue to align to the People Promise, particularly around **'We each have a voice that counts'**

At the Trust, our staff, patients and visitors voice is very important to us. In addition, our value of Respect aligns with the People Promise of **'We are compassionate and inclusive'.**

The four key purposes for our Integrated Care System (ICS) are:

- Improving outcomes in population health and healthcare;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money;
- Supporting broader social and economic development.

The four key purposes for our ICS and the outcomes for our people are observed in the RJAH Inclusion strategy, which aligns with the commitment from RJAH that, **we are committed to providing a working environment that is welcoming, inclusive, respectful and is free from unlawful discrimination.**



Our Inclusion Vision

Following feedback from the Listening Events, we heard your voices and we have aligned our Inclusion Vision to state;

- We hold the principles of equality and inclusion at the heart of everything we do and all that we stand for.
- We will connect and align our vision and ethics to everyone.
- We want underrepresented groups at senior levels (such as women, people with disabilities, ethnic diverse and LGBTQ+ communities) to realise their potential in a sustainable way.

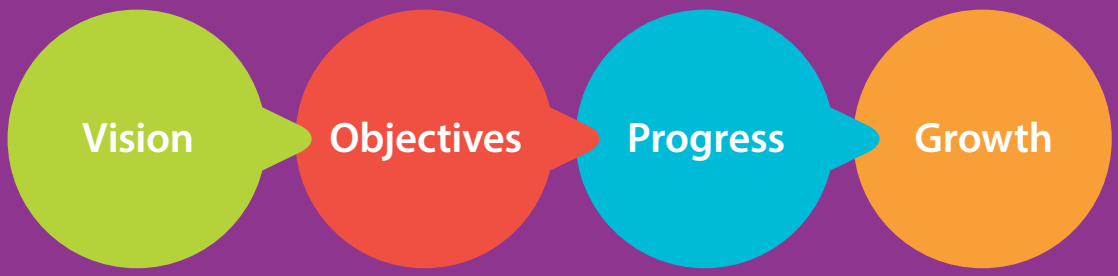
Ensuring **inclusion** and **belonging** for all

We use our expertise and influence to create inclusive culture, which values and celebrates our diversity. We listen to our people and take action to ensure there is equity for everyone.

Our Values

Our values are more than just words; they define who we are, how we treat each other and how we deliver care. Our values drive and connect how we understand and practice inclusion at RJAH.

Delivering Our Vision



Our Vision

"We hold the principles of equality and inclusion at the heart of everything we do and all that we stand for"

Equality Objectives

We will achieve our ambition to be an inclusive organisation (in line with the NHS People Plan) through a clear set of strategic objectives and an action plan which will work across all areas of the Trust.

The objectives will build on us creating an exceptional inclusive environment at the RJAH which will continue to improve everyone's experience.

Objectives to enable our Trust to;

- Tackle and remove all forms of discrimination in our workplace and for our patients
- Create an inclusive and healthy RJAH culture through our values
- Give the workforce a voice to speak up through Staff Network Groups
- Ensure all our leaders, managers and colleagues can role model in a compassionate and inclusive way
- Ensure the Equality and Diversity Action Plan delivers on the objectives and outcomes

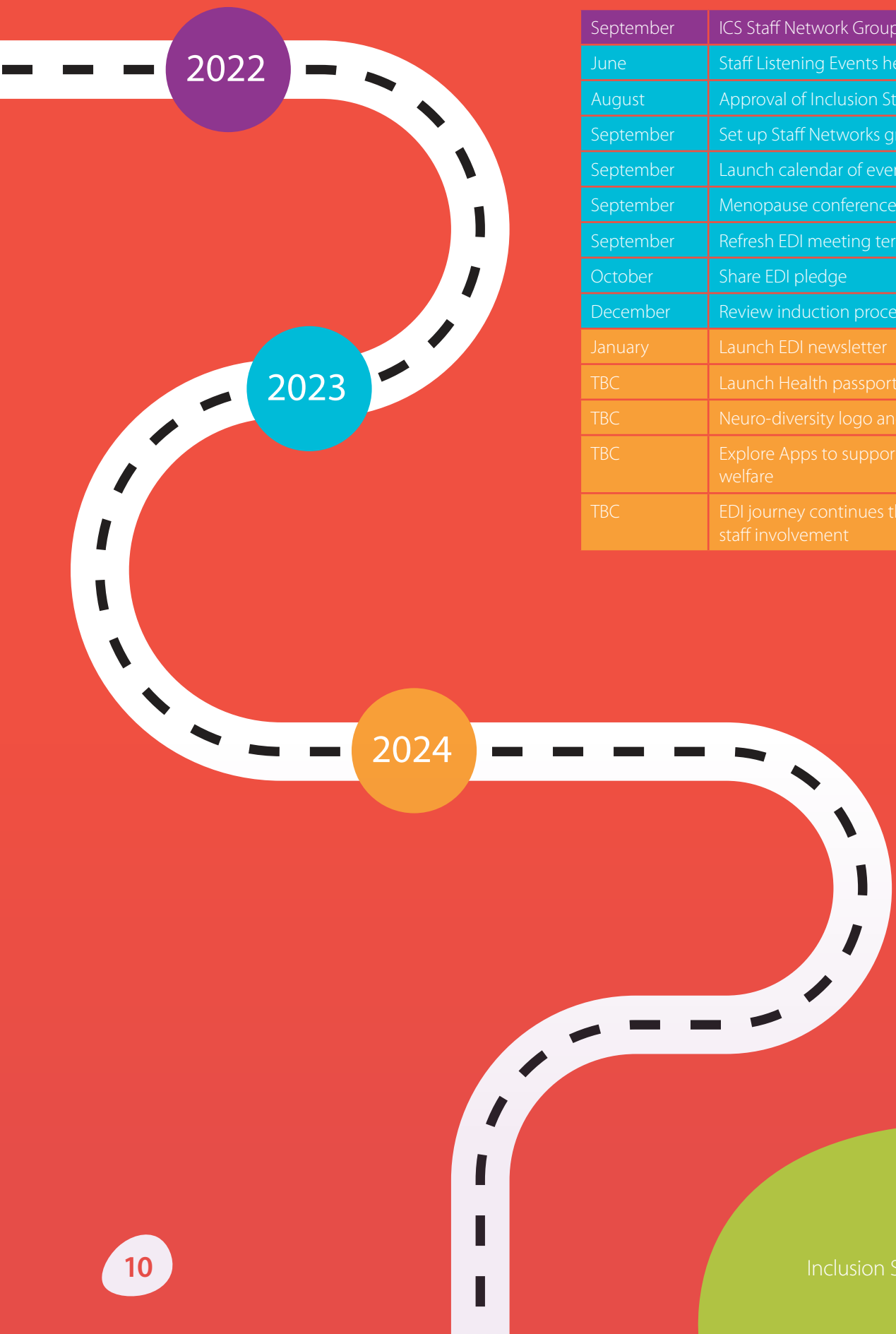
Our progress and achievements so far

- Received 52% response for our Staff Survey
- Published WRES, WDES, Workforce Report and Gender Pay Gap report
- Developed EDI mandatory training on e-learning modules
- Used feedback from staff induction to launch a development session in relation to LGBTQ+
- Held Staff listening events to help shape this strategy and a platform for staff to share experiences

How we can grow in this space

- Develop an RJAH EDI pledge
- Develop communication channels for training offers and networking
- Support the SAND project (Safe Ageing No Discrimination)
- Commit to align resources of staff to support the inclusion objectives and actions
- Create an EDI newsletter
- Develop and grow Trust Staff Network Groups
- Involvement in reverse mentoring
- Review the EDI elements of our induction process & leadership programme
- Board Development Sessions

Inclusion roadmap



September	ICS Staff Network Groups established
June	Staff Listening Events held
August	Approval of Inclusion Strategy
September	Set up Staff Networks groups
September	Launch calendar of events
September	Menopause conference
September	Refresh EDI meeting terms of reference
October	Share EDI pledge
December	Review induction process
January	Launch EDI newsletter
TBC	Launch Health passports
TBC	Neuro-diversity logo and badge
TBC	Explore Apps to support EDI and staff welfare
TBC	EDI journey continues throughout with staff involvement

National framework

As a Trust we will continue to work to the regulatory NHS measures as required. These are provided in summary below and we will review these against our action plan for the greatest effect on Inclusion at our Trust.

National NHS staff survey

All Trusts are required to undertake the staff survey which is completed during October and November on an annual basis. Feedback can highlight and provide key issues and opportunities, across different teams but also in diverse groups. The staff survey information is used across the Trust in many different ways.

National NHS Frameworks

The Trust is required to work under the Public Sector Equality Duty (PSED) of the Equality Act 2010. One of these requirements is for the Trust to share the content of this report with the public through our ROH website. This information includes:

- Workforce Race Equality standards (WRES)
- Workforce Disability Equality standards (WDES) standards
- Gender Pay gap
- EDS 2 framework

Meeting our public sector equality duty

Under the Equality Act 2010 as a public body we have a general public sector equality duty to:

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Foster good relations between people with different backgrounds

Workforce Race Equality Standard (WRES)

Since 2015, all NHS Trusts have been required to collect and publish data on their progress around delivering race equality for staff.

Workforce Disability Equality Standard (WDES)

Since 2017, all NHS Trusts have similarly been required to collect and publish data on their progress around delivering equality for staff with disabilities and long-term health conditions.

Gender Pay Gap

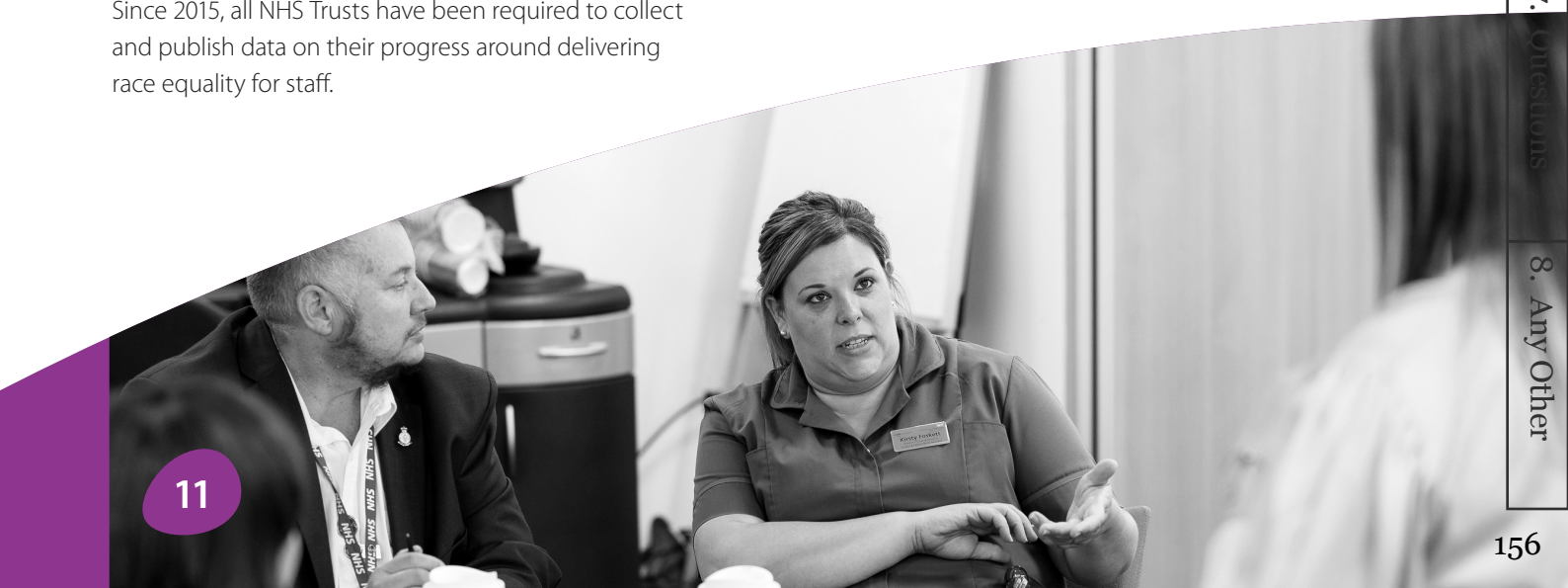
The mandatory gender pay gap analysis requires us to report workforce data across gender and pay bands and develop an action plan to address any gaps or over/under representation.

Equality Delivery System

The Trust utilises the Equality Delivery System 2 as a performance improvement framework to deliver and monitor our progress against our statutory requirements. NHS providers are expected to use EDS2 to help them improve their equality performance for patients, communities and staff, as well as helping them to meet the Public Sector Equality Duty.

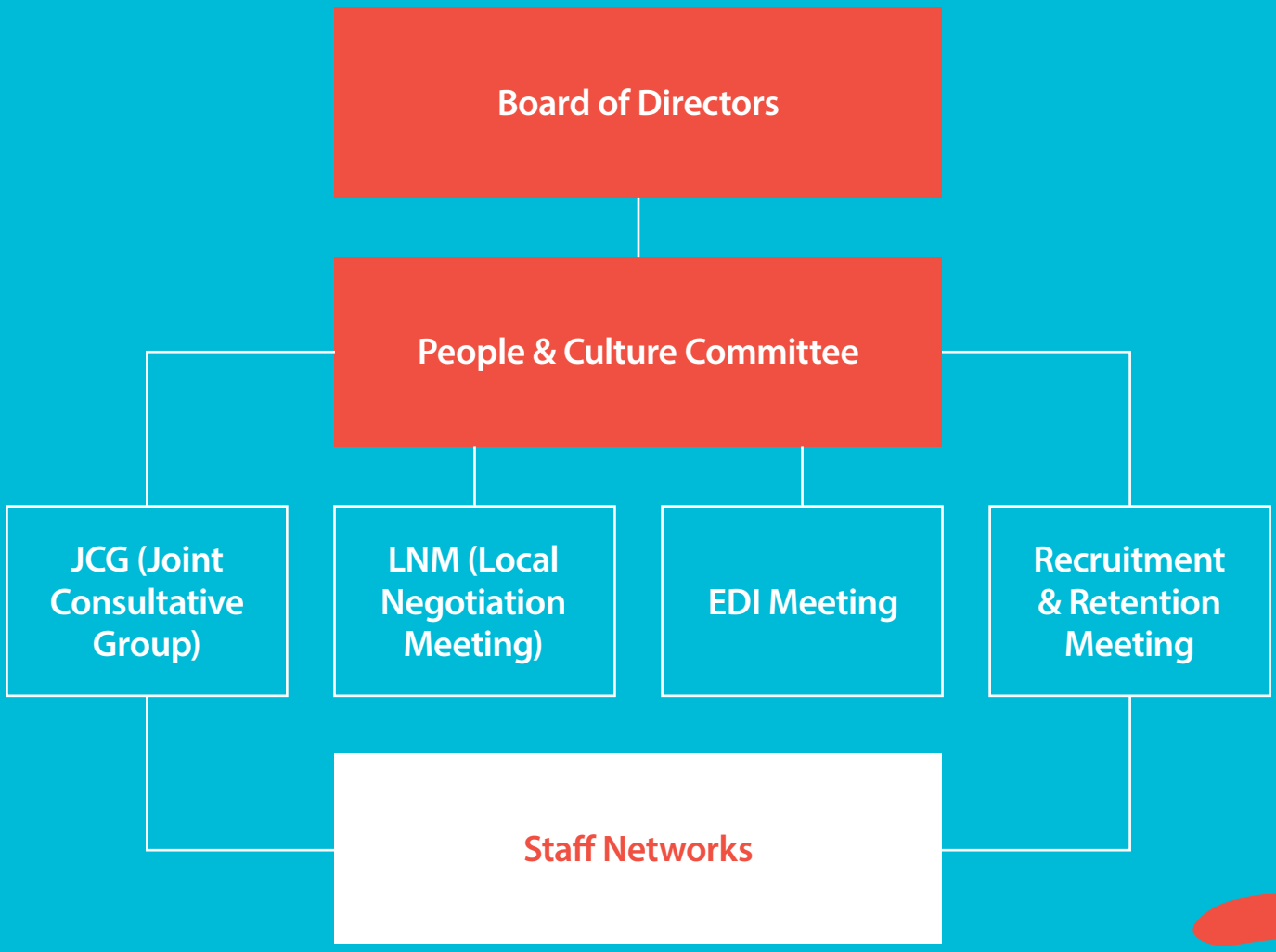
The EDS2 has four goals which are:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supportive workforce
4. Inclusive leadership



Governance for RJAH inclusion

The Trust has a clear governance and support structure for inclusion. This enables all parties to be involved and work together to ensure there is a clear strategy for Inclusion and that inclusion is built into the governance of the Trust.



Definitions

The Trust has a clear governance and support structure for inclusion. This enables all parties to be involved and work together to ensure there is a clear strategy for Inclusion and that inclusion is built into the governance of the Trust.

Diversity	Acknowledges and values the full range of differences between people both in the workplace and in wider society
Equality	Is about creating a fairer society where everyone can participate and has the same opportunity to fulfil their potential. Equality is backed by legislation (e.g., Equality Act 2010) designed to address unfair discrimination, harassment and victimisation
Inclusion	Is about positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential
Protected Characteristics	Are age, disability, sex, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation, marriage and civil partnerships

Commitment

"We all have a personal responsibility for making our workplaces more inclusive.

Our individual mindsets, attitudes and behaviours directly impact on the lives of others and help to shape our work environment.

We must be proactive and reach out to others, especially those who we do not know or would not normally work with.

We can help to influence and shape our organisation's policies, strategies and goals around equality, diversity and inclusion".

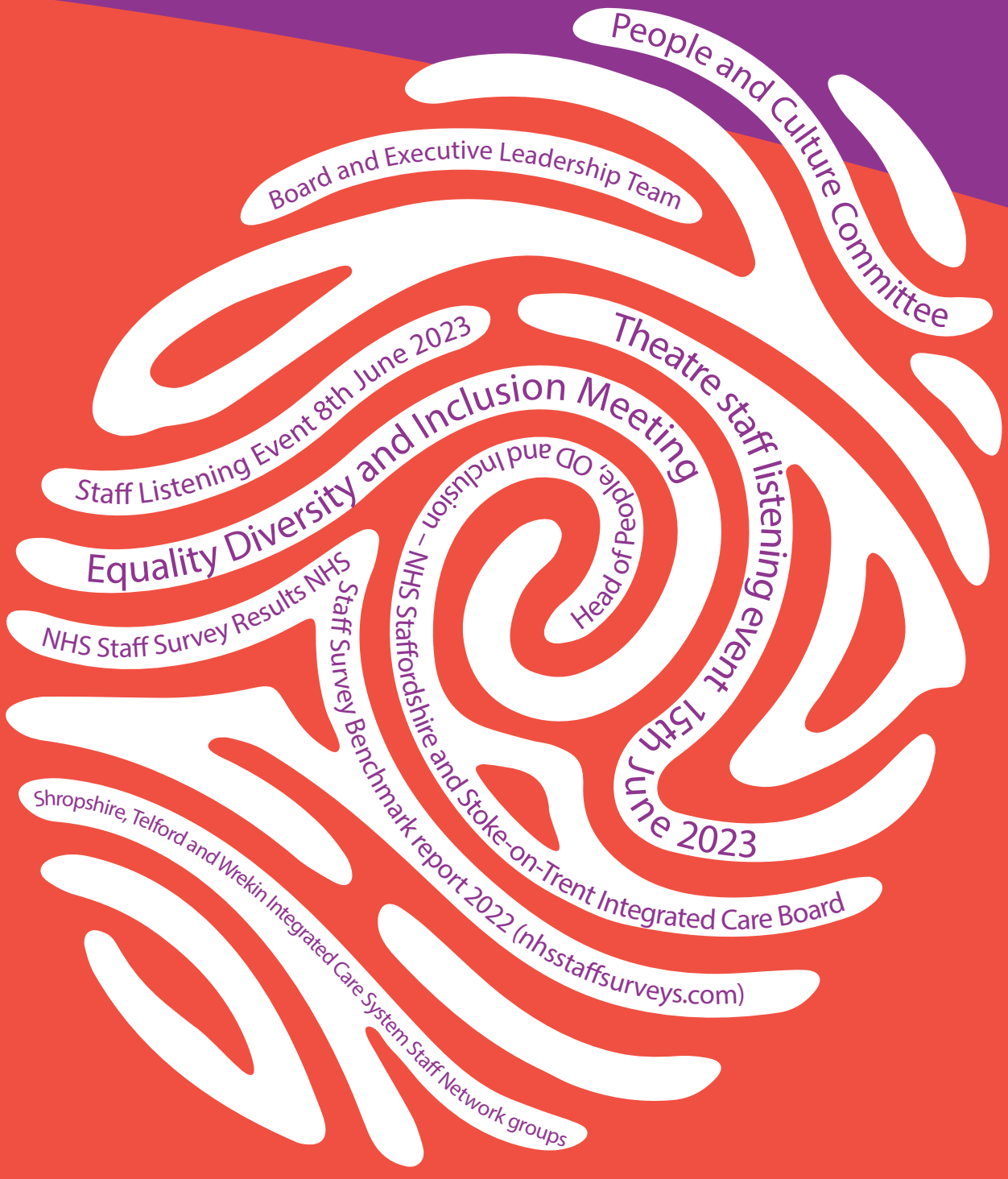
Links to other RJAH Strategies

The Inclusion strategy does not sit independently and is linked most importantly to the following strategies:

- **The RJAH five year people plan**
- **The RJAH Clinical Audit Strategy**
- **Workforce Strategy**
- **Patient Experience Strategy**
- **Quality Strategy**
- **Violence Prevention and Reduction Strategy**
- **Communication and Engagement Strategy**

Development of the Inclusion Strategy

This strategy has been developed in partnership with:



Monitoring and review

This strategy will be subject to review and evaluation on a yearly basis. The priority actions set out in this strategy will be prioritised in accordance with RJAH Corporate Objectives and BAF. The Equality, Diversity and Inclusion Meeting has ownership of and responsibility for the implementation of this strategy. The action plan will be monitored by the meeting members on a regular basis.

JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC

Key Reference documents

[1] **NHS Constitution for England**

[2] **Equality Act 2010**

[3] **Messenger Review – Leadership for a collaborative and inclusive future**
www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future

[4] **NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts**
www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts

[5] **Workforce Disability Equality Standard: 2021 data analysis report for NHS trusts and foundation trusts**
www.england.nhs.uk/publication/workforce-disability-equality-standard-2021-data-analysis-report-for-nhs-trusts-and-foundation-trusts

[6] **Equality, diversity and inclusion (EDI) in the workplace Factsheet CIPD**
www.cipd.org/uk/knowledge/factsheets/diversity-factsheet/#gref

[7] **NHS Confederation (2020) Action for Equality: the time is now**
www.nhsconfed.org/system/files/media/Action-for-equality-the-time-is-now_4.pdf

[8] **Compassionate leadership: sustaining wisdom, humanity and presence in health and social care and King's Fund (2022)**
www.kingsfund.org.uk/publications/what-is-compassionate-leadership

[9] **NHS Equality, Diversity and Inclusion Improvement Plan**
www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan

[10] **RJAH Equality Policy**

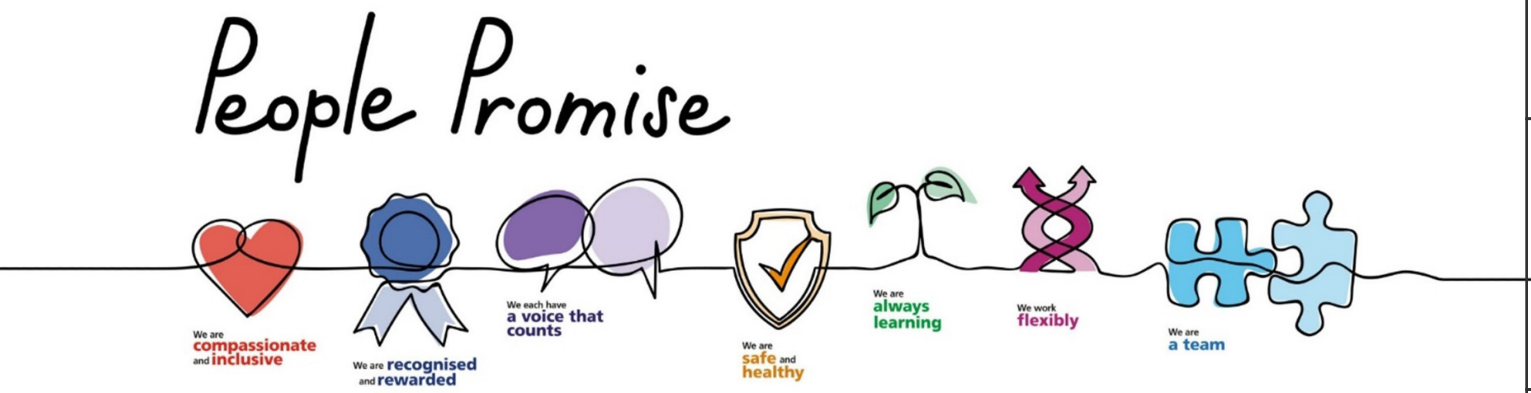
[11] **NHS Long Term Workforce Plan**
www.england.nhs.uk/publication/nhs-long-term-workforce-plan

[12] **STW ICS Rural Racism report**

Inclusion action plan 2023–26

Topic	Action	Target Date
LQBTQIA+	SANDS training to be made accessible to Theatres to support in language awareness.	Year 1 and ongoing
LQBTQIA+	Set up an RJAH Staff Network Group with a Chair and Sponsor. Promote the ICS Staff network group.	Year 1
Menopause	Share documentary link on Percy and highlighted by comms to offer an insight and awareness to all.	Year 1
	Menopause Champions to be implemented and to include male champions to support in men understanding the changes women go through.	
	Trust Policy to be reviewed and revised to align to this Trust.	
Ethnic Diverse	Set up an RJAH Staff Network Group with a Chair and Sponsor.	Year 1
	Promote the ICS Staff network group.	
Protected Characteristics	All staff to be invited to Staff Network Groups as Allies.	Year 1
Men's Mental Health	Men's Network to be implemented to support in safe listening spaces, signpost support and discuss any issues.	Year 1 and 2
Freedom to Speak Up	Process and guidance on this to be made clear and assurance offered to staff on action being taken on issues raised.	Year 1 and 2
Culture	Human Factors and Civility Saves Lives training to be accessible to all staff to support in culture change and communications.	Year 2
Policies	Focus groups or policy forum to be established to allow Theatre staff involvement in reviewing and amending policies.	Year 2
Neuro-Diversity	Social Re-charge battery badges to be discussed with focus group.	Year 1 and 2
	Neuro-Divergent / Invisible Disabilities Staff Network to be established to offer support and improvements for staff and patients.	
	Individuals to be trained in Understanding Autism to train across the Trust.	
	Raise further awareness across the Trust and initiate discussions for better understanding.	
Board Development	Information sessions at the end of each Board Staff network presentations of lived experience to raise awareness	Year 1, 2 and 3
	Attendance at staff networks	
	'Back to the Floor' Days to engage with staff and patients	
Rural racism report and action plan	Review Policies.	Year 1 and 2
	Anti-racism training.	
	'Nudge' posters should remind staff and patients of non-racist expected values and behaviours.	
	Managers should be trained to proactively support international staff to successfully progress in their career.	
	All staff should be educated about how challenging it is for international staff not trained in the UK and with a different first language to overcome acculturation problems.	

Launch Celebration calendar	www.inclusiveemployers.co.uk/diversity-calendar develop in conjunction with Staff Network groups	Year 1 and ongoing
Compassionate leadership	Inclusive leadership pledge | NHS Confederation Sign up to the Inclusive Pledge NHS confed	Year 1
Staff Networks	Develop the roles of Allies to the network groups	Year 1 and 2
Equality Meeting	Re-energise the Committee with new Terms of Reference and reporting links	Year 1 and 2
Staff Survey action plan and results	Ensure we link feedback from the staff feedback to inform future areas of work and development	Year 2 and 3
NHS equality, diversity, and inclusion improvement plan	**Six High impact actions:** • Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. • Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. • Develop and implement an improvement plan to eliminate pay gaps. • Develop and implement an improvement plan to address health inequalities within the workforce. • Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff. • Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	Year 1 and 2
Workforce Race Equality and Inclusion Strategy (WREI)	Implement actions as part of development plan	Year 2 and 3



The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Title:	Openness (Whistle Blowing) Policy		
Unique Identifier:	POL014	**Document Type:**	Policy
Version Number:	V 7.0	**Status:**	Draft
Responsible Director:	Chief of People		
Author:	Denise Harnin		
Scope:	Trust wide		
Replaces:	Version 6.0		
To be Read in Conjunction with the Following Documents: (List related policies)	Freedom to Speak Up Policy Complaints Policy		
Keywords:	Openness, Whistleblowing, Behaviour, Disclosure.		

Considered By Executive Owner:	Chief of People	**Date Considered:**	17/07/2023
Endorsed By:	JCG	**Date Endorsed:**	
Approved By:	People Committee	**Date Approved:**	
Issue Date:		**Review Date:**	
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Contents

1 Introduction

- Employees have a responsibility to raise concerns, there are several ways to do this that are outlined within the Trust's Freedom to Speak Up policy. Where they do not feel able to do this, or have not gained a satisfactory answer, employees can refer to this policy.

- The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust ("the Trust") is committed to achieving the highest possible standards of service and ethical standards in public life in all its practices. As such, the Trust is committed to creating a culture of openness and accountability and encourages all employees to raise genuine concerns and constructive criticism without fear of action being taken against them for doing so, in accordance with the Public Interest Disclosure Act 1998.

- A range of policies already exist within the Trust that deals with standards of behaviour at work, such as Disciplinary and Grievance. However, there may be times when the matter needs to be handled in a different way. Such matters often involve the disclosure (or whistle blowing), internally or externally, by employees regarding malpractice, as well as illegal acts or omissions. It may be that there is a concern of unlawful conduct, financial malpractice, or dangers to the public or the environment. Examples (non-exhaustive list) may be:
  - The ill-treatment of a patient;
  - A criminal offence has been committed, is being committed, or is likely to be committed;
  - Suspected fraud including improper unauthorised use of public or other funds;
  - Disregard for legislation, particularly in relation to health & safety at work;
  - The environment has been, or is likely to be, damaged;
  - Breach of standing financial instructions;
  - Showing undue favour over a contractual matter or a job applicant;
  - A breach of a code of conduct;
  - Abuse of authority;
  - Other misconduct or malpractice;
  - Or, where information on any of the above has been, is being, or is likely to be, concealed.

2 Responsibilities

2.1 Line Managers are responsible for giving feedback within the timescales required where an informal concern is raised with them.

2.2 Designated Officers (Chief Medical Officer, Chief Nurse, Chief Finance & Planning Officer, Non-Executive Directors, Chair of JCG, Chair of LNC, Child Protection named professionals, Freedom to Speak Up Guardians) are responsible for;

- Receiving internal formal disclosures
- Fact finding with the individual making the disclosure
- Instructing an appropriate investigation
- Reaching a decision outcome, recording, and following up any recommendations

2.3 Freedom to Speak Up Guardians (for concerns raised under that policy) are responsible for receiving, assessing, and investigating concerns raised via the Freedom to Speak Up Policy and provide feedback on the outcome.

3 Making a Disclosure

3.1 Raising an Informal Concern (See appendix 1 for process)

- If employees have a concern about malpractice* (see list of examples above) they are required to raise the matter immediately with their line manager. If the line manager is suspected to be involved or is condoning malpractice, employees are required to raise the matter with a more senior manager (or in the case of concerns concerning the Chairman or Chief Executive Officer with a Non-Executive

Director) in the first instance. This may be done verbally or in writing. Employees are required to explicitly state that they are making a disclosure under this Policy to assist the Trust to accurately record and track progress of any whistleblowing concerns.

- Concerns, when reported under this Policy, must be in the public's interest.

- Feedback will be given within 5 working days regarding the management action being taken, with due regard to the Trust's duty of confidence and without infringing the rights of other parties, for example where disciplinary action is being taken against another employee.

** Employees can raise concerns across the organisation and not only concerning clinical practice*

3.2 Escalating an Informal Concern

- If a satisfactory response is not received within 5 working days of raising the whistleblowing concern, or the employee feels unable to report concerns to their line manager or more senior manager, they should contact the Chief People Officer. This may be done verbally or in writing. Employees are again required to explicitly state that they are making a disclosure under this Policy.

3.3 Making an Internal Formal Disclosure

- If the concerns have not been dealt with satisfactorily, or the matter is deemed too serious for the informal stages, employees are encouraged to raise the matter formally and immediately to one of the following designated officers:

    - Chief Nursing Officer
    - Chief Medical Officer
    - Chief Finance & Planning Officer
    - Chief People Officer
    - Non-Executive Director
    - Chairman of the Joint Negotiating Committee (Staff-Side)
    - Chairman of the Local Negotiating Committee (Medical staff)
    - Child Protection Named Professional
    - Freedom to Speak Up Guardian

- Contact can be by telephone but will preferably be via email or in writing. All correspondence should be marked "in confidence to be opened by the addressee only". Again, employees are required to explicitly state that they are making a disclosure under this Policy.

- The person making a formal disclosure should, as soon as practicable, disclose in confidence the grounds for their belief of malpractice or serious risk to one of the designated officers identified above. The person making the disclosure should provide as much supporting evidence as possible about the grounds for his or her belief although there is no requirement to 'prove' the malpractice allegations. When a person reports a concern, it is likely that they will be requested to provide more information. Therefore, when making a disclosure or raising a concern, they should try to include as much of this detail as possible.

- If the person receiving the formal disclosure does not feel that this Policy is appropriate to use, they may refer to other organisational policies that exist for dealing with concerns. For example:

    - Safeguarding Policies
    - Disciplinary Policy
    - Grievance Policy
    - Management of Serious Incident Policy
    - Policies to deal with dignity and respect in the workplace
    - Management of Serious Incident Policy

- (Where a non-staff member raises concern, a decision would be made by the Chief Nursing Officer to identify the appropriate policy to follow).

- A designated officer may decline to become involved on reasonable grounds. Such grounds include previous involvement or interest in the matter concerned, incapacity or unavailability or that the designated officer is satisfied that a different, designated officer would be more appropriate to consider the matter in accordance with this procedure.

3.4 Investigating the disclosure

- On receipt of the disclosure, the designated officer will offer to interview, in confidence, the person making the disclosure. Such an interview will take place as soon as practicable after the initial disclosure and should usually start by the fifth day after the disclosure is received. The purpose of the interview will be for the designated officer to obtain as much information as possible about the grounds for the belief of malpractice and to consult about further steps which could be taken. The person making the disclosure may be accompanied by a Staff Side / trade union representative or work colleague at the interview. The designated officer may be accompanied by an administrative assistant to take notes. Due regard will be given to confidentiality wherever possible.

- Where the designated officer is satisfied that the use of this Policy is appropriate, they shall decide on the nature of the investigation of the allegations. This may be an internal investigation by organisational staff, referral of the matter to the police or other appropriate public authority, or the commissioning of an independent enquiry, for example by the Trust's auditors or Local Counter Fraud Officer. If a Safeguarding Children concern is presented and the feature of the 'Position of Trust' is in question, existing Safeguarding Children procedures need to be followed and, where necessary, the LADO (Local Authority Designated Officer) arrangements put into operation.

- Any investigation should not exceed 4 weeks except in exceptional circumstances, which must be discussed with the Chief People Officer for approval for the exception. Where appropriate, the individual who made the disclosure should be kept informed of the progress of the investigation, however consideration should be given as to the appropriateness of sharing the outcome with the individual where the outcome results in disciplinary action against another individual, or the sharing of information would undermine other investigations taking place.

- If the designated officer decides that this Policy is inappropriate in respect of the matter disclosed, they shall inform the discloser, giving reasons in writing. These could be on grounds that:

    - The matter should be, is already or already has been the subject of appropriate proceedings under one of the Trust's other procedures;
    - The matter is already the subject of legal proceedings, or has already been referred to the police or other public authority;
    - There is reasonable doubt as to the discloser's good faith and/or reasonable belief about malpractice or serious risk.

- Upon conclusion of the process of investigation, the designated officer will reach a decision and outcome.

- If the discloser is not satisfied with the designated officer's decision, they may ask the Chief People Officer to review the matter of the disclosure, the information and evidence presented, the process followed and the grounds for the decision. If the Chief People Officer decides that the matter should be investigated under this Policy, they shall direct a second designated officer to arrange an appropriate investigation. If they decide to uphold the view of the original designated officer, no further action will be taken under this process. The discloser may then consider whether to refer the allegations of malpractice or serious risk to an external agency (see below).

3.5 Making a Regulatory External Disclosure

- While it is hoped that this Policy gives employees the confidence to raise their concern internally, there may be circumstances where they feel they can only report the concern to an appropriate, external organisation. Organisations relevant to the NHS include:

- The Care Quality Commission (CQC);
- The Audit Commission;
- The Health and Safety Executive;

- If a concern is about fraud and corruption, the NHS Fraud Hotline can be contacted.

3.6 Making a Wider External Disclosure

- Examples of wider, external disclosures include Police, Media, MPs, and Non-Prescribed Regulators. Employees are advised that wider disclosures may also be 'protected disclosures' under very particular circumstances. As with regulatory disclosures, the discloser must make the disclosure in the public's interest.

- In addition, a further pre-condition to secure protection for a wider disclosure must be met. This is where:

  - The person reasonably believed he/she would be victimised if the matter was raised either internally or with a prescribed regulator; or
  - There was no prescribed regulator, and he/she reasonably believed the evidence was likely to be concealed or destroyed; or
  - The concern had already been raised with the Trust or a prescribed regulator without being addressed in a timely manner; or
  - The concern is of an exceptionally serious nature.

- Employees should note that failure to meet these requirements means that they would not qualify for protection under this Policy and may be subject to disciplinary action for fundamental breach of contract and/or disclosure of confidential information.

3.7 Additional Advice and Support to Staff

- Where there is doubt as to the way forward (e.g., the employee is not sure whether to make a formal disclosure), they may seek a confidential meeting with one of the designated officers detailed in this Policy to discuss whether it would be appropriate to make a formal disclosure under PIDA 1998. An individual seeking or taking part in such a meeting is guaranteed the same protection against personal detriment as is given to someone making a formal disclosure, whether a formal disclosure then follows.

- Employees have the option to share their concerns in the first instance with colleagues or other representatives including Staff Side / trade union officials. Staff may also be accompanied by a colleague or representative when discussing allegations and suspicions with management.

- Although it is far more effective for management to discuss matters with an identified person, it is permissible for concerns to be shared anonymously, where a disclosure would not otherwise be made.

3.7.1 Enhanced Protection

Regulations require NHS bodies ensure those applying for jobs are not treated adversely due to whistleblowing at other Trusts.

The regulations prohibit discrimination by NHS employers in the recruitment of an applicant on the grounds that they have made, or appear to have made, a protected disclosure in previous NHS employment.

The term applicant is broad and will include any individual who applies to an NHS employer for a contract of employment, a contract to do work personally or an appointment to an office or post.

4.0 Training and Dissemination

- This policy can be accessed via the Trust's Document Centre.
- Advice on implementation can be accessed from the People Services team.

5.0 Implementation Plan

- Management training will be revised to ensure it is aligned to this new policy.

6.0 Monitoring / Audit

- The Trust will maintain sufficient records of formal case management to support high level reporting and trend analysis

7.0 Review Date

- 3 years after approval date.

8.0 Equality Impact Assessment

Title of Document/function	Openness (Whistle Blowing) Policy
Type of document/function: *i.e. is it a strategy / business case / proposal (e.g. for a new build, change to working practices or changes to service and delivery) or a main policy document?*	Policy
Status of document/work practice: *i.e. is it proposed; draft; existing; other?*	Draft
Name of Person completing the Equality Impact Review Form *(Please print)*	Denise Harnin
Please give details of the goals or purpose of this document/work practice i.e. *Why we need to have this document/work practice?*	To ensure that staff are able to raise concerns confidentiality and confidentialy.

Impact review

For support in completing this review, please refer to the Equality Impact Review Guidance Document

In reviewing this strategy, business case / proposal / policy document / work practice have you identified either a potential positive or negative impact on any of the protective characteristics* or other disadvantaged groups? **No**

1.	Have you acquired support or information in understanding the impact/or ways of mitigating the impact? Please provide details of support / information sought.	No
2.	If you felt there to be no requirement to seek additional support please explain reasons for this	
3.	If an impact has been identified please provide the detail	

If an impact has not been identified there is no requirement to complete questions 4, 5, 6 & 7 below. **You should now complete the review date and signature section at the end of this form and attach to your document.**		
4.	How do you intend to consult in relation to the identified impacts *i.e. consider consultation with the Patients panel, Senior Management, Nursing Staff, Estates, staff, representatives of the disadvantaged group*	
5.	Following consultation, what actions are you taking to mitigate or remove the impact? *(Refer to examples on guidance sheet)*	
6.	How do you intend to communicate the proposed actions for improvement, risk or changes to the policy/function? i.e. consider communication with the Patients panel staff, representatives of the disadvantaged group	

7.	How will you monitor the outcomes of your actions so as to ensure success? i.e. how will you measure the outcomes of your actions? Will you *gather specific data, staff satisfaction reports, patient responses etc.*	

Equality Impact Review date: 17/07/2023

Signature of person completing the form: D.Harnin

Date completed: 17/07/2023
A copy of the impact Assessment should be attached to the back of the strategy/ business case / proposal / policy document / work practice documentation and an electronic copy forwarded to the Trust Office Assistant for logging on the EIA spread sheet

***Protective Characteristics:**
Religion, Race, Age, Gender, Sexual Orientation, Disability, Transgender, Marriage and Civil Partnership, Pregnancy and Maternity

***Disadvantage groups** will change according to the circumstances / situation and would be best described as simply any identified group disadvantaged by this strategy, business case / proposal / policy document / work practice.*

*Examples of disadvantaged groups and potential impacts are provided on the **Disadvantaged Groups Guidance Document**.*

9.0 Appendix 1.

Openness Whistleblowing Process

TBC

10.0

Template for Recording Minor Amendments

Record of Amendments to:					
Amendments approved by:					
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**	**Date**

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
People and Culture Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	06 September 2023
Executive Sponsor:	Denise Harnin, Chief People Officer	**Paper written on:**	03 September 2023
Paper Reviewed by:	Martin Evans, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors - Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the People and Culture Committee. The Board is asked to consider the recommendations of the People and Culture Committee.

2. Context

2.1 Context

The Trust Board has established a People and Culture Committee. According to its terms of reference: *"The purpose of the People and Culture Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes, and controls in place throughout the Trust to:*

- *Promote excellence in staff health and wellbeing;*
- *Identify, prioritise, and manage risks relating to staff;*
- *Ensure efficient and effective use of resources."*

In order to fulfil its responsibilities, the Committee has established sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The People and Culture Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from People and Culture Committee

This report provides a summary of the items considered at the People and Culture Committee on 24 August 2023. It highlights the key areas the People and Culture Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The People and Culture Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

EDI Strategy

The Committee received and discussed the new EDI strategy. The Committee were pleased that the information from the recent listening events has been incorporated and the photographs are from the recent hospital events. The committee supported the document and recommended it is approved by the Board of Directors. The EDI action plan will be reported through the EDI meeting with the People and Culture Committee having oversight.

Terms of Reference
Following a review of the membership, the terms of reference were considered and supported by the Committee. The Committee recommends the Board approves the revised terms of reference for the People and Culture Committee.

3.2 Areas of on-going monitoring with new developments

ADVISE - The People and Culture Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Workforce Performance Report
The Committee were assured with the positive step change with regards to the recruitment agenda, the vacancy control reflects the hard work being implemented.
The committee highlighted, in particular, the successful recruitment of theatre staff, with 17 staff on induction and noted those areas such as anesthetists that are not yet at establishment.
The Time to recruit KPI was reported for the first month and it was agreed that there was a need for improvement in some areas. It was agreed to await the model hospital data before deciding on specific targets for key areas of the recruitment process.
The Committee discussed the outpatient booking team which reported a high turnover. Reassurance was provided that the numbers of patients being booked within specific timeframe has improved following the report being collated. The significant turnover within the department was acknowledged which has led to planned bookings not being achieved (other factors included industrial action which affected clinic availability).
The Committee requested a breakdown of sickness absences across departments to provide further assurance and oversight as it was noted that some areas had higher levels of sickness than the Trusts 4% target.

Agency Report
Partial assurance was noted as the Trust reported an improved position on the overall spend for the month. It was acknowledged that this was supported by the industrial action as activity was significantly reduced. Off framework position has also significantly improved although the Trust are still an outlier within the system.
The in-sourcing costs were highlighted as a concern, the action plan to address the risks is due to be presented to Board for further scrutiny.

International Nurse Staff Story
The Committee welcomed two international nurses to the meeting. They highlighted the positives within their journey so far; recruitment process was supportive and exams set-up effectively, 3-month accommodation on-site was appreciated, and staff have been welcoming and friendly.
The nurses also highlighted some areas that had not been so positive such as induction training on the wards, job matching and lack of support in understanding key living requirements such as utility bills, council tax and insurance requirements.
Accommodation following the initial 3 months was highlight as being extremely challenging and had clearly caused high levels of anxiety.
The Committee discussed and were reassured of some of the steps the Trust are taking to support accommodation, but it was clear that this work needs to continue. They were also assured that all current international recruits have now secured accommodation.
The Committee requested that the Trust complete a review of the international nurse recruitment, to identify issues experienced from all recent recruits and to provide assurance on what learning has been identified and improvements are being implemented. Additionally, the people services team agreed to link with SaTH to ensure that job matching was being completed correctly to ensure that nurses were arriving to the roles they were offered at recruitment.

E-Rostering Report
The committee received a more detailed review of progress against the E-rostering attainment levels action plan to achieve attainment level 4 as required by NHSI having noted in previous meetings that the Trust had not moved on from attainment level 0.
The progress against plan had been broken down into the three areas of nursing, AHP and Medical

and it was very clear that it was the medical area of business that was holding the Trust back from progressing through the attainment levels.
The committee were informed that it was forecast to achieve Level 4 by the end of December 2023 however the committee requested further assurance to be provided by way of a more detailed action plan which outlined clear actions, timescales and ownership which would be reviewed at the next meeting.

Employment Policy Compliance Audit
The Committee welcomed the introduction of a new compliance audit which had reviewed compliance against 94 new starters which had identified 14 non compliance related issues. Assurance was provided that the issues raised were being addressed and were from a time when the Trust used a 3rd party identity checking service which is no longer the case. The committee questioned whether the compliance issues would have been picked up should the audit not have taken place and the Trust confirmed the process is now under review along with the DBS check process. It was agreed that this audit would be completed quarterly going forward and reported to Committee to ensure that any discrepancies and areas for improvement are highlighted immediately. Due to the risks associated with the checks, the Committee requested a wider review of the Trust's compliance which is to be reported back to the next meeting.

3.3 Areas of assurance

ASSURE - The People and Culture Committee considered the following items and did not identify any issues that required escalation to the Board.

Leadership Programme Staff Story
The Committee welcomed a member of staff to the meeting who shared her feedback on the leadership program which is offered by the Trust. She described the course as well planned with vast content. A comprehensive booklet is circulated which was helpful with reflection. It was assuring to note that the cohort had varied staff groups and varied grades offering insight and sharing and a good networking opportunity for staff. She felt the course would be beneficial for further staff groups to allow understanding and changes across the wider Trust. The committee were delighted to hear examples of how she had taken learning away from the course to help her and her team in their day-to-day work.

Corporate Risk Register
The Committee were assured on the processes implemented to enhance risk management across the organisation. The summary of the risks which are subject to further review were shared with the Committee to reflect the direction of reporting as well as how the Board Assurance Framework and wider agenda of the Committee.

Nursing Recruitment Report
The Committee were assured that the Trust continues to maintain safe staffing levels across the organisation.

Re-advertisement of Jobs
A report was shared with the Committee following a previous discussion relating to recruitment uptakes. The Committee took assurance from the report which had not highlighted an area of concern.

People Services Structure
The structure was presented following the approval of the investment to support capacity within People Services Team. The committee noted that the structure will support in recruiting to current vacancies and building a robust team to support the ongoing People Plans within the Trust.

5 Year People Plan
The committee received and welcomed the new 5-Year People plan. Assurance was provided that the Trust is working with other counterparts within the system to support in achieving the plan. The Committee noted that the plan is aligned to the ICS 5 Year People plan which covers the wider system priorities.

Case Summary Report
The Committee took assurance from the newly formatted report which included a break down across a number of diversity strands. The report was noted by Committee and no areas of concern were identified.

Chair Reports
The Committee noted the following chairs report, there were no issues to raise.

- EDI Meeting
- Local Negotiating Meeting

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps – non to consider this month.
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.

People and Culture Committee
Terms of Reference (~~May~~ August 2023)

1. Constitution

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

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors (including the Associate Non-Executive Directors) and the Executive Directors of the Trust and shall consist of:

- Up to four Non-Executive members
- Chief People and Culture Officer
- Chief Nurse and Patient Safety Officer
- ~~Chief Medical Officer~~
- Chief Operating Officer
- Chief Finance and Planning Officer

Non-~~e~~Executive members may be drawn from the Non-Executive Director membership of the Board or the Associated Non-Executive Directors.

In exceptional circumstances a deputy may attend in place of an Executive Director. The nominated deputy can act on behalf of the absent Executive Director. This is to be noted at the beginning of the meeting.

The Board of Directors will appoint a Committee Chair from the Non-Executive members of the Committee In the absence of the appointed Chair, the Committee will appoint another Non-Executive member Director will be nominated to chair meetings in the absence of the to chair the meeting.

A quorum will be two Non-Executive member and two Executive members. Deputies representing Executive members will count towards the quorum but at least one of the Executive members must be drawn from the listed membership.

3. Attendance

The Trust Secretary and Deputy Chief People and Culture Officer will be expected to attend each meeting.

The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Chief Executive Officer will receive a standing invitation to attend.

Service mangers, unit representative and subject matter experts will only be expected to attend when a relevant paper is being presented. A time slot will be allocated to those individuals to support the logistics of the meeting.

An invitation is extended to the Council of Governors to observe the meeting.

4. Frequency of meetings and meeting administration

The Committee will meet monthly for regular business. The Chairman of the Committee may call additional meetings.

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

5. Authority

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

6. Reporting

A written Chair's Assurance Report will be presented to the Board no later than the Board meeting the following month (or the soonest available meeting if a Board meeting does not fall that month). The Chair's Report shall:

1. Alert the Board to any issues that:
   - Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address; OR
   - Require the approval of the Board for work to progress.
2. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
3. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

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

7. Key responsibilities

- The purpose of the People and Culture Committee is to assist the Board obtaining assurance that the Trust's workforce strategies and policies are aligned with the Trust's strategic aims and support a patient-focused, performance culture where staff engagement, development and innovation are supported. The Committee will work with the Audit and Risk Committee to ensure that there are adequate and appropriate governance structures, processes and controls in place throughout the Trust to:
  - Promote excellence in staff health and wellbeing
  - Identify, prioritise and manage risks relating to staff
  - Ensure efficient and effective use of resources
- To ensure the Trust is meeting it statutory and regulatory requirements in relation to workforce management.
- To oversee the development and implementation of the People Plan and any related workforce plans
- To monitor and develop the Trust's plans for talent management, succession planning, staff engagement, performance, reward and recognition strategies and policies
- To receive an agreed level of workforce data and trend analysis to inform and analyse workforce issues
- To ensure that the Committee has adequate information on which to advise and assure the Board on 'Caring for Staff'
- To receive reports from meetings that report into the Committee, currently including:
  - Equality Diversity and Inclusion Meeting

  - Learning and Development Meeting
  - Joint Consultancy Group Meeting
  - Local Negotiating Meeting

- To receive reports as provided by the ICS People Committee

- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.

- Review progress made in delivering key enabling workforce strategies raising any significant risks regarding their delivery to the Board.

- To assure and provide advice to the Board on any arising People Services issues of significance

Trust Board - Performance
July 2023 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

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

SPC Chart Rules

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

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

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

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

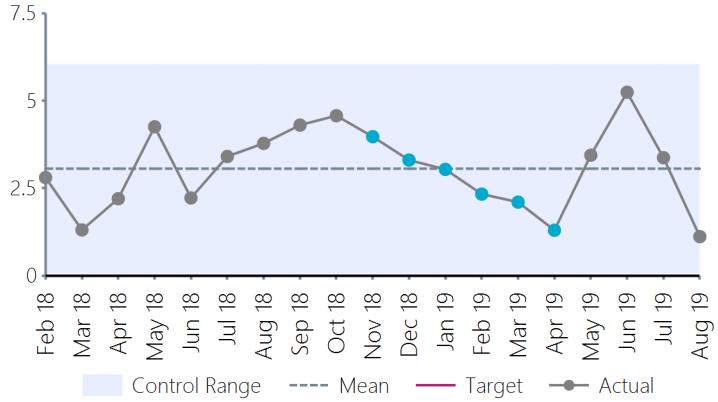
Some examples of these are shown in the images to the right:

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

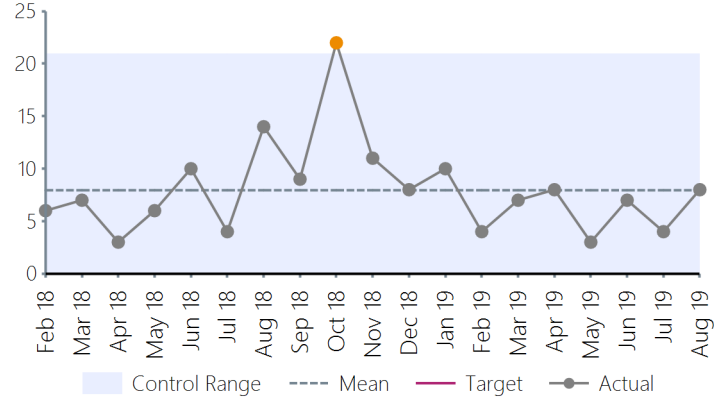
b) shows a point of concern sitting above the control range.

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.

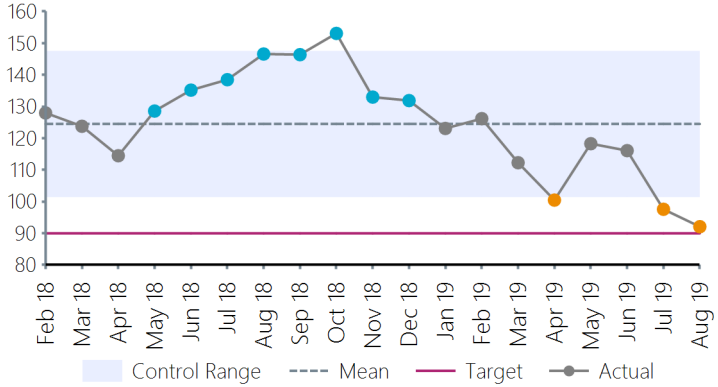
a)



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.

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Cancer Plan 62 Days Standard (Tumour)*	85.00%	33.33%			?	+	24/06/21
28 Day Faster Diagnosis Standard*	75.00%	89.58%			?		
18 Weeks RTT Open Pathways	92.00%	50.55%		L	F	+	24/06/21
Patients Waiting Over 52 Weeks – English	0	1,210	1,410	L	F	+	24/06/21
Patients Waiting Over 52 Weeks - Welsh (Total)		859			No Target	+	24/06/21
Patients Waiting Over 78 Weeks - English	0	4	0	L	F	+	
Patients Waiting Over 78 Weeks - Welsh (Total)		208		L	No Target	+	
Patients Waiting Over 104 Weeks - English	0	1		L	F	+	
Patients Waiting Over 104 Weeks - Welsh (Total)		51		L	No Target	+	
Overdue Follow Up Backlog	5,000	11,707		L	F	+	

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
6 Week Wait for Diagnostics - English Patients	85.00%	86.61%		H	Moving Target	+	
8 Week Wait for Diagnostics - Welsh Patients	100.00%	95.38%		H	F	+	

Summary - Caring for Finances

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Elective Activity Against Plan (volumes)	998	835			Moving Target	+	24/06/21
Overall BADS %	85.00%	76.63%			?	+	
Total Outpatient Activity against Plan (volumes)	14,714	12,993			Moving Target	+	24/06/21
Total Outpatient Activity - % Moved to PIFU Pathway	5.00%	5.15%		H	Moving Target	+	
Total Diagnostics Activity against Plan - Catchment Based	2,572	2,603			Moving Target		

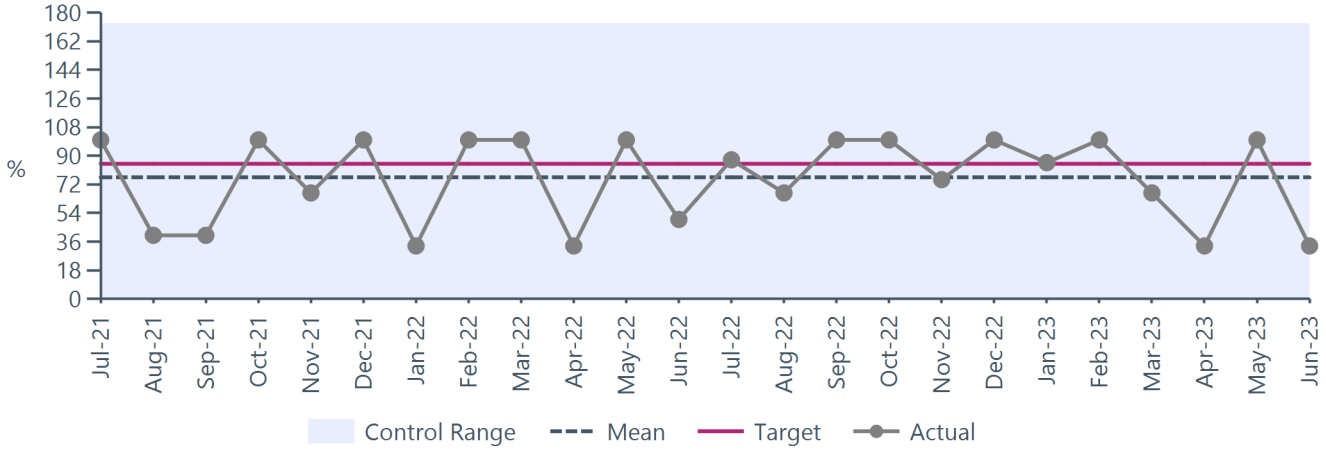
Cancer Plan 62 Days Standard (Tumour)*

% of cancer patients treated within 62 days of referral (*Reported one month in arrears) 211045

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	33.33%		

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).

Narrative

The Cancer 62 Day Standard was not met in June; this measure is reported in arrears. The June performance is reported at 33.33% against the 85% target. This equates to three patients, of which two were breaches. In both cases, the patient pathways have been allocated to RJAH in error where another Trust has used the incorrect site code so we are liaising with that Trust to rectify and will update the figures once that update has been made.

Actions

At the time of IPR production, Cancer Patient Pathway Co-Ordinator has made contact with the relevant Trust requesting the national data is updated. Once the national data has been updated, the data reported in the IPR will be amended to reflect that. Service Manager for the Tumour Service will also be raising this as it has happened a number of times this year.

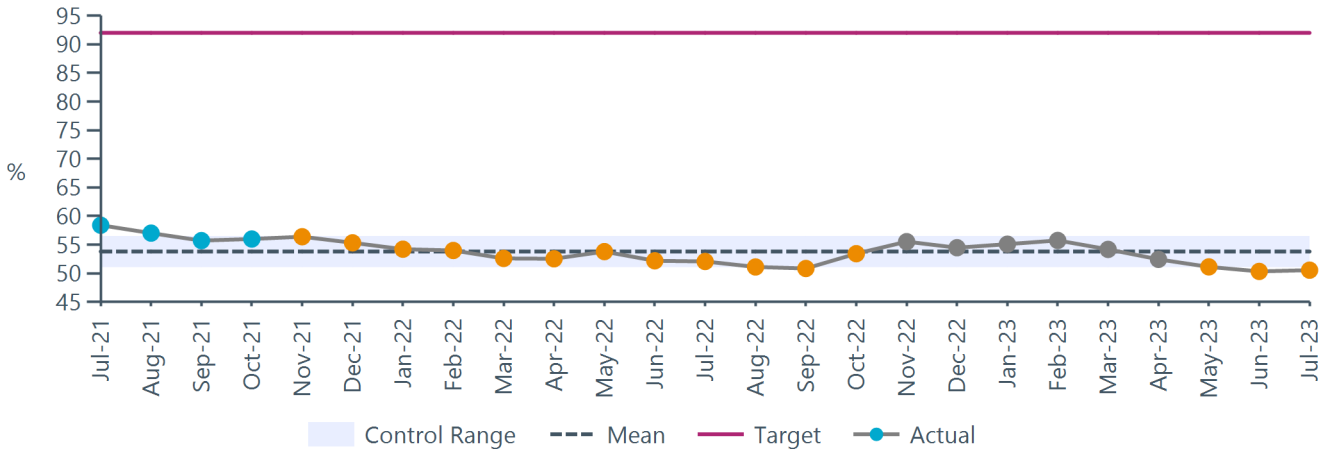
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
87.50%	66.67%	100.00%	100.00%	75.00%	100.00%	85.71%	100.00%	66.67%	33.33%	100.00%	33.33%	

18 Weeks RTT Open Pathways

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
92.00%	50.55%	L	F



Trajectory

What these graphs are telling us

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

Narrative

Our July performance was 50.55% 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 – 8028 patients waiting of which 2600 are breaches
* MS2 - 1310 patients waiting of which 818 are breaches
* MS3 - 5411 patients waiting of which 3875 are breaches

Following the system transition to MUSST service, we expect to see a 4% negative impact on this measure.

2023/24 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025
The Trust continues to address patients who continue to wait greater than 78 weeks with a route to zero planned by end of quarter one.

Actions

The Trust has been focusing on treatment of its longest waits. Agreements made for mutual aid support with both ROH and Walton. Patients being contacted and transferred where appropriate for our most challenged sub-specialty.

The Trust has a continuous validation programme in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. Validating patients down to 12 weeks is in progress.

Planning assumptions for 2023/24 include increases in capacity throughout the year aligned to productivity, workforce and estates programmes of work. Transformation, alongside increases in capacity, will continue to be assessed against the impact to overall list size. The Trust will also be taking actions during 2023/24 to assess waiting lists alongside health inequalities assessments.

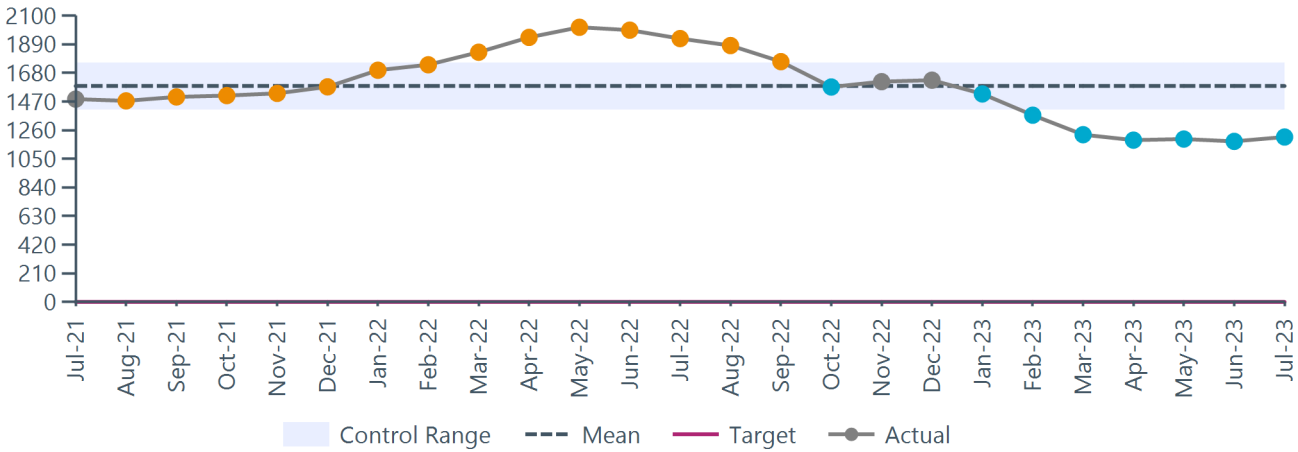
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
52.07%	51.11%	50.84%	53.43%	55.53%	54.47%	55.09%	55.74%	54.18%	52.44%	51.12%	50.33%	50.55%

Patients Waiting Over 52 Weeks – English

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1,210	L	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of July there were 1210 English patients waiting over 52 weeks; below our trajectory figure of 1410 by 200. The patients are under the care of these sub-specialities; Arthroplasty (516), Upper Limb (180), Knee & Sports Injuries (168), Foot & Ankle (149), Spinal Disorders (146), Paediatric Orthopaedics (15), Metabolic Medicine (9), Tumour (9), ORLAU (5), SOOS GPSI (4), Physiotherapy (3), Rheumatology (2), SOOS Physiotherapy (1), Spinal Injuries (1), Orthotics (1), and Geriatrics (1). Patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 1206 patients
* >78 to <=95 weeks - 3 patients
* >95 to <=104 weeks - 0 patients
* >104 weeks - 1 patient

2023/24 operational planning guidance stipulates that Trusts should:

* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025 .

Discussions continue with our Welsh Commissioners to ensure we are aligned to their ambitions too.
The Trust continues to address patients who continue to wait greater than 78 weeks with a route to zero planned by end of quarter one.

Actions

The national planning requirements issued in December stipulate that Trusts should eliminate waits of over 65 weeks for elective care, by March-24 (except where patients choose to wait longer or in specific specialties). To eliminate waits of over 65 weeks by March-2024, the Trust is focusing on all patients that will be greater than 52 weeks by the end of December to ensure they have a first appointment by the end of quarter two. The Trust has submitted a plan to NHSE that forecasts zero 65+ weeks waits by March-24. Impacts due to continued Industrial Action are being reviewed recognising the impact of reduced activity levels which are required to meet this standard.

The Trust has a continuous validation programme in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. Validating patients down to 12 weeks is in progress.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods.

Internal insourcing options are being explored to further increase capacity.

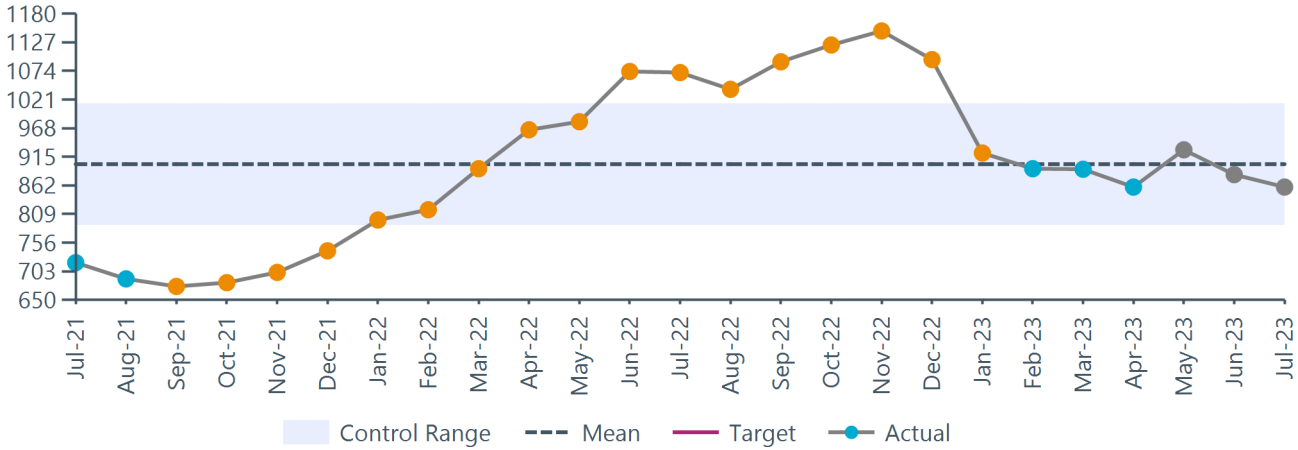
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
1932	1881	1763	1577	1616	1627	1526	1370	1227	1187	1195	1178	1210

Patients Waiting Over 52 Weeks - Welsh (Total)

Patients Waiting Over 52 Weeks - Welsh (Total) - Welsh and Welsh (BCU Transfers) combined 217788

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	859		No Target



Trajectory

What these graphs are telling us

Metric is experiencing common cause variation.

Narrative

At the end of July there were 859 Welsh patients waiting over 52 weeks. The patients are under the care of the following subspecialties; Spinal Disorders (309), Arthroplasty (188), Knee & Sports Injuries (122), Upper Limb (88), Foot & Ankle (82), Veterans (40), Paediatric Orthopaedics (23), Tumour (2), Metabolic Medicine (2), Rheumatology (2), and Neurology (1).

Patients are under the care of the following commissioners: BCU (483), Powys (353), Hywel Dda (21), Cwm Taf University LHB (1) and Cardiff & Vale (1). The number of patients waiting, by weeks brackets is:

* >52 to <=78 weeks - 651 patients
* >78 to <=95 weeks - 133 patients
* >95 to <=104 weeks - 24 patients
* >104 weeks - 51 patients

Actions

The Welsh guidance differs from NHS England guidance. The Trust continues to monitor equity across our commissioners whilst recognising guidance and differences in pathway monitoring. Discussions continue with Welsh Commissioners to understand commissioning intentions for 2023/24; the guidance remains outstanding.

The Trust has a continuous validation programme in place whilst these patients continue to wait and ensures harm is continually reviewed as per the Trust's Harm Policy. Validating patients down to 12 weeks is in progress.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods.

Internal insourcing options are being explored to further increase capacity.

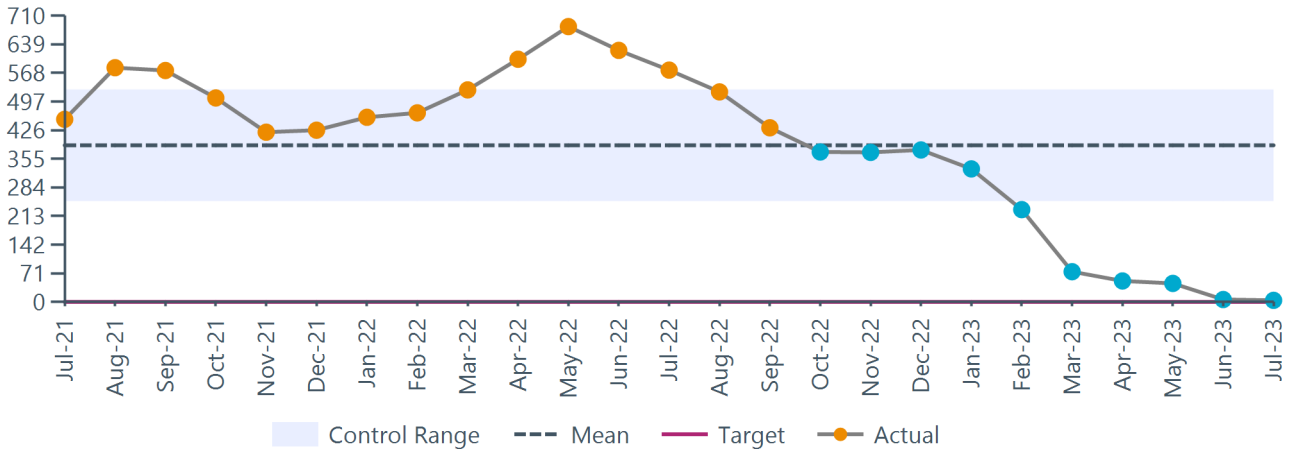
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
1071	1040	1091	1122	1148	1095	922	893	892	859	928	882	859

Patients Waiting Over 78 Weeks - English

Number of English RTT patients waiting 78 weeks or more at month end 217774

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	4	L	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of July there were 4 English patients waiting over 78 weeks; this was 4 patients above our trajectory of 0. Submitted plans are visible in the trajectory line above. The patients are under the care of the following sub-specialities; Knee & Sports Injuries (2), Upper Limb (1) and Foot & Ankle (1).

46 patients declined the offer of mutual aid leading to non-admitted clock stops; the patients remain on our internal waiting lists. This is in line with updated national guidance.

2023/24 operational planning guidance stipulates that Trusts should:
* Eliminate waits of over 65 weeks by March 2024 - exceptions are patient choice / specific specialties
* Continue to develop plans to reduce 52 week waits, with NHSE ambition, to eliminate them by March 2025 .
Discussions continue with our Welsh Commissioners to ensure we are aligned to their ambitions too.
The Trust continues to address patients who continue to wait greater than 78 weeks with a route to zero planned by end of quarter one.

Actions

The Trust is now reporting against this standard by exception with the Trust making significant improvements against this standard in quarter one. In line with national planning expectations the Trust aims to further reduce long waits to less than 65 weeks by March-24.
The Trust has sought mutual aid to support its most challenged specialty. Agreements made with both ROH and Walton for support with this being reviewed with those providers. Patients being contacted and transferred where appropriate and agreed with the patient and relevant provider.
Agreement in place to participate in the Digital Mutual Aid system that is being led by NHS England. A mutual aid co-ordinator and validation resource are in place and this resource has been extended into 23/24 to support actions being taken. Chief Operating Officer discussions also take place between providers to monitor progress.
Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible during the periods.

Internal insourcing options are being explored to further increase capacity.

Further internal assessments underway to explore options where kit delays exist.

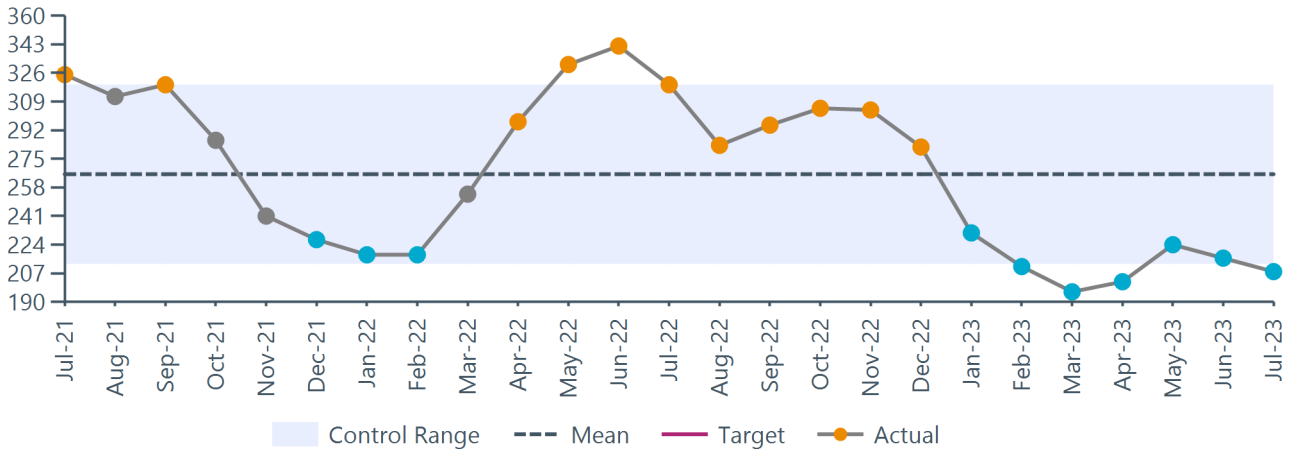
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
575	521	432	372	371	377	330	229	75	52	46	6	4

Patients Waiting Over 78 Weeks - Welsh (Total)

Number of Welsh RTT patients waiting 78 weeks or more at month end 217802

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	208	L	No Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of July there were 208 Welsh patients waiting over 78 weeks.

The patients are under the following sub-specialties; Spinal Disorders (133), Knee & Sports Injuries (34), Foot & Ankle (14), Upper Limb (12), Arthroplasty (9), Veterans (4), Paediatric Orthopaedics (1) and Neurology (1).

Actions

In line with Welsh Assembly expectations, the Trust is taking action to address the longest waiting patients. The Trust continues to treat Welsh patients alongside English patients, balancing both long waits and clinical urgency. Discussions continue with Welsh Commissioners to understand commissioning intentions for 2023/24; the guidance remains outstanding. This includes whether additional capacity is required to be sourced. Trajectories are currently in development for our Welsh Commissioners.

Internal pooling is underway to further support progressing our longest waits.

Industrial Action impacts continue to be monitored within the Trust, with clinically urgent and long waits being prioritised, where possible, during the periods.

Internal insourcing options are being explored to further increase capacity.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
319	283	295	305	304	282	231	211	196	202	224	216	208

Patients Waiting Over 104 Weeks - English

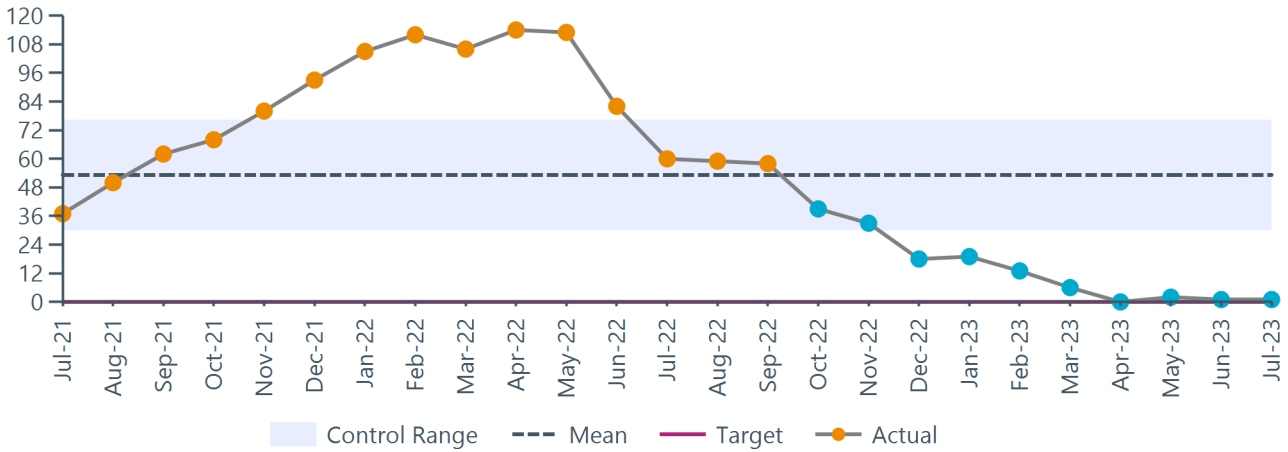
Number of English RTT patients waiting 104 weeks or more at month end 217588

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
0	1	L	F

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

At the end of July there was 1 English patients waiting over 104 weeks with details as follows:
* Knee & Sports Injuries (1): Complex case requiring a bespoke piece of kit sourced from abroad (ongoing supply issues) which has been raised with NHSE

The Trust is forecasting this one breach will remain for the end of August.

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
60	59	58	39	33	18	19	13	6	0	2	1	1

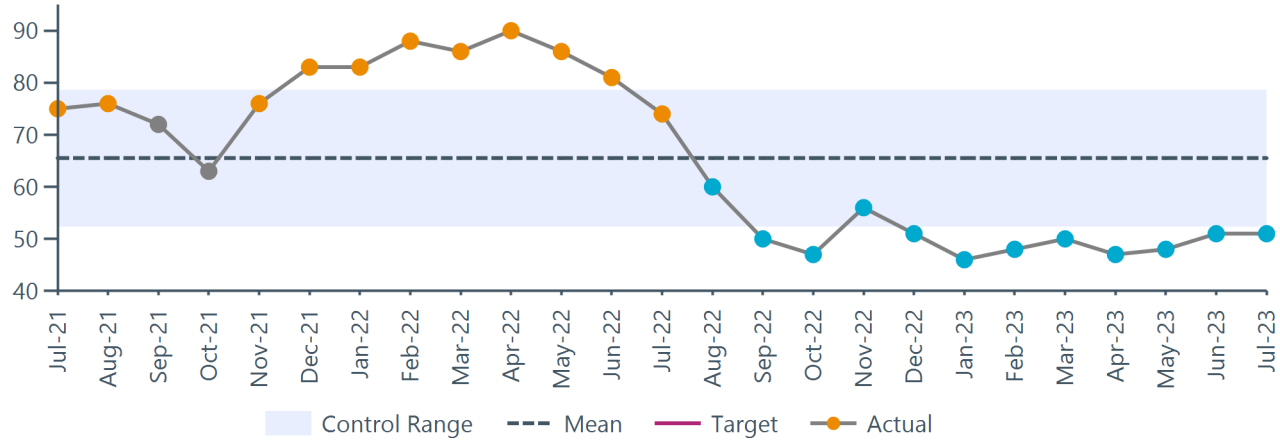
Patients Waiting Over 104 Weeks - Welsh (Total)

Number of Welsh RTT patients waiting 104 weeks or more at month end 217803

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
-	51	L	No Target

Actual
Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature.

Narrative

At the end of July there were 51 Welsh patients waiting over 104 weeks.

The patients are under the care of the following subspecialties:
* Spinal Disorders (49)
* Neurology (1)
* Veterans (1)

Actions

The Trust continues to monitor its longest waits and will flag any forecast breaches against this standard going forward. The majority of breaches are now attributable to our most challenged sub-specialty. Conversations with Welsh Commissioners continue to understand commissioning intentions for 2023/24. We anticipate a decision on whether NHSE mutual aid providers can be utilised to treat Welsh patients.

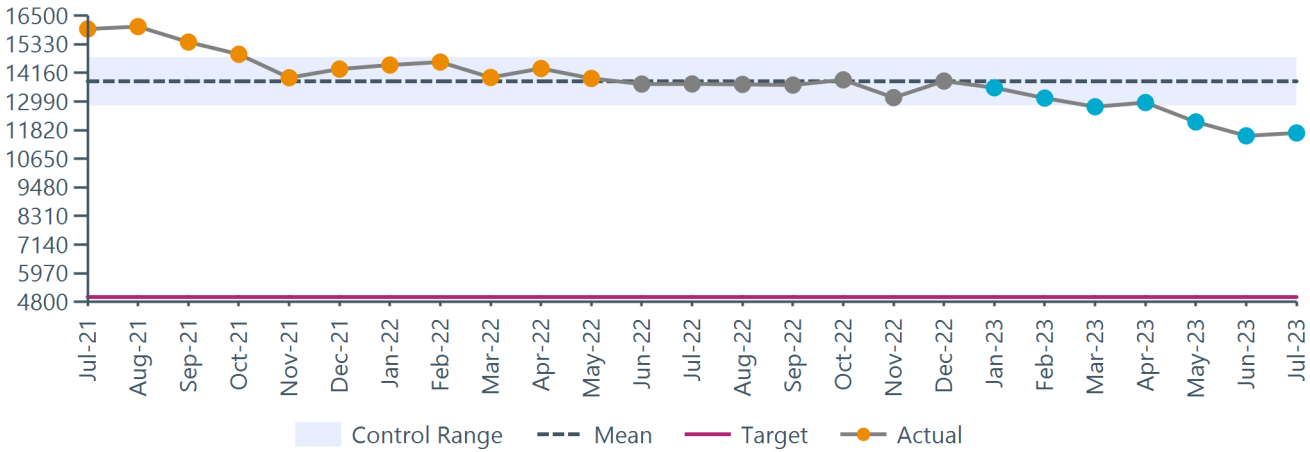
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
74	60	50	47	56	51	46	48	50	47	48	51	51

Overdue Follow Up Backlog

All dated and undated patients that are overdue their follow up appointment 217364

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5,000	11,707	L	F



Trajectory

What these graphs are telling us

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

Narrative

At the end of July, there were 11707 patients overdue their follow up appointment. This is broken down by:
- Priority 1 - 7406 with 1192 dated (16%) (priority 1 is our more overdue follow-up cohort)
- Priority 2 - 4301 with 1185 dated (28%);

* The sub-specialities with the highest percentage of overdue follow ups are: Arthroplasty - 18.6%; Rheumatology - 16%; Spinal Injuries - 10.9%;
* The backlog increased by 118 from last month. It is noted that a total of 1703 patients were removed from the backlog in July; the lowest number removed per month since December 2021. It is noted that 136 follow up appointments were cancelled in July as a result of strike action.
* MSK backlog at the end of July is 5100; 3.5% higher than it was in April 2020. Specialist backlog at the end of June is 6607; 32% higher than it was in April 2020.
* The main focus within the Trust has been on long waiters, with a specific focus on the NHSE ask to meet the 65 week milestone 1 target.
* Planning expectations for 2022/23 were to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023, however, our plans do not meet this aspiration. One of the factors to non-achievement is recognition that the Trust continues to address its overdue follow-up backlog.

Actions

* The overdue follow up working group is on hold to allow the dedicated focus needed on the NHSE long wait RTT targets. The plan is to re-instate this group in the coming months, recognising it's importance but balancing resource against the RTT long waits national ask.
* The follow up PTL has been streamlined to make it easier to use for the bookings teams.
* The Information team have made improvements to sub-speciality reports which are shared at firm meetings for discussion, these include a slide on overdue follow ups by consultant.
* The Validation team have a long term follow up database and follow ups are validated regularly. Arthroplasty, in particular, have a high validation rate. Currently scoping focused validation for Rheumatology.
* In Rheumatology, additional capacity is now in place for follow ups.
* PIFU for overdue follow ups continues within Spinal Disorders.
* Clinical discussions are taking place with regards to validation of overdue follow ups.
* MSK consultants have been completing desktop reviews of their overdue follow ups in July.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
13710	13693	13665	13878	13151	13828	13554	13132	12777	12949	12158	11589	11707

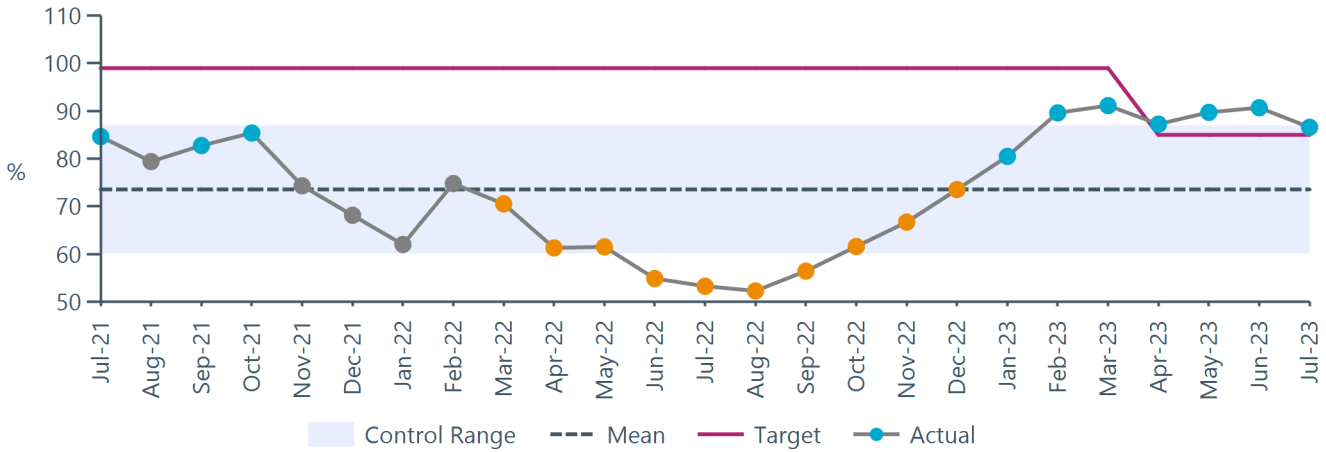
6 Week Wait for Diagnostics - English Patients

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

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	86.61%	H	Moving Target

Trajectory



What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. Due to target change, this shows as a moving target.

Narrative

The target for this measure has been updated to 85% to reflect the national planning expectations for this year. The metric is included as an exception due to the sustained improvement where July's position is reported at 86.61%. Reported performance equates to 128 patients who waited beyond 6 weeks. Of the 6-week breaches; 4 are over 13 weeks (Ultrasound). Breakdown below outlines performance and breaches by modality:

* MRI - 99.31% - D4 (Routine - 6-12 weeks) - 3 dated
* CT - 94.59% - D2 (Urgent - 0-2 weeks) - 2 dated, D4 (Routine - 6-12 weeks) - 4 with 2 dated
* Ultrasound - 69.33% - D2 (Urgent - 0-2 weeks) - 1 dated, D4 (Routine - 6-12 weeks) - 112 with 49 dated
* DEXA Scans - 100%

It must be noted that MRI met the 99% target which is the first time since February '20.

To support the percentage of patients receiving a diagnostic test within 6 weeks, NHSE are increasing focus on >13 weeks. National expectations was to have no 13 weeks by end of June 2023. The 4 breaches over 13 weeks within ultrasound were due to the breakdown of the scanner, however, due to increase in referrals for ultrasound, performance has deteriorated within this modality for the past four months. March 2024 ambition is to achieve 85% against the 6-week standard within all modalities. It must be noted that both MRI and CT are already achieving the 6-week standard. Both Ultrasound and MRI activity plans were met in July.

Actions

* Mobile MRI Scanner is back on-site 20th August for 13 days and there are 13 unassigned days for the MRI scanner that need to be scheduled before 31st March '24.
* Plans to increase activity at weekends within ultrasound for Spinal Injuries
* Investigate current KUB (Kidney, Ureter & Bladder) ultrasound sessions to check if they are being fully utilised
* Review current demand and capacity within ultrasound

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
53.30%	52.31%	56.47%	61.62%	66.73%	73.55%	80.51%	89.63%	91.15%	87.27%	89.74%	90.71%	86.61%

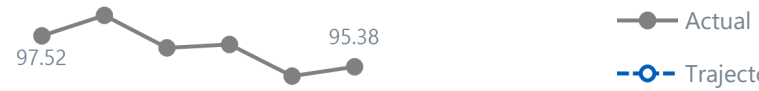
8 Week Wait for Diagnostics - Welsh Patients

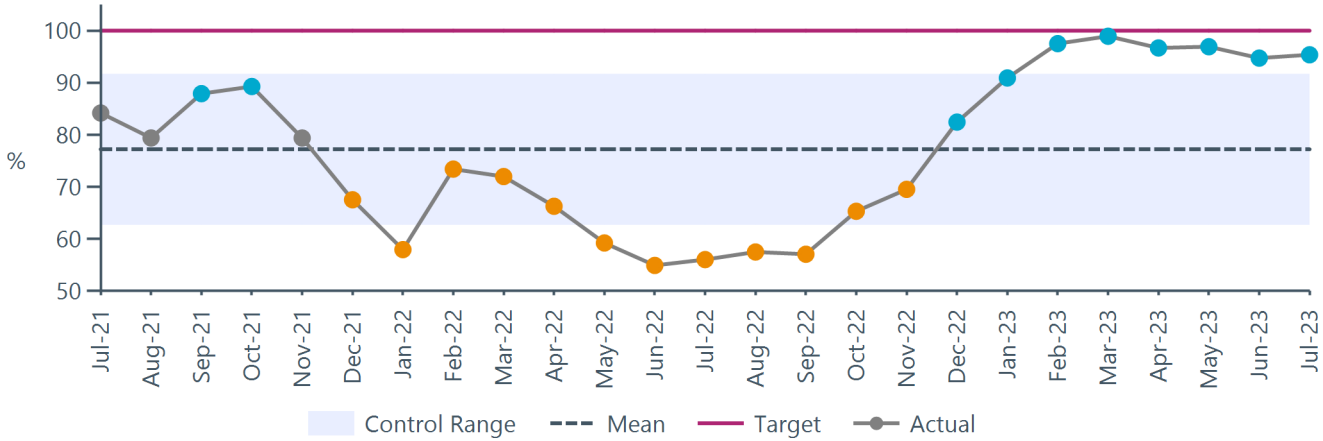
% of Welsh patients currently waiting less than 8 weeks for diagnostics 211027

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
100.00%	95.38%	H	F

Trajectory





What these graphs are telling us

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

Narrative

The 8 week standard for diagnostics was not achieved this month and is reported at 95.38%.

Reported performance equates to 17 patients who waited beyond 8 weeks. Breakdown below outlines performance and breaches by modality:
* MRI - 99.60% - D4 (Routine - 6-12 weeks) - 1 dated
* CT - 97.22% - D4 (Routine - 6-12 weeks) - 1 undated
* Ultrasound - 81.48% - D4 (Routine - 6-12 weeks) - 15 with 11 dated
* DEXA Scans - 100%

The trust continues to treat by clinical priority. It must be noted that both ultrasound and MRI activity plans were met in July.

Actions

* Mobile MRI Scanner is back on-site 20th August for 13 days and there are 13 unassigned days for the MRI scanner that need to be scheduled before 31st March '24.
* Plans to increase activity at weekends within ultrasound for Spinal Injuries
* Investigate current KUB (Kidney, Ureter & Bladder) US sessions to check if they are being fully utilised
* Review current demand and capacity within ultrasound

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
56.03%	57.48%	57.05%	65.30%	69.52%	82.44%	90.92%	97.52%	98.94%	96.69%	96.92%	94.74%	95.38%

Elective Activity Against Plan (volumes)

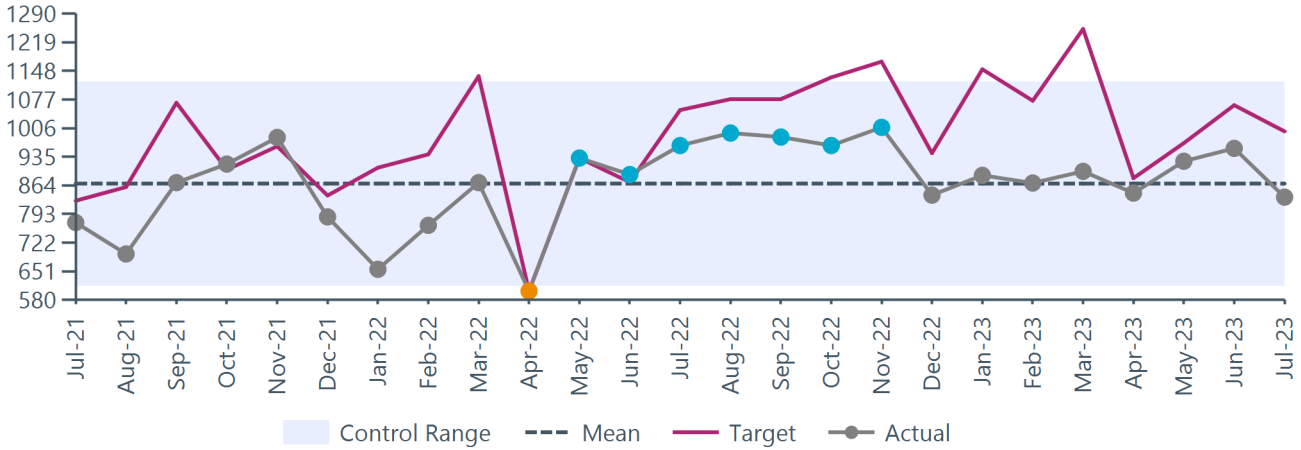
Total elective activity rated against plan. 217796

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
998	835		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

Total elective activity reported externally against plan 2023/24 in July was 835, 163 below plan of 998 (83.67%).
Factors affecting delivery:
- Planned reduction in Theatre activity before and during the period of industrial action 13th to 17th and 20th to 21st July.
- Staffing issues in Theatres inclusive of strike period.
- 97 theatre cancellations (30 on the day and 67 ahead of TCI)
- Shortfall in NHS theatre sessions (-53.5)
- IJP activity not maximised and shortfall in OJP activity
- Cases per session behind plan

Non theatre activity accounted for 20.72% of spells this month which is the lowest level year to date - Q1 average was 25.49%.

Actions

Delayed implementation of Theatre improvement initiatives has contributed to underperformance year to date:
* Underutilisation of Spines emergency lists for P2 patients is being addressed by improved alignment of list scheduling with consultant availability.
* Review of 18 Week Insourcing planned for September, which will support collaborative working and improve understanding between the Trust and 18 Week Insourcing.
* The commencement of 5 joint lists has been delayed (staffing alignment); 6-4-2 meetings are addressing consultant concerns about known staffing and is running well; additional activity is being taken at this meeting.
* Extended theatre days to 2.5 sessions has not progressed as planned; absence of theatre staff to support is raised via 6-4-2. It is aimed the early starts will be expanded to several consultants in October, when the plan is to work to 12 theatres. This will also support the enhanced recovery project.
* Headley Court Day Case Facility lists are being staffed in September and discussions are ongoing with OPD manager; requests are going out to relevant consultants to offer more for the procedure room. Use of the space for 18 Week Insourcing is being explored.
* Improved payment for theatre staff at weekends commenced 1st August. Most staff in local training will complete by end of September, supporting aim to increase capacity to 12 theatres.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
963	994	984	963	1008	840	889	870	899	845	924	956	835

Overall BADS %

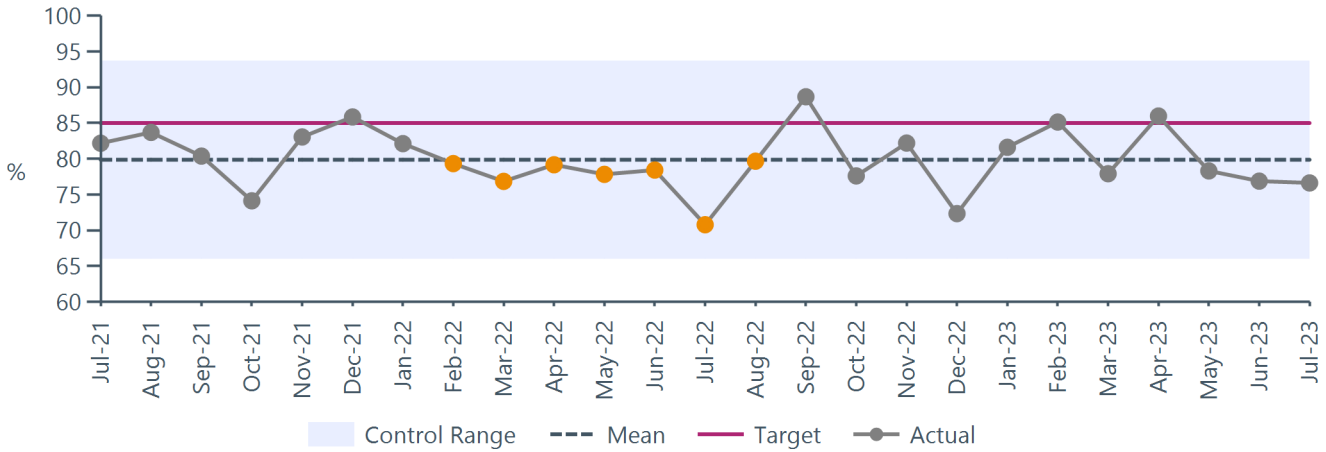
% of BADS procedures performed as a day case 217813

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
85.00%	76.63%		

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

This measure reflects the overall % Trust performance of day cases against the latest online British Association Of Day Surgery directory of procedures; Orthopaedic and Urology pages.

In July the Trust is reporting 77.05% BADS day cases against a target of 85% and has been behind plan for three months.

Actions

Performance is monitored via the Day Case Working Group and actions include:
* To improve day surgery success rates (against BADS).
* To extend range of procedures done as day cases.
* To meet process checklist set out in GIFRT day surgery delivery document.
Theatres Manager to meet with Day Case lead to support these ambitions.

* To improve the data quality of Day Case patients by:
- Working with Access Team to improve data quality of bookings and alignment between PAS and Bluespier.
- Working with nursing and admin staff to improve timeliness of patient discharge from PAS.

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
70.79%	79.67%	88.67%	77.61%	82.20%	72.34%	81.61%	85.14%	77.92%	85.98%	78.31%	76.88%	76.63%

Total Outpatient Activity against Plan (volumes)

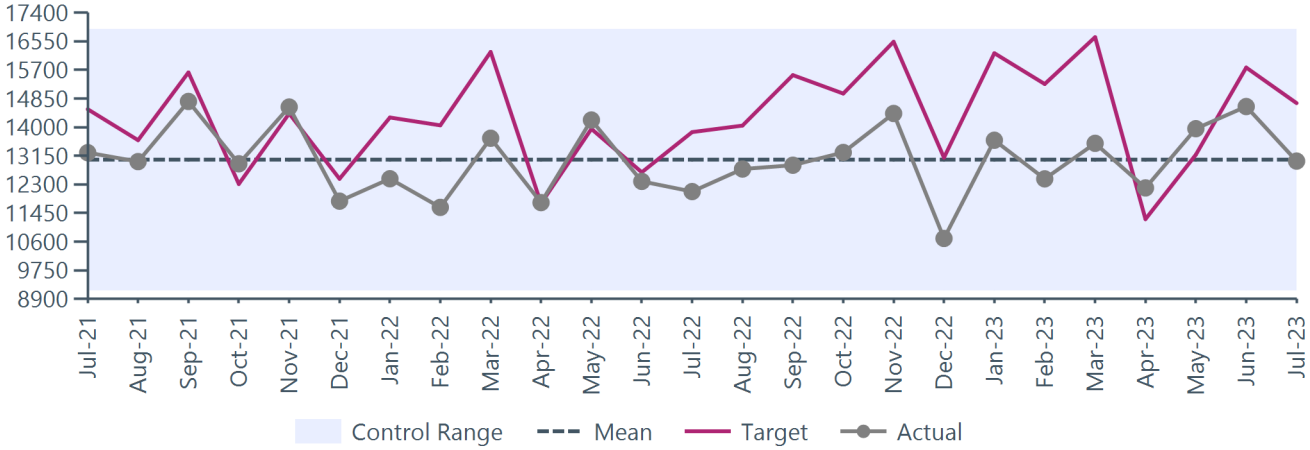
Total outpatient activity (consultant led and non-consultant led) against plan. 217795

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
14,714	12,993		Moving Target

Trajectory

Actual
Trajectory



What these graphs are telling us

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

Narrative

Total outpatient activity undertaken in July was 12993 against the 2023/24 plan of 14714; a shortfall of 1721 that equates to 88.3% of plan.
This is broken down as:
* New Appointments - 4203 against 4453 - equating to 94.39%
* Follow Up Appointments - 8790 against 10261 - equating to 85.66%
The sub-specialities with the lowest activity against plan in July are:
* SOOS - 811 against 1359 - 548 against plan;
* Upper Limb - 737 against 1226 - 489 behind plan; 73.6% of IJP plan met, 42.03% of OJP plan met
* Arthroplasty - 1262 against 1619 - 357 behind plan; 95.3% of IJP plan met, 53.29% of OJP plan met
In July, 194 outpatient appointments were lost due to industrial action.
Year to date performance is under plan by 1178 cases (97.86% of plan). The activity numbers are always taken on 5th working day to allow 4 working days for administrative transactions. We are aware that this timescale isn't met for some clinics and so we may see an increase when figures are refreshed next month.

Actions

* Outpatient Improvement Group meets Fortnightly to discuss performance and actions in relation to Overdue Follow Ups, DNAs, PIFU & Virtual KPI's.
* Three other groups are in their infancy but will support with key areas of improvement, which are: Therapies Improvement Group, Radiology Improvement Group and Rheumatology Improvement Group
* All four of the above groups then feed into an Oversight group that meets monthly.
* Requirement to revisit plans at sub-speciality level.

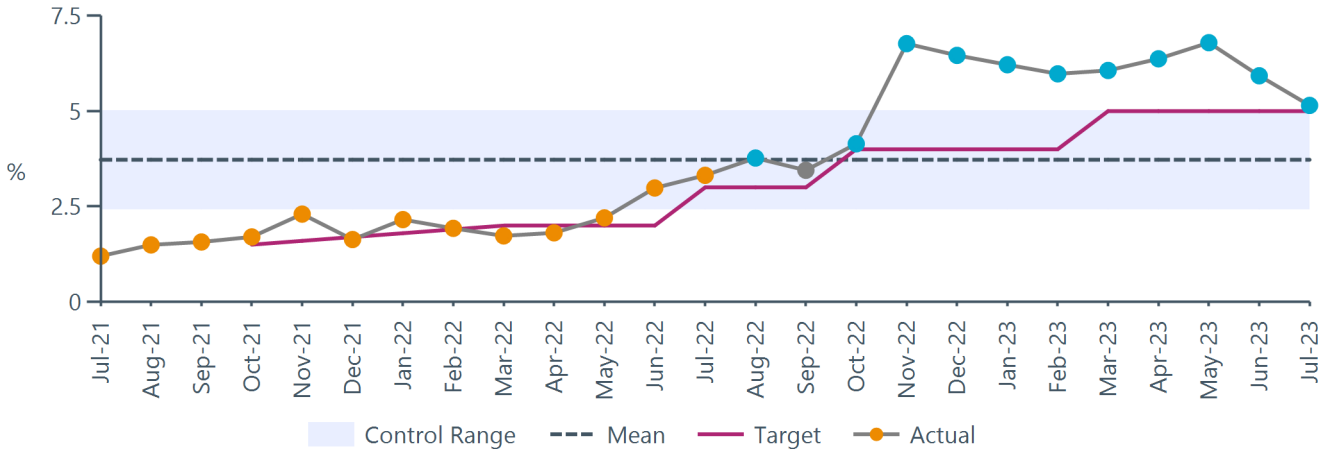
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
12088	12758	12871	13250	14407	10696	13613	12466	13521	12197	13956	14613	12993

Total Outpatient Activity - % Moved to PIFU Pathway

Total Outpatient Activity - % Moved to Patient Initiated Follow Up Pathway against plan 217715

Exec Lead:
Chief Operating Officer

Target/Plan	Latest Value	Variation	Assurance
5.00%	5.15%	H	Moving Target



Trajectory

What these graphs are telling us

Metric is experiencing special cause variation of an improving nature. This measure has a moving target.

Narrative

The target for the number of episodes moved to a PIFU Pathway is 5% of all outpatients attendances. In July the target was met with 5.15% of total outpatient activity moved to a PIFU pathway. However, this has been highlighted this month as an exception because if we exclude SOOS from the numerator and denominator then in July our performance stands at 3.37%.

We are also monitoring our performance in this metric excluding SOOS numbers, being mindful of the transition to the new MSST service. SOOS team have a high PIFU rate of 28%.

Actions

* System action - working with STW MSK with the transition of the MSST service from SOOS

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
3.32%	3.77%	3.45%	4.14%	6.77%	6.46%	6.21%	5.98%	6.06%	6.37%	6.79%	5.93%	5.15%

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The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

RJAH Long Waiters - 2023/24

Trust Board

6th September 2023

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2023/24 July and August** Performance

		Plan	Actual	Difference
July	English 104+ Weeks	0	1	1
	Welsh 104+ Weeks	-	51	
	English 78+ Weeks	0	4	4
	Welsh 78+ Weeks	-	208	
	English 65+ Weeks	454	330	-124
	Welsh 65+ Weeks	-	436	

		Plan	Forecast*	Difference
August**	English 104+ Weeks	0	1	1
	Welsh 104+ Weeks	-	48	
	English 78+ Weeks	0	10	10
	Welsh 78+ Weeks	-	219	
	English 65+ Weeks	513	392	-121
	Welsh 65+ Weeks	-	480	

*** Unvalidated. 30th August Snapshot.*

NHS England Updates:

Patient choice: - NHSE Interim guidance - NHSE Active Monitoring RTT rule changes being made to patients declining mutual aid and 2 x TCI dates. Impacts English ONLY

System mutual aid: - Patients transferred from SaTH to RJAH during 2022/23. Ongoing assessments during 2023/24.

2023/24 – FOCUS TO MOVE TO 0 X 65+ WEEKS BY MARCH 2024

NHS Wales Updates:

2023/24 – Awaiting confirmation on targets.

Mutual aid discussions ongoing

2023/24: - NHSE 65+ weeks Submitted Plans

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
476	402	441	454	513	467	460	365	321	303	196	0

ss patient care

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NHS Foundation Trust

Theatre activity forecast & impact assessment

August 2023

Mike Carr & Craig Macbeth

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Operational Delivery Assurance on schemes to achieve plan

Scheme	Full year plan (activity)	Sep	Oct	Nov	Dec	Jan	Supporting information, supporting assurance KPIs and actions
Plan – Baseline to be delivered **(11 operational theatres Monday to Friday)**	**9,547**						• Total theatre workforce required is 159 for 11 theatres, projection for September is 168.12 and October is 174.42. • 17 staff currently in local training,7 completed by end of September. • Anaesthetic capacity constraint mitigations in place from September.
Weekend working inc Insourcing (32 NHS and 5 insourcing sessions)	868	**74**	**74**	**74**	**74**	**74**	• weekend sessions (NHS and Insourcing combined) booked currently at 46 sessions as compared to plan of 37 sessions. • Equates to +18 cases per month above plan.
Extended days – 0.5 sessions	63	0	7	7	7	7	• Delivered 13 extended sessions YTD (ahead of plan but action required to deliver monthly plan. • **Early start programme with consultant being agreed**
5 joint lists	147	14	21	21	21	21	• Of 2 initial consultants, 1 no longer supportive and other had extended leave in Q1. • Additional consultants identified. • Requires staffing resource within theatres for the revised time.
P2 Spinal Emergency capacity	68	6	6	6	6	6	• Commenced from June and delivering anticipated levels in June and July.
12th theatre operational from November 23 (workforce plan)	435	0	0	94	94	94	• Total theatre workforce required is 175 for 12 theatres, projection for September is 168.12 and October is 174.42. • 17 staff currently in local training, 13 completed by end of October.
Theatre TIF 2	282	0	0	0	0	94	• Appointed contractor schedule sets out completion and handover in March 2023.

Theatre productivity assumptions

Scheme	Full year plan (activity)	Sep	Oct	Nov	Dec	Jan	Supporting information, supporting assurance KPIs and actions
Mitigation schemes							
12th theatre operational from September workforce plan	107	13	94				• Total theatre workforce required is 175 for 12 theatres, projection for September is 168.12 and October is 174.42.
Additional weekend working inc Insourcing	126	18	18	18	18	18	• Additional Weekend working throughout the year, provides an extra 126 cases. • 9 sessions (18 cases) above plan at weekends secured to date for September
Mitigations total	233	31	112	18	18	18	
Net Theatre activity plan surplus/shortfall	-85	+31	+112	+18	+18	-76	• Includes TIF 2 Impact in February and March

Industrial Action Impact

- Q1 96 (junior doctors only)
- July impact 71 (Junior doctors and Consultants)
- August planned dates (Junior Dr and Consultants)
- September planned dates (Consultants)
- FYE potential to be 879 if continues at similar pattern to recent strike days

Cumulative Activity impact

	Impact
Operational plan	
Activity reductions	
YTD Underperformance combined exc IA	-212
TIF2 Delay	-282
Further insourcing delays Q2	-5
	-499
Mitigations	
workforce ahead of schedule for 12th theatre	107
Additional saturdays Q3&Q4	126
	233
Net Impact	-266

Further Mitigations

- Use of external facilities in Q4 with RJAH theatre staff.
- Additional weekend working (Sundays, trial in September)
- Wider roll out of the extended sessions

Industrial Action Risk

- YTD to July impact is 167 with possible future impact of 879 total of -1046

Theatre activity forecast & impact assessment

August 2023

Mike Carr & Craig Macbeth

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

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Industrial Action Risk

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M4 Financial Position Update

I&E Position

Performance Against Plan £'000s							
Category	Annual Plan	In Month Position			23/24 YTD Position		
		Plan	Pass through Adj Actual	Variance	Plan	Pass through Adj Actual	Variance
Clinical Income	128,125	10,057	9,713	(344)	39,419	38,514	(905)
Private Patient income	6,354	471	616	145	2,139	2,371	232
Other income	7,302	608	710	102	2,430	2,471	41
Pay	(86,284)	(7,083)	(7,177)	(94)	(28,410)	(28,533)	(123)
Non-pay	(48,801)	(3,769)	(3,802)	(33)	(15,262)	(15,280)	(18)
EBITDA	6,696	284	60	(224)	316	(457)	(773)
Finance Costs	(7,341)	(601)	(497)	104	(2,402)	(2,121)	281
Capital Donations	150	0	8	8	75	67	(8)
Operational Surplus	(495)	(317)	(429)	(112)	(2,011)	(2,511)	(500)
Remove Capital Donations	(150)	0	(8)	(8)	(75)	(67)	8
Add Back Donated Dep'n	836	69	68	(1)	278	264	(14)
Control Total	191	(248)	(370)	(122)	(1,807)	(2,314)	(507)

Overall £370k deficit in month, £122k adverse to plan (includes elective income adjustment of £222k in line with national guidance)

YTD £2,314k deficit, £507k adverse to plan (includes elective income adjustment of £1,112k in line with national guidance)

- Clinical Income £344k adverse:
  - Theatre activity £637k (145 case shortfall)
  - MSK outpatients shortfall £127k

  offset by:
  - MCSI activity £157k
  - Elective income adjustment £222k
- Private Patients £145k favourable driven by volume
- Pay £96k adverse:
  - MCSI £91k (includes £30k 1-2-1)
  - Theatres super nummary staff (14.5 wte) £50k
- Non Pay £33k adverse:
  - Theatre consumables £63k
  - OJP £45k

  Offset by:
  - Implant cost reduction (volume related) £101k

Agency £229k spend in month, £29k below agency cap
19% off framework usage in month (reduced from 42% last month)

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I&E Forecast

Category	Forecast Position		
	Plan	Pass through Adj Actual	Variance
Clinical Income	128,125	127,016	(1,109)
Private Patient income	6,354	6,957	603
Other income	7,302	7,255	(47)
Pay	(86,284)	(86,729)	(445)
Non-pay	(48,801)	(49,249)	(448)
EBITDA	6,696	5,250	(1,446)
Finance Costs	(7,341)	(6,588)	753
Capital Donations	150	150	0
Operational Surplus	(495)	(1,188)	(693)
Remove Capital Donations	(150)	(150)	0
Add Back Donated Dep'n	836	822	(14)
Control Total	191	(516)	(707)

Overall forecast £707k adverse to plan prior to further mitigations being identified/agreed

Assumptions as follows :

Clinical income
- Theatre activity based on forecast presented to August Board
- Industrial action impact c£4m is assumed to be mitigated by national guidance for both England and Wales (Welsh element flagged as risk). Detailed guidance awaited

Private Patients Income
- Assumes continuation of YTD run rate at average of 5 additional patients per month as a mitigation

Other Income
- Assumes current run rate with improvements to research aligned to forecast.

Pay
- Agency pressures aligned to agency forecast.
- Release 50% of annual leave accrual in second half of the year as a mitigation.
- Additional pay assumed for activity mitigations through additional sessions.

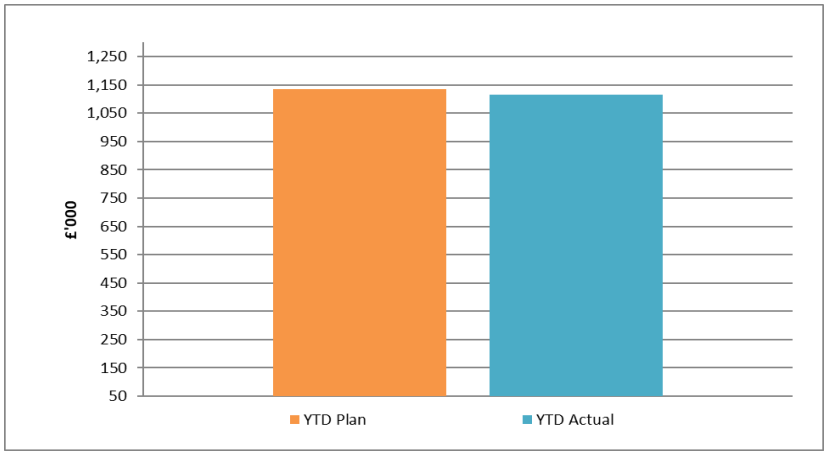
Non-Pay
- Implants & Consumables linked to activity forecast presented to August Board
- Additional implants and consumables linked to private activity.

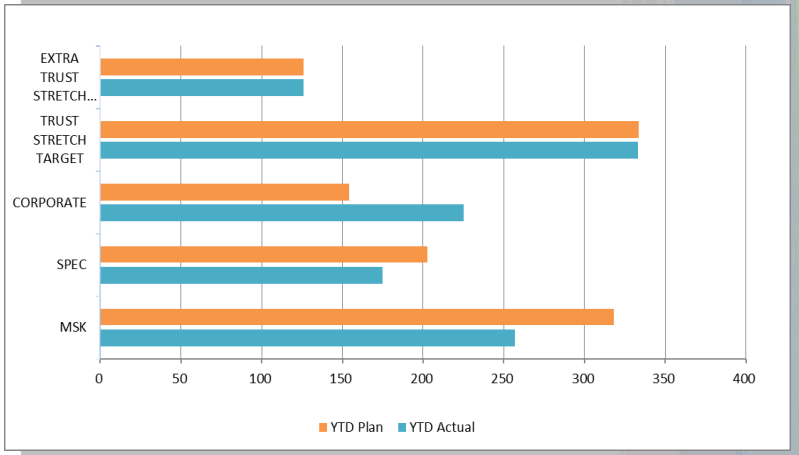
Finance Costs
- Interest receivable based on current run rate (supporting efficiency programme)

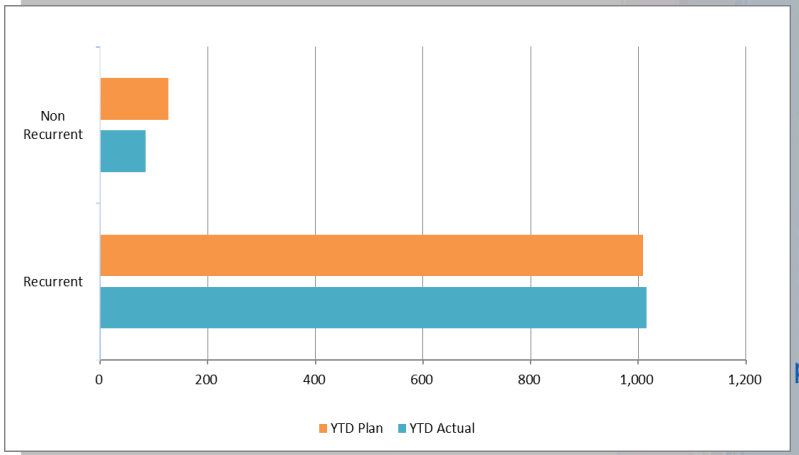
Additional Risks
- Unmitigated risks not included in forecast of £2.1m (see separate risk slide)

Further Mitigations Under Review
- Further activity recovery through additional weekend sessions to mitigate the additional theatre delay (impact valued at £700k)..
- Should above prove insufficient then further action will need to be taken on pausing controllable expenditure.

Efficiencies







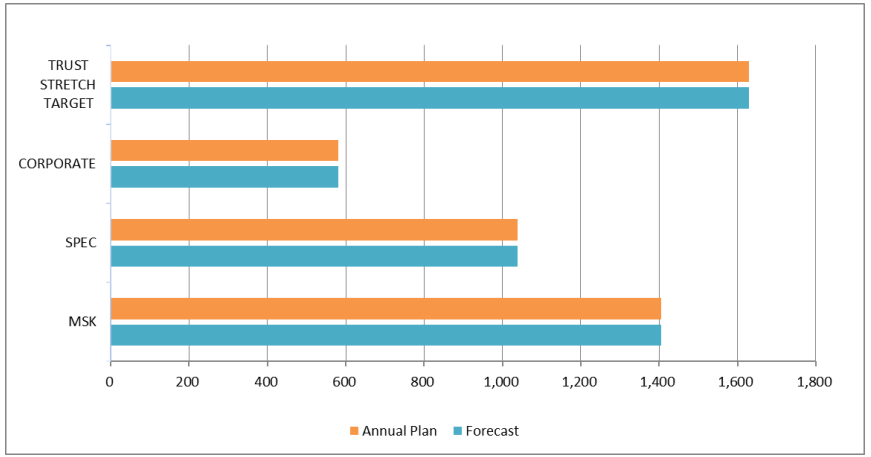
Efficiency performance is £35k adverse to plan year to date.

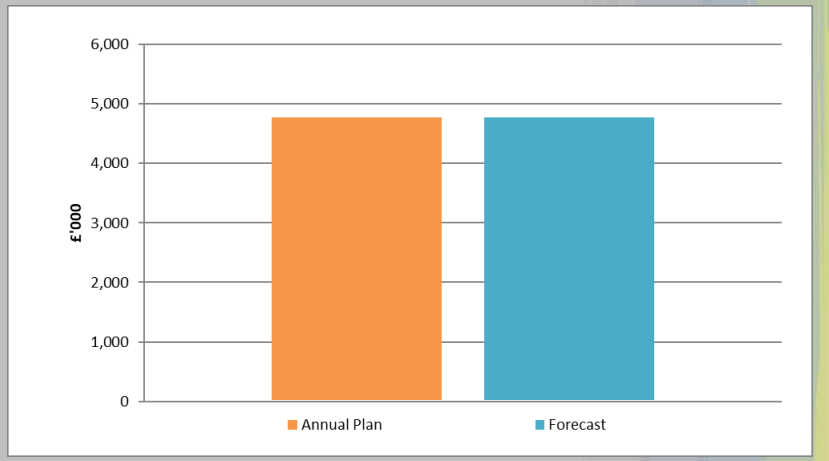
- MSK unit £78k adverse to plan ytd
- Specialist unit £28k adverse to plan ytd
- Corporate £71k favourable to plan ytd

Extra stretch target achieved in month through 1/3rd recurrent schemes identified and 2/3rds non recurrent interest receivable mitigations.

patient care

Efficiencies Forecast





Annual plan requirement of £4.7m (3.7%) including initial stretch of £1m and extra stetch of £0.6m.

Forecast is £4.7m of which £0.7m is red rated and £0.4m is non recurrent.

Unit	Annual Plan	£'000s		
		Recurrent	Non Recurrent	Forecast
CORPORATE	2,329	1,909	420	2,329
SPEC	1,039	1,039	0	1,039
MSK	1,405	1,405	0	1,405
Total	4,773	4,353	420	4,773

RAG	Forecast
g	2,976
a	1,116
r	681
Total	4,773

Risks to the financial plan

Risk Type	Risk name	Risk Description	Estimated Value	Risk ID	Annual Risk £'000 at 1st April 2023	Forecast Risk Remainder of Year £'000	Mitigations £'000	Net Risk £'000	Liklihood	Consequence	Risk Rating	Mitigations / actions
Internal	Variable income performance - Restoration	Planned activity requires an increase of 10% on previous year average before the new theatre development. As the Trust now operates under PbR, failure to deliver carries an income risk.	A 1% shortfall in activity delivery is valued at net impact £325k. Total risk based on recovery from 90% to 100% activity.	3027	£ 3,250	£ 2,167	£ 2,167	£ -	4	4	16	Action plan linked to operational plan delivery assurance based on Q1 stock take to Board identifying mitigations for productivity slippage. Mitigating actions taken to bring forward additional sessions linked to successful workforce recruitment.
Internal	Variable income performance - Theatre Development	Delays to the new theatre development planned to go live in January 2024 will have adverse impact on elective inpatient activity which will in turn impact on clinical income.	Additional activity from the new theatre is planned at 282. If not delivered this will impact clinical income at average casemix of £5k, the non pay and overhead expenditure will be saved giving a net loss of 40% linked to pay and committed costs.	3083	£ 1,410	£ 1,410	£ 705	£ 705	4	4	16	All options being explored to bring forward the Go Live date and further sessional/productivity mitigations.
External	Industrial Action (Strikes) - England	Further strike action potential for doctors and nurses impacts on ability to delivery planned activity levels with a resulting impact on pbr income.	Based on July contract performance under pbr repeating for remainder of year including consultant and junior doctor industrial action.	3054	£ 800	£ 3,080	£ 3,080	£ -	4	4	16	Engagement with local unions. Robust plans to mitigate activity loss during strike action days. Ambition to recover activity where possible later in the year. Nationally recognised issue, revised guidance on elective activity thresholds expected to be announced, this is assumed to mitigate the impact for England leaving residual risk for Wales.
External	Industrial Action (Strikes) - Wales	Welsh commissioners technically remain on pbr contract rules with no specific guidance on industrial action mitigations or ERF.	Based on July contract performance under pbr repeating for remainder of year including consultant and junior doctor industrial action.	3054	£ -	£ 1,320	£ 264	£ 1,056	4	4	16	Regular discussions with Welsh commissioners to present RJAH position and view. Escalation to NHSE regional team. Detailed ERF guidance.
Internal	Low Value Activity Block Overperformance	Low Value Activity (non contract) is funded as a block but valued at historical levels (3 year average), this doesn't adequately reflect growth in tertiary referrals for specialist work aligned to national and local strategy.	Overperformance in 22/23 was £0.5m, if this continues this will not be recognised in 23/24. Updated forecast performance for 23/24 is c£0.5m.	3052	£ 500	£ 333	£ -	£ 333	5	3	15	Look to identify offsetting non recurrent contract gains to offset potential risk. Ensure clear communication with regulator on impact.
Internal	Agency Pressures leading to breach of cap	If workforce recruitment trajectories slip there will be continued overreliance on agency to fill gaps to deliver planned activity levels.	£480k estimate based on agency premium net of vacancies. Agency forecast to deliver within cap but as this is premium cost workforce the net impact remains adverse.	3050	£ 480	£ 320	£ 170	£ 150	4	3	12	Recruitment plans linked to operational plan delivery assurance focused on RN, HCSW and consultants overseen by People Committee. Oversight through internal and external agency reduction groups led by CNO. Actions in units to target off framework agency reductions, review of processes and sign off arrangements.

Risks to the financial plan

Risk Type	Risk name	Risk Description	Estimated Value	Risk ID	Annual Risk £'000 at 1st April 2023	Forecast Risk Remainder of Year £'000	Mitigations £'000	Net Risk £'000	Liklihood	Consequence	Risk Rating	Mitigations / actions
Internal	Efficiency Programme Slippage	Challenges within STW system have led to organisations setting very ambitious efficiency plans of 3.7%, this improvement is built into the delivery of the financial plan.	20% slippage risk + further £0.6m system stretch unidentified.	2858	£ 1,441	£ 1,174	£ 613	£ 561	3	4	12	Executive review of efficiency plans at outset, where plans fall short continued escalation until 20% contingency identified. Monthly review of performance through TPOIB. Monthly assurance through FPD.
Internal	Injury Cost Recovery (ICR) / Road Traffic Accident Income (RTA) income notification reductions	Injury Cost Recovery (ICR) previously known as Road Traffic Accident (RTA) is a passive income source to the Trust linked to the treatment of patients who have been involved in a road accident. This income is unpredictable and reductions in notifcations impact the bottom line.	Value is based on income notifications and withdrawals in 23/24 which RJAH has no control of.	3084	£ -	£ 200	£ 200	£ -	3	4	12	Closely monitor income notifications and withdrawals through the ICR system ensuring prompt recognition and avoid duplications. Where possible identify non recurrent income sources to mitigate in year impact.
External	Inflationary Environment	UK RPI is still running at 10%, tariff funding has been devolved for 5.5% so potential for further pressures to arise in year if current inflationary environment continues.	Risk based on 22/23 pressure. Full evaluation at month 4 shows living within planned allowance after devolving budget for inflationary pressures.	2886	£ 400	£ 400	£ 400	£ -	4	3	12	Procurement steering group monthly review of inflation pressures. Robust management of inflation proposals from supplies and strategic use of inflation reserve. Robust negotiation of controllable costs under contracts and pricing challenges.
External	Urgent Care / System Pressures	System escalation pressures requiring Sheldon ward beds to be used for rehabilitation - this would impact on agency costs and additional income from extension of spinal injuries bed base.	Potential for £72k per month lost income from MCSI beds. Risk based on 6 month loss of capacity.	3053	£ 432	£ 432	£ 432	£ -	3	3	9	System process for RJAH involvement in escalation. System winter funding allocations.
			Total		£ 8,713	£ 10,836	£ 8,031	£ 2,805				

- Annual risks identified at £8.7m, forecast risk for remaining of year £10.8m – increase predominantly linked to increased industrial action and inclusion of consultants.
- Mitigations identified at £8.0m leaving a residual risk to plan delivery of £2.8m.
  - Industrial action Welsh impact £1.0m, mitigations include national guidance, NHSE escalation and negotiation with commissioners
  - Theatre delay £0.7m, mitigations being reviewed through additional activity
  - Efficiency programme £0.6m, mitigations include 20% overidentification of schemes, non recurrent opportunities
  - Low Value Activity £0.3m, mitigations include NHSE escalation and non recurrent benefits to offset
  - Agency pressures £0.2m, mitigations include further reduction actions from agency reduction group

Trust Board - Finance
July 2023 – Month 4

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

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

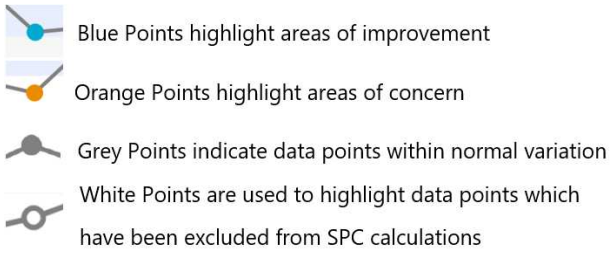
There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

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

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

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



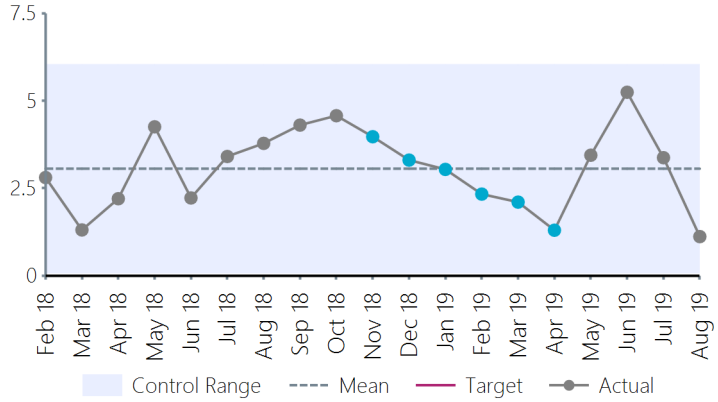
Some examples of these are shown in the images to the right:

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

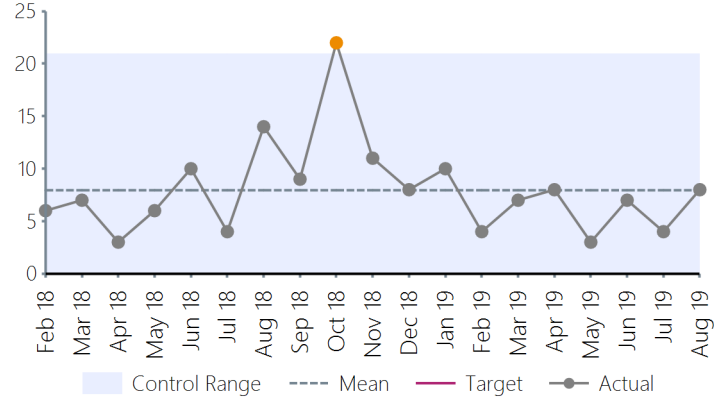
b) shows a point of concern sitting above the control range.

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.

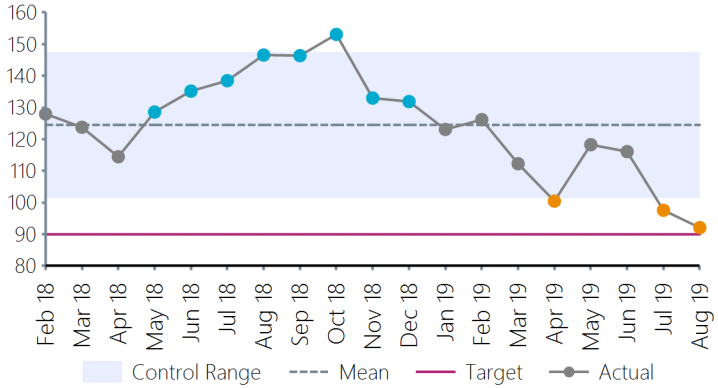
a)



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.

Data Quality Rating Reading Guide

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

Colours

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

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

Dates

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

Summary - Caring for Finances

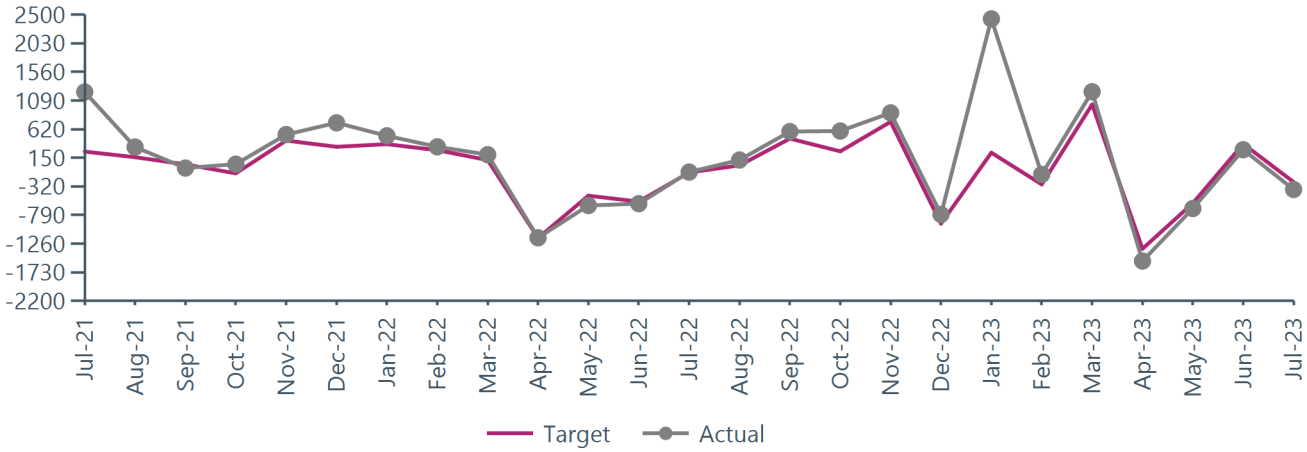
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Financial Control Total	-247	-370		N/A to SPC	Moving Target	+	
Income	11,137	11,039		N/A to SPC	Moving Target	+	
Expenditure	10,852	11,472		N/A to SPC	Moving Target	+	
Efficiency Delivered	399	380		N/A to SPC	Moving Target	+	
Cash Balance	24,052	27,056		H	Moving Target		
Capital Expenditure	692	182		N/A to SPC	Moving Target		
Value Weighted Assessment	85.20%	78.50%		N/A to SPC	Moving Target	+	

Financial Control Total

Surplus/deficit adjusted for donations 215290

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
-247	-370	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Overall £370k deficit in month, £122k adverse to plan (includes elective income adjustment of £222k in line with national guidance)

YTD £2,314k deficit, £507k adverse to plan (includes elective income adjustment of £1,112k in line with national guidance)

Actions

- Recover activity shortfall which has impacted clinical income
- NHSE standard financial controls implemented including controls on pay and non pay
- Agency reduction action plan, linked to recruitment pipeline to reduce reliance on premium pay cost

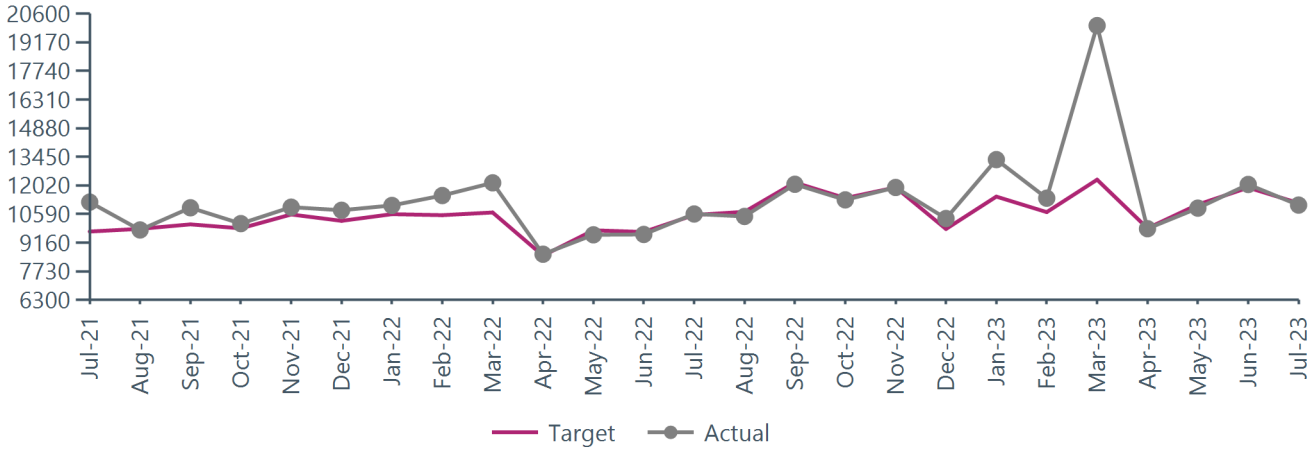
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
-84	114	581	590	888	-780	2431	-122	1236	-1545	-682	283	-370

Income

All Trust Income, Clinical and Non-Clinical 216333

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
11,137	11,039	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Clinical Income £344k adverse (excluding pass through) driven by:
- Theatres £637k (145 case shortfall)
- Outpatients £127k

Offset by:
- MCSI including Sheldon beds £157k
- Elective income adjustment to plan (in line with national guidance) £222k

- Private Patient income favourable - activity driven

Actions

Escalate Low Value Activity block funding as an issue with NHSE
Activity recovery plans inpatients and outpatients
Confirm treatment of elective income for M1-4 through national guidance

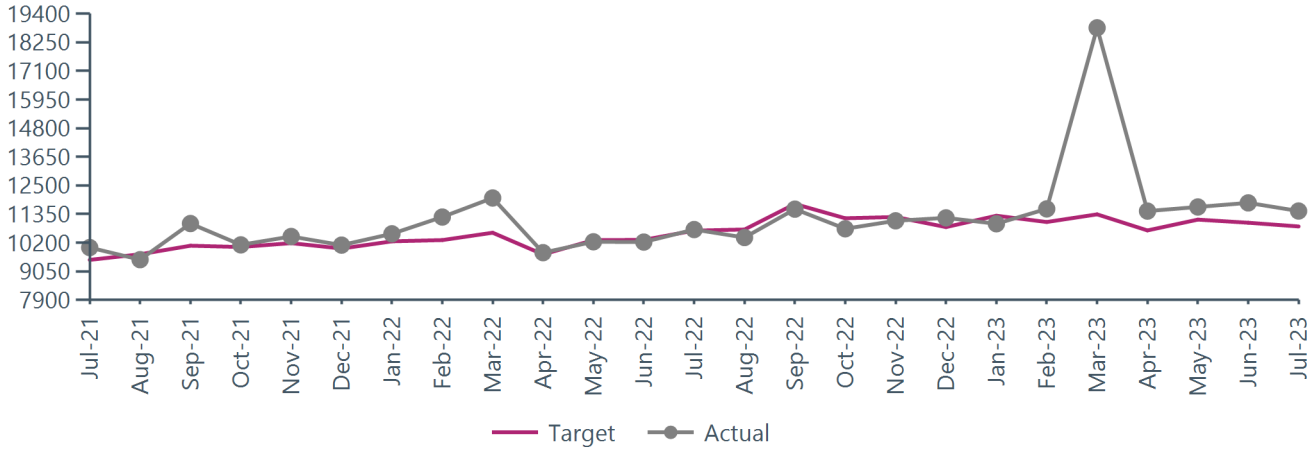
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
10594	10471	12079	11299	11918	10368	13312	11383	20006	9859	10886	12069	11039

Expenditure

All Trust expenditure including Finance Costs 216334

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
10,852	11,472	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Expenditure £25k adverse (excluding pass through),

- Pay pressures of £96k arising from MCSI volumes and 1-2-1 care, Sheldon Ward agency and Theatres super nummary staff.
- Non Pay £72k favourable as a result of reduced implants offset by higher consumable costs and OJP

Actions

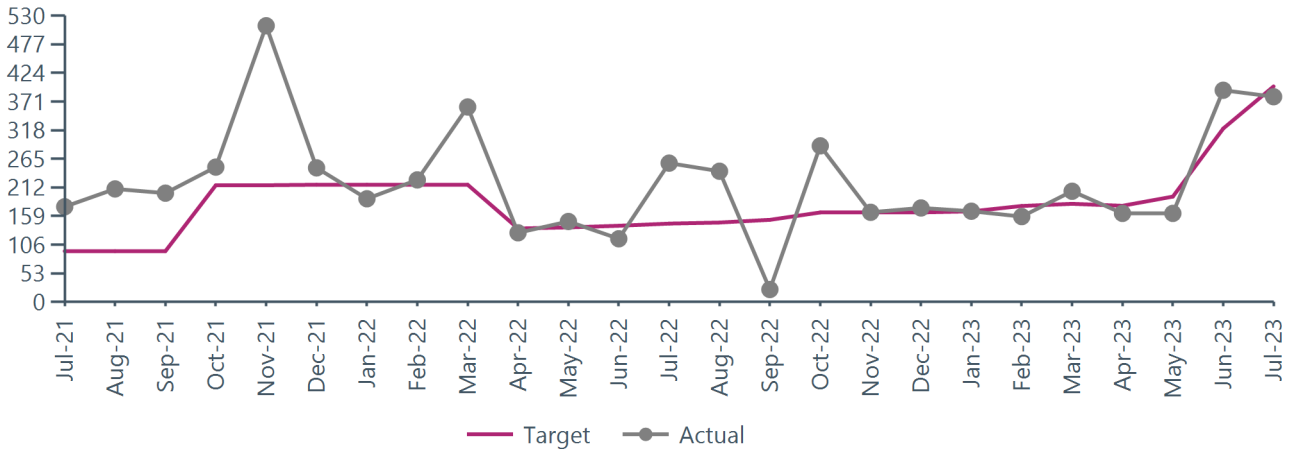
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
10728	10407	11548	10759	11080	11197	10960	11558	18833	11469	11635	11800	11472

Efficiency Delivered

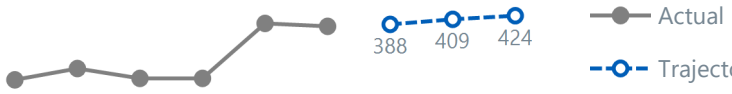
Efficiency requirements 215298

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
399	380	N/A to SPC	Moving Target



Trajectory



What these graphs are telling us

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

Narrative

3.5% efficiencies achieved in month against a phased plan of 3.7%.

Actions

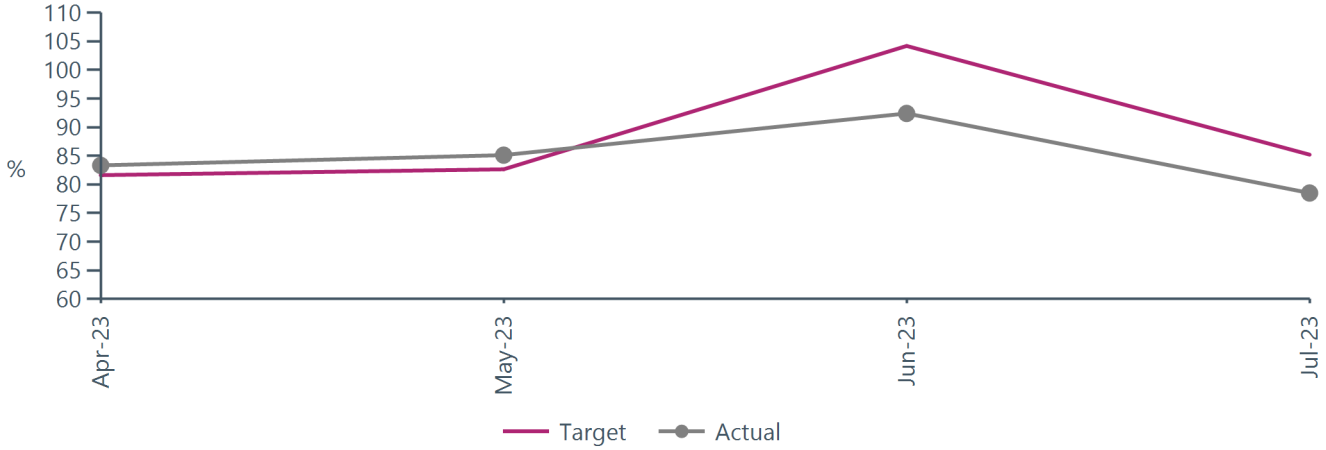
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
257	242	23	289	166	174	168	158	205	164	164	392	380

Value Weighted Assessment

Relative value in pounds (£) of patient activity from the 2019/20 baseline to the 2023/24 actual delivery (English only) 217818

Exec Lead:
Chief Finance and Planning Officer

Target/Plan	Latest Value	Variation	Assurance
85.20%	78.50%	N/A to SPC	Moving Target



Trajectory

What these graphs are telling us

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

Narrative

Adverse to plan ytd, M4 theatre performance impact

Actions

Recover activity shortfall

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
									83.33%	85.12%	92.40%	78.50%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Finance, Performance and Digital Committee

0. Reference Information

Author:	Mary Bardsley, Assistant Trust Secretary	**Paper date:**	06 September 2023
Executive Sponsor:	Craig Macbeth, Chief Finance and Planning Officer	**Paper written on:**	22 August 2023
Paper Reviewed by:	Sarfraz Nawaz, Committee Chair	**Paper Category:**	Governance
Forum submitted to:	Board of Directors – Public	**Paper FOIA Status:**	Full

1. Purpose of Paper

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

This is an assurance report from the Finance, Performance and Digital Committee. The Board is asked to consider the recommendations of the Finance, Performance and Digital Committee.

2. Context

2.1 Context

The Trust Board has established a Finance, Performance and Digital Committee. According to its terms of reference: *"The Board of Directors has delegated responsibility for the oversight of the Trust's financial performance to the Finance, Performance 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."*

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Finance, Performance and Digital Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

3. Assurance Report from Finance, Performance and Digital Committee

This report provides a summary of the items considered at the Finance, Performance and Digital Committee on 17 August 2023. It highlights the key areas the Finance, Performance and Digital Committee wishes to bring to the attention of the Board.

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The Finance, Performance and Digital Committee wishes to bring the following issues to the Board's attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Board for work to progress.

Activity Mitigations

The Committee were reassured following discussion relating to the planned step changes which are required to meet the operational plan target however, with the reporting of the underperformance from previous months the Committee asked for further assurance particularly in respect of the assumptions regarding extended days and five joint lists. Excluding Industrial Action, the Trust is forecasting to be 499 cases down against the operational plan. The implementation of mitigations is expected to recover 233 cases leaving a total of 266 cases unmitigated The Trust is to consider additional Sunday working for the remainder of the year so as to utilise the workforce built for the

delayed additional Theatre. The Committee were keen for a progress update to be given at next Board.

Financial Performance Report
The Committee were informed of the following:

- Trust fell further behind plan in month by £122k and is now £507k off plan year to date
- The English elective income has once again been accrued to plan up to July in line with national guidance. and this is partially mitigating the impact of activity shortfalls.
- Further guidance in respect of revised ERF baselines is expected to be applied from August.
- The Trust are forecasting to be £0.7m adverse to plan after the application of mitigations identified to date
- There is further risk of £2.1m not included in the forecast
- The mitigation being worked up for the 266 activity shortfall is expected to offset the current forecast gap but further mitigations will be required to offset the risk.

Terms of Reference
Following a review of the Committee membership, the terms of reference were considered and supported by the Committee subject to amendments noted with in the meeting. The Committee noted that the digital agenda items will be aligned to the new Digital, Education, Innovation and Research Committee (DERIC).
The Committee recommends the Board approves the revised terms of reference for the Finance and Performance Committee.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Finance, Performance and Digital Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Corporate Risk Register
The Committee received the revised Corporate Risk Register along with assurance relating to the review and reporting process of risks. To accommodate further progress and assurance, the Committee suggested the following information is incorporated into the register; last review date, future review date and risk owner.

Performance Report (OPOD)
The Committee were assured with the actions being implemented to improve the Trusts performance. Further analysis is required to present the difference between in job plan and out of job plan data to offer the Committee clarity on the figures.

Agency Oversight- Insourcing Action Plan
The Committee gained oversight on the action plan submitted to NHSE in respect of Insourcing costs It was noted that the plan is a live document which is regularly updated. The action plan is shared with the ICS forum to present assurance on the current status of the Trust actions and strategy to reduce usage. The Trust confirmed oversight of core agency is undertaken by the People and Culture Committee.

3.3 Areas of assurance

ASSURE - The Finance, Performance and Digital Committee considered the following items and did not identify any issues that required escalation to the Board.

Theatre Improvement Work
The Committee commended the improvement work being implemented within the department. Updates were received on initiatives including, 6-4-2, GIRFT, super lists, alignment to NHSE and the system as well as benchmarking theatre sessions times. The Committee requested that owners and timelines be added to the plan given the urgency to get Theatre activity back on track.

Chairs Assurance Reports

The Committee noted the following chair reports and comments:

- Trust Performance and Operational Improvement Group – no concerns were raised.
- Capital Management Group – no concerns were raised.
- MSK Committee (STW) – assurance was given that some of the alerts presented were aligned to the Integrated Deliver Meeting withing the System and not the Trust.

4.0 Conclusion / Recommendation

The Board is asked to:

1. CONSIDER the content of section 3.1 and agree the next steps.
2. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
3. NOTE the content of section 3.3.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Terms of Reference (~~May~~ Aug 2023)
Finance and Performance ~~and Digital~~ Committee

1. Constitution

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

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors (including the Associate Non-Executive Directors) and the Executive Directors of the Trust and shall consist of:

- Up to four Non-Executive members
- Chief Finance and Planning Officer
- Chief Operating Officer
- ~~Chief Medical Officer~~

Non-Executive members may be drawn from the Non-Executive Director membership of the Board or the Associated Non-Executive Directors.

In exceptional circumstances a deputy may attend in place of an Executive Director. The nominated deputy can act on behalf of the absent Executive Director. This is to be noted at the beginning of the meeting.

The Board of Directors will appoint a Committee Chair from the Non-Executive members of the Committee In the absence of the appointed Chair, the Committee will appoint another Non-Executive member to chair the meeting.

A quorum will be two Non-Executive members and two Executive Directors. Deputies representing Executive members will count towards the quorum but at least one of the Executive members must be drawn from the listed membership.

3. Attendance

Other Executive Directors and Managing Directors will be required to attend when appropriate.

The Trust Secretary, Managing Director for Planning and Strategy, Performance Insight and Improvement Manager~~,~~ and Operational Director of Finance ~~and Director of Digital~~ will attend each meeting.

An open invitation is extended to the Council of Governors, who are invited to attend as an observer only. The Governors will have the opportunity to feed back any comments under the Any Other Business agenda item.

The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Chief Executive Officer will receive a standing invitation to attend.

4. Frequency of Meetings and meeting administration

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

When appropriate Committee meetings will take place virtually, in line with the virtual board good governance guidance.

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

5. Authority

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

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

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

6. Reporting

A written Chair's Assurance Report will be presented to the Board no later than the Board meeting the following month (or the soonest available meeting if a Board meeting does not fall that month). The Chair's Report shall:

1. Alert the Board to any issues that:
   - Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address; OR
   - Require the approval of the Board for work to progress.
1. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
2. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

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

7. Key Responsibilities

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

<u>Strategy</u>

- To consider and approve the key planning and financial assumptions to be used in the five-year strategy and annual operational plan.
- Oversight of strategic issues related to income e.g., changes to tariff, commissioning intentions, tendering for new services, risks from competition and market share.
- To consider recommendations of investment and disinvestment of Trust sub-specialty / service reviews ensuring strategic steer in keeping with the Trust strategy and objectives.
- Capital planning oversight, ensuring forward planning, regular review and recommendations including acquisitions and disposal of assets, in line with the Trust strategy and objectives.
- To consider, evaluate and if appropriate recommend for Board approval commercial developments and partnerships opportunities in keeping with the Trust strategy and objectives.

- To consider and recommend Board approval of material business cases as defined by the Trust SFI's (currently investments above c£250k)
- Consider post project evaluation reports on significant capital investments. This will include all schemes over £250k and other schemes which are considered to represent a significant risk to the Trust.
- ~~To consider and recommend Board approval of the Trust's Digital Strategy~~
- ~~Oversight of the Trust's digital risks~~

Oversight and Scrutiny

- Receive regular reports on financial performance including the overall financial performance against plan and associated risk rating, performance of Capital programme and the performance of activity against contract
- To evaluate progress and recommend further actions from the review of in year financial, CIP, activity, RTT and productivity performance information, including SLR review
- Review the Trust's investment register of cash investment as required
- To evaluate progress of service transformation and investment plans, ensuring establishment of models of best practice in line with the Trust strategy.
- Promoting sustainability and receiving sustainability KPIs
- To receive routine Chairs' Assurance Reports from meetings that report into the Committee, as appropriate.
- Receive relevant internal audit reports.
- To provide oversight in respect of all aspects of business planning, partnerships, and development.
- To provide oversight to the Trust annual plan and its subsequent delivery.
- ~~To oversee the delivery of the Trust's digital strategy~~
- To receive deep dives for scrutiny and further assurance into key performance areas. At the time of the meeting, the Committee will decide which deep dive will be presented at the following meeting.

Policies/Strategies

- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.
- Review progress made in delivering key enabling strategies such as (but not limited to) Estates~~,~~ and Procurement~~, and Digital Services~~ raising any significant risks regarding their delivery to the Board.